WORLD HEALTH ORGANIZATION

FIFTY-FOURTH
WORLD HEALTH ASSEMBLY

GENEVA, 14-22 MAY 2001

SUMMARY RECORDS OF COMMITTEES
AND MINISTERIAL ROUND TABLES
REPORTS OF COMMITTEES

GENEVA
2001
FIFTY-FOURTH
WORLD HEALTH ASSEMBLY

GENEVA, 14-22 MAY 2001

SUMMARY RECORDS OF COMMITTEES
AND MINISTERIAL ROUND TABLES
REPORTS OF COMMITTEES

GENEVA
2001
ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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<td>ACC</td>
<td>Administrative Committee on Coordination</td>
</tr>
<tr>
<td>ACHR</td>
<td>Advisory Committee on Health Research</td>
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<tr>
<td>ASEAN</td>
<td>Association of South-East Asian Nations</td>
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<tr>
<td>CIOMS</td>
<td>Council for International Organizations of Medical Sciences</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
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<td>IAEA</td>
<td>International Atomic Energy Agency</td>
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<td>IARC</td>
<td>International Agency for Research on Cancer</td>
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<td>ICAO</td>
<td>International Civil Aviation Organization</td>
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<tr>
<td>IFAD</td>
<td>International Fund for Agricultural Development</td>
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<td>ILO</td>
<td>International Labour Organization (Office)</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>IMO</td>
<td>International Maritime Organization</td>
</tr>
<tr>
<td>ITU</td>
<td>International Telecommunication Union</td>
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<td>OAU</td>
<td>Organization of African Unity</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNCTAD</td>
<td>United Nations Conference on Trade and Development</td>
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<tr>
<td>UNDCP</td>
<td>United Nations International Drug Control Programme</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNEP</td>
<td>United Nations Environment Programme</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>Office of the United Nations High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNIDO</td>
<td>United Nations Industrial Development Organization</td>
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<tr>
<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine Refugees in the Near East</td>
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<td>WFP</td>
<td>World Food Programme</td>
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<td>WIPO</td>
<td>World Intellectual Property Organization</td>
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<td>WMO</td>
<td>World Meteorological Organisation</td>
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<td>WTO</td>
<td>World Trade Organization</td>
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The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.
The Fifty-fourth World Health Assembly was held at the Palais des Nations, Geneva, from 14 to 22 May 2001, in accordance with the decision of the Executive Board at its 106th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

- Resolutions and decisions, annex – document WHA54/2001/REC/1
- Verbatim records of plenary meetings, list of participants – document WHA54/2001/REC/2
- Summary records of committees and ministerial round tables, reports of committees – document WHA54/2001/REC/3
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MEMBERSHIP OF ITS COMMITTEES

President
Dr HONG Sun Huot (Cambodia)

Vice-Presidents
Dr A.M. KASI (Pakistan)
Mrs M. ARGUELLO (Nicaragua)
Mr P.J.E. TAPSOBA (Burkina Faso)
Dr I.B. ZELENKEVICH (Belarus)
Mr Ri Tcheul (Democratic People’s Republic of Korea)

Secretary
Dr Gro Harlem BRUNDTLAND, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Austria, Bangladesh, Bosnia and Herzegovina, Liberia, Libyan Arab Jamahiriya, Luxembourg, Malaysia, Mozambique, Paraguay, Saint Kitts and Nevis, Syrian Arab Republic, Uganda.

Chairman: Dr A.S.M. MUSHIOR RAHMAN (Bangladesh)
Vice-Chairmen: Dr M. FIKRI (United Arab Emirates) and Dr C.T. OTTO (Palau)
Rapporteur: Dr N.S. BARTEE (Liberia)
Secretary: Mr T.S.R. TOPPING, Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Argentina, Belize, Chad, China, Costa Rica, Croatia, Democratic People’s Republic of Korea, Ecuador, Eritrea, France, Gambia, Guinea, Israel, Jordan, Malta, Nepal, Nigeria, Papua New Guinea, Qatar, Russian Federation, Sudan, United Kingdom of Great Britain and Northern Ireland, Vanuatu, Venezuela, and Dr L. Amathila, Namibia (President, Fifty-third World Health Assembly, ex officio).

Chairman: Dr L. AMATHILA (Namibia)
Secretary: Dr Gro Harlem BRUNDTLAND, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Bahrain, Bhutan, Bolivia, China, Cuba, Democratic Republic of the Congo, Dominica, France, Guinea-Bissau, Iran (Islamic Republic of), Japan, Mali, Niger, Russian Federation, Sweden, United Kingdom of Great Britain and Northern Ireland, United States of America.

Chairman: Dr HONG Sun Huot (Cambodia)
Secretary: Dr Gro Harlem BRUNDTLAND, Director-General

MAIN COMMITTEES

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

Committee A

Chairman: Professor S.K. ONGERI (Kenya)
Vice-Chairmen: Dr M. FIKRI (United Arab Emirates) and Dr C.T. OTTO (Palau)
Rapporteur: Mrs L. POPESCU (Romania)
Secretary: Dr S. HOLCK, Director, Health Information Management and Dissemination
Committee B

**Chairman:** Mr D.Á. GUNNARSSON  
(Iceland)

**Vice-Chairmen:** Dr M. DAHL-REGIS  
(Bahamas) and Dr PAKDEE POTHISIRI  
(Thailand)

**Rapporteur:** Dr J.M. KUNENE (Swaziland)

**Secretary:** Dr M. KARAM, Strategy Development and Monitoring for Eradication and Elimination
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5. [deleted]

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13. Technical and health matters
   13.1 Global strategy for infant and young child feeding
   13.2 Health promotion
   13.3 Communicable diseases
      • Global health security: epidemic alert and response
      • Control of schistosomiasis
   13.4 Strengthening health services delivery
      • Strengthening nursing and midwifery
      • Strengthening health systems in developing countries
   13.5 Tobacco control
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      • Other activities
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   15.3 Special arrangements for settlement of arrears
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   16.4 Appointment of representatives to the WHO Staff Pension Committee

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

18. Collaboration within the United Nations system and with other intergovernmental organizations
   • International Decade of the World's Indigenous People

19. Use of languages in WHO

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A54/37 Proposed programme budget for 2002-2003: fourth report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-fourth World Health Assembly

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Diverse

A54/DIV/4 and Corr.1  Ministerial round tables
A54/DIV/6  Open letter from the Director-General to the Heads of delegations
A54/DIV/7  Implementation of resolution EB107.R8, Health systems' performance assessment
A54/DIV/8  Round tables: mental health
PART I

SUMMARY RECORDS OF MEETINGS OF COMMITTEES
GENERAL COMMITTEE
FIRST MEETING
Monday, 14 May 2001, at 12:00
Chairman: Dr HONG Sun Huot (Cambodia)
President of the Health Assembly

1. ADOPTION OF THE AGENDA (Document A54/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 33 of the Rules of Procedure of the Health Assembly, its first task was to consider item 1.4 (Adoption of the agenda and allocation of items to the main committees) of the provisional agenda, which had been prepared by the Executive Board and issued as document A54/1. The Committee would also consider proposals for the addition of two supplementary agenda items, the allocation of items of the agenda to the main committees and the programme of work of the Health Assembly.

Deletion of agenda items

The CHAIRMAN indicated that, if there was no objection, one item on the provisional agenda would be deleted, namely, item 5 (Admission of new Members and Associate Members).

It was so agreed.

2. PROPOSED SUPPLEMENTARY AGENDA ITEMS (Documents A54/GC/2 and A54/GC/3)

First proposed supplementary agenda item

The CHAIRMAN drew the Committee's attention to a proposal for inclusion of a supplementary agenda item, in accordance with Rule 12 of the Rules of Procedure of the Health Assembly, from the governments of Panama, Palau, Sao Tome and Principe, El Salvador, Honduras, Paraguay and Dominican Republic, "Invitation to the Republic of China (Taiwan) to participate in the World Health Assembly as an observer". He added that the Director-General had received a joint letter from the Ambassadors of the Permanent Missions in Geneva of the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua and Panama, as well as a letter from the Permanent Representative of Fiji to the United Nations in New York, supporting such participation. The Chairman noted that the same proposal had been made at several previous Health Assemblies and each time had been rejected.

1 Contained in document A54/GC/2.
The delegate of CHINA strongly opposed the proposal regarding Taiwan's participation in the Health Assembly as an observer. The rejection in each of the previous four years of similar proposals could be taken as evidence that most Member States of WHO were opposed to the idea.

She recalled that in 1971 the United Nations General Assembly had adopted resolution 2758(XXVI) and in 1972 the Health Assembly had adopted resolution WHA25.1, which had once and for all resolved the issue of the representation of China in both the United Nations and WHO. Taiwan, as a province of China, was not entitled to participate in WHO activities in any manner or to attend the Health Assembly under any name. Proposals for its participation in the Health Assembly were legally groundless.

The question of Taiwan was entirely an internal affair and had to be resolved by the Chinese people themselves. No foreign country had the right to meddle or interfere. Any proposal to include Taiwan in WHO activities for whatever reason or under whatever name was politically motivated with the aim of creating “two Chinas” or “one China, one Taiwan”. Such an act constituted an encroachment on China's sovereignty and territorial integrity and was an intolerable interference in its internal affairs. The Chinese Government had always attached great importance to protecting the legitimate rights and interests, including health, of its compatriots in Taiwan. It was ready to seek a negotiated settlement on relevant issues, including those related to health, through the proper channels and to make appropriate arrangements for cross-strait exchanges in the field of health, provided that the Taiwan authorities desisted from their wrongful attempt to create “two Chinas” or “one China, one Taiwan” in the international arena and committed themselves to the reunification of China. To show their concern for the health of the people of Taiwan, countries should work in the interests of Chinese reunification. She therefore maintained that the proposal for the inclusion of the supplementary agenda item should be rejected.

The observer of HONDURAS strongly supported the proposal for addition of the supplementary agenda item. He firmly believed that Taiwan, with its 23 million people, should not continue to be cut off from the services of WHO. It had demonstrated its vast experience in the field of health and its sincere wish to collaborate closely with the Member States of WHO, particularly those most in need. Everyone knew of Taiwan's humanitarian credentials and its unconditional support to developing countries, the poorest nations, and countries in transition, through its programme of humanitarian, technical and financial assistance. It was neither just nor humane to continue to deprive Taiwan of the right to be an observer.

He deplored the attempt to distort the good intentions of the authors of the proposal for political motives. For humanitarian reasons, he called on all the Member States of WHO to endorse the proposal to accept Taiwan as an observer in the present and future Health Assemblies. He expressed the hope that the initiative would be supported by all nations committed to the spirit, principles and universal vocation of WHO.

The delegate of CUBA recalled that the international community had long recognized the People’s Republic of China as the legitimate representative of all the Chinese people, as demonstrated by previous resolutions adopted by the United Nations and the Health Assembly. Despite the claims made by certain Member States that the situation of the territory had changed, the issue of Taiwan continued to be a matter that should not be addressed by the Health Assembly, as it undoubtedly constituted an internal policy issue concerning an inalienable part of the country that only the People and Government of China could resolve. Any initiative to invite Taiwan to be an observer therefore constituted interference by the Health Assembly in the internal affairs of China.

The internationally recognized health system in China was expanding rapidly, contributing not only to the well-being of the Chinese people, but also to the improvement of health conditions elsewhere. It was admired internationally as an example for developing countries. WHO was a

1 Attending under Rule 31 of the Rules of Procedure.
specialized agency of the United Nations in which sovereign states could be represented; the proposal to invite Taiwan to participate in the Health Assembly as an observer was therefore inappropriate.

The delegate of the RUSSIAN FEDERATION, citing the constitutional documents and instruments of the United Nations and its specialized agencies, opposed the participation of Taiwan in the Health Assembly in any capacity and the proposal to place the item on the agenda.

The Vice-President of the Health Assembly, speaking in his capacity as delegate of PAKISTAN, expressed regret that the attention of the Health Assembly was being diverted from its core function by yet another proposal to grant Taiwan observer status. The Health Assembly was not mandated to discuss political issues, and could not take any decision that impinged on the unity and territorial integrity of any Member State. The issue of the representation of the People's Republic of China had been settled by the United Nations General Assembly, and Taiwan's status as a province of that country was recognized in international law; a province or part of a Member State could not seek separate status in any intergovernmental organization. The people of Taiwan would benefit from the work and programmes of WHO once Taiwan and China were unified.

Acceptance of the proposal would set a dangerous precedent that could pave the way for other separatist attempts in the future and threaten the unity and territorial integrity of every Member State of the United Nations and WHO, including those States that had submitted the proposal. The Committee should therefore reject the proposal without further discussion.

The delegate of the DEMOCRATIC REPUBLIC OF THE CONGO also expressed concern about setting a dangerous precedent. His country, divided by an unjust war of aggression, could not accept such a proposal.

The delegate of DOMINICA, supporting the proposal, cited the humanitarian services provided by Taiwan to many developing countries. The international community could not continue to deny Taiwan the right to health or the benefits of participation in the Health Assembly.

The delegate of BHUTAN said that, in considering any proposal for participation, the Committee should be guided by United Nations General Assembly resolution 2758(XXVI) on the representation of China.

The Vice-President of the Health Assembly, speaking in his capacity as delegate of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA, supported the position of the People's Republic of China in opposing the proposal.

The Vice-President of the Health Assembly, speaking in her capacity as delegate of NICARAGUA, fully supported the statement by the observer of Honduras and, as in previous years, strongly supported the participation of Taiwan as an observer. Firmly upholding the basic principles of the Constitution of WHO, she observed that Taiwan, which had a democratic government, had overcome enormous difficulties to become an increasingly developed nation and had formed political and economic ties with most countries participating in the Health Assembly. It deserved the opportunity to cooperate with the international community particularly in a matter as universal as health.

Taiwan had provided constant support to Nicaragua particularly in the form of humanitarian and medical assistance in connection with the crises of recent years. It was contrary to the goals of WHO to allow Taiwan's population to be marginalized. The United Nations Secretary-General had stated that unless the rights of the individual were respected, no nation, community or society could be truly free. She therefore urged the Committee to support the proposal, so that it could be said in the near future that health really was for all.
The Vice-President of the Health Assembly, speaking in his capacity as delegate of BURKINA FASO, emphasized that health problems, which knew no boundaries, were more important than issues of law and interference in the internal affairs of countries. If an epidemic broke out in Taiwan, it would be normal for WHO to be able to provide support to prevent its spread there and to other countries. Moreover, WHO should be able to benefit from the research carried out in Taiwan. He therefore firmly supported the proposal.

The observer of BANGLADESH recalled that the previous United Nations General Assembly and Health Assembly resolutions clearly established the representation of China. Moreover, the Constitution of WHO and the Rules of Procedure of the Health Assembly permitted only a sovereign state to apply for observership. The situation had not changed since previous years, when similar proposals had been rejected by the Committee. Based on his belief in the “one China” policy, he opposed the proposal.

The observer of MEXICO, expressing support for the sovereignty and territorial integrity of China, said that the proposal was not in the interests of WHO. There was no justification for reviewing the relevant resolutions adopted by the United Nations General Assembly and the Health Assembly. She therefore urged the Committee to reject the proposal. Those views were endorsed by the observer of NEPAL.

The CHAIRMAN, concluding that the Committee was not in favour of the proposal to include a supplementary agenda item to invite the Republic of China (Taiwan) to participate in the Health Assembly as an observer, proposed that a recommendation should be made to that effect to the Health Assembly at its plenary meeting to discuss adoption of the agenda.

It was so agreed.

Second proposed supplementary agenda item

The CHAIRMAN drew the Committee’s attention to a proposal for inclusion of a supplementary agenda item from the Government of Pakistan, “Effective functioning of the governing bodies of WHO”. The Vice-President of the Health Assembly, speaking in his capacity as delegate of PAKISTAN, said that his country believed that the Health Assembly, as the principal organ of the Organization, should keep under constant consideration its own functioning and that of the Executive Board in order to ensure that both performed the roles assigned to them in the Constitution. The effectiveness of both bodies was diminishing each year; the existing Rules of Procedure made it difficult for Member States to follow their proceedings. Since Pakistan had not been a member of the Executive Board at the time, it had been unable to make any proposal when the Board had discussed the draft agenda of the Health Assembly at its 107th session. The Rules of Procedure of the Board allowed limited participation by Member States not represented. He suggested that the Health Assembly might also examine, under the same item of the agenda, the working methods of the Board with a view to making them more participatory.

The delegate of CHINA, commenting that all Member States of WHO were equal, said that equal participation and democratic decision-making were basic principles governing the actions of WHO and an important reason for WHO’s long and positive role in the field of health globally. It was

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1 Attending under Rule 31 of the Rules of Procedure.
2 Contained in document A54/GC/3.
vital to ensure that the Executive Board, as the executive organ of the Health Assembly, reflected the views of Member States, democratically and transparently, to enable the Organization to discharge its responsibilities. She therefore supported the proposal by Pakistan.

The delegate of FRANCE observed that the Board had demonstrated in recent years that it was indeed capable of change. Radical changes in the way the governing bodies functioned could mean changes in the Rules of Procedure or even the Constitution, which might be unwarranted. The Committee should consider carefully the wisdom of adding an item of such scope and importance, which would need extensive discussion, to an already heavy agenda. Instead, he suggested that the item should be placed on the agenda of the 108th session of the Executive Board.

The delegate of the UNITED STATES OF AMERICA endorsed the suggestion of the previous speaker, adding that, as the matter of concern appeared to be the effective functioning of the Executive Board, it should be the prerogative of the Board to consider the subject first.

The delegate of PAKISTAN explained that experience of the 107th session of the Board, when many Member States had found themselves unable to express their views democratically, had led to the proposal before the Committee. After consultations, his delegation had concluded that its concern about the poor functioning of the Board and Health Assembly, acknowledged by the delegates of France and the United States of America, was shared by many Member States, especially those currently not entitled to designate a person to serve on the Executive Board. It was not for the Executive Board, but the Health Assembly, as the parent body in which all WHO Member States were represented, to consider the issue and reach its conclusions in a participatory and democratic way.

The delegate of FRANCE emphasized that his objection concerned the means and not the end. It would be inappropriate to mete out cursory treatment to a subject as important as a review of working methods, and unfair to those who desired change. He requested clarification on whether the General Committee was able to express the wish that the Executive Board should set up an open-ended working group to review its methods of work. Such a group would have sufficient time before the 109th session of the Board in January 2002 to come up with sound proposals.

The delegate of CUBA felt that the issue was so complex that it should be considered by the maximum number of participants possible.

The LEGAL COUNSEL said that the General Committee could make recommendations to the plenary on whether to include supplementary items on the agenda, and that it could put forward suggestions for future procedure. The recommendations of the General Committee would then appear in the verbatim record of the plenary meeting. It was open to question whether the plenary, on the basis of a recommendation by the General Committee, would make a binding decision to refer the matter to the Executive Board if the item was not on the agenda of the Health Assembly.

The delegate of PAKISTAN observed that the Committee appeared to acknowledge a problem that needed to be addressed. As that problem affected all Members of WHO, it should be debated by the entire membership at the Health Assembly, which should be able to reach a decision, even given the limited time, to initiate a process of reform within the Organization. His delegation was open to any suggestions, including the alternative put forward by the delegate of France, in the context of the proposed supplementary agenda item.
The CHAIRMAN, concluding that the Committee was in favour of the proposal to include on the agenda of the Health Assembly a supplementary item, "Effective functioning of the governing bodies of WHO", proposed that a recommendation to that effect should be made to the Health Assembly at its plenary meeting that afternoon.

It was so agreed.

3. ALLOCATION OF ITEMS TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY (Documents A54/1 and A54/GC/1)

The CHAIRMAN noted that the Committee's recommendation on item 1 would be transmitted to the next plenary meeting. Items 2 to 4 and 6 to 9 would be taken up in plenary.

With regard to item 10 (Round tables: mental health) four concurrent round tables had been proposed. Each would be considered as a separate committee of the Health Assembly with membership limited to those ministers of health or delegates designated to represent ministers of health who had registered for participation. All other delegations, representatives of Associate Members and observers, including members of the delegation of the ministers of health participating in the round table, could attend as observers. The purpose of the round tables was to exchange views; there was no mandate to adopt resolutions. One of the chairmen of the round tables would submit an oral summary of the discussions to the Health Assembly in plenary. He proposed the following ministers of health as chairmen of the four round tables: Mr P. Goddard (Barbados), Mr L.S. Ngedup (Bhutan), Mrs A. King (New Zealand) and Professor M.E. Chatty (Syrian Arab Republic).

It was so agreed.

The CHAIRMAN took it that the Committee wished to recommend to the Health Assembly the acceptance of the allocation of the items to the main committees as set out in the provisional agenda. He drew attention to the preliminary timetable prepared by the Executive Board, and proposed that the supplementary agenda item, "Effective functioning of the governing bodies of WHO", should be allocated to Committee B.

It was so agreed.

The General Committee then drew up the programme of work of the Health Assembly until Wednesday, 16 May.

The CHAIRMAN reminded the Committee that its next meeting would be held on Wednesday, 16 May at 17:30. He drew attention to decision EB107(3) to the effect that the Fifty-fourth World Health Assembly should close no later than Tuesday, 22 May.

The meeting rose at 13:30.

1 Document A54/GC/1.
1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD

The CHAIRMAN reminded members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and by Rule 102 of the Rules of Procedure of the Health Assembly. To help the General Committee in its task, three documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 12 Members whose term of office would expire at the end of the Fifty-fourth World Health Assembly and which had to be replaced. The second tabulated, by region, Members of the Organization which were or had been entitled to designate persons to serve on the Executive Board. Vacancies, by region, were: Africa, 2; the Americas, 3; South-East Asia, 1; Europe, 2; the Eastern Mediterranean, 2; and the Western Pacific, 2. The third document contained a list of the 12 Members that it was suggested should be entitled to designate a person to serve on the Executive Board.

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

There being no objection he concluded that it was the Committee's decision, in accordance with Rule 102 of the Rules of Procedure, to transmit a list comprising the names of the following 12 Members to the Health Assembly, for the annual election of Members entitled to designate a person to serve on the Executive Board: Colombia, Cuba, Egypt, Eritrea, Ethiopia, Grenada, Kazakhstan, Myanmar, Philippines, Republic of Korea, Saudi Arabia and United Kingdom of Great Britain and Northern Ireland. The list would be transmitted to the Health Assembly.

It was so agreed.

The delegate of FRANCE asked why there had been 12 vacancies when, on the basis of a third of the membership of the Executive Board of 32, there should have been 11.

The LEGAL COUNSEL responded by referring to the expansion of the membership of the Board from 31 to 32 Members (resolution WHA39.6) and the timing of that amendment coming into force.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The General Committee heard reports from Professor ONGERI (Kenya), Chairman of Committee A, and Mr GUNNARSSON (Iceland), Chairman of Committee B, on the progress of work in their committees.
The CHAIRMAN proposed to review progress of work with the Chairmen of the committees and to revise the programme accordingly, if necessary.

It was so agreed.

The General Committee then drew up the programme of meetings for Thursday, 17 May, Friday, 18 May, Saturday, 19 May, Monday, 21 May and Tuesday, 22 May.

3. CLOSURE

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

The meeting rose at 17:55.
 COMMITTEE A  
 FIRST MEETING  
 Tuesday, 15 May 2001, at 14:45  
 Chairman: Professor S.K. ONGERI (Kenya)  

1. OPENING OF THE COMMITTEE: Item 11 of the Agenda (Document A54/1 Rev.1)  

The CHAIRMAN expressed his gratitude at having been elected and promised to guide the deliberations of the Committee in as friendly, constructive and efficient a manner as possible. He welcomed the representatives of the Executive Board assigned to Committee A, Dr G. Thiers and Dr D. Bodzongo.  

Election of Vice-Chairmen and Rapporteur (Document A54/41)  

The CHAIRMAN drew the Committee’s attention to the third report of the Committee on Nominations (document A54/41), in which Dr M. Fikri (United Arab Emirates) and Dr C.T. Otto (Palau) had been nominated as Vice-Chairmen of Committee A and Mrs L. Popescu (Romania) as Rapporteur.  

**Decision:** Committee A elected Dr M. Fikri (United Arab Emirates) and Dr C.T. Otto (Palau) as Vice-Chairmen and Mrs L. Popescu (Romania) as Rapporteur.  

2. ORGANIZATION OF WORK  

The CHAIRMAN suggested that the Committee’s hours of work should be from 9:00 to 12:30, and from 14:30 to 17:30. He called upon delegates to take their seats promptly so that it was clear when the necessary quorum had been obtained. He asked them to limit their statements to three minutes whenever possible.  

**It was so agreed.**  

The CHAIRMAN drew the Committee’s attention to item 13 of the agenda, entitled “Technical and health matters”, which it would be discussing later in the session. Some delegations had asked for the subitems to be discussed in a different order from that laid down in the agenda. He therefore suggested that the subitems should be taken up in the following order: 13.1 (Global strategy for infant and young child feeding), 13.6 (HIV/AIDS), 13.8 (Revised drug strategy), 13.2 (Health promotion), followed by the remaining sub-items in the original order.  

**It was so agreed.**  

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1 See page 303.  
2 Decision WHA54(4).
Ms BALOCH (Pakistan) said that her delegation was particularly interested in item 13.4, entitled “Strengthening health services delivery”. She asked that the relevant documents submitted to the Executive Board at its 107th session in January 2001, especially The world health report 2000 and its associated documents, be made available to the Committee, including resolution EB107.R2.

She asked about the deadline for submission of new draft resolutions.

Mr BURG (Office of the Legal Counsel) said that, according to Rules 52 and 85 of the Rules of Procedure of the Health Assembly, no proposal or amendment should be discussed or put to the vote unless copies had been circulated to all delegations at least two days previously, although that requirement could be waived if the Committee so decided.

3. PROGRAMME BUDGET: Item 12 of the Agenda

General programme of work: Item 12.1 of the Agenda (Resolution EB107.R1; Documents A54/4 and GPW/2002-2005)

Dr BODZONGO (representative of the Executive Board) said that the Board had welcomed the new format and more focused approach of the general programme of work for 2002-2005, which offered improved guidance. The document covered a shorter period than previous general programmes of work, and was more closely linked to the Proposed programme budget 2002-2003 (document PB/2002-2003). During the debate, Board members had emphasized the need to establish clear priorities in the Organization’s work and had welcomed the restricted number of priorities laid down in the document, which would make it easier to attract new investment. However, in addition to those 11 priorities, other programme areas, such as child health, environmental health, accident prevention and health of elderly people, might be considered particularly important in some regions.

The Board had noted the Director-General’s decision to define 35 areas of work across the entire Organization, which were reflected in the budget headings in the Proposed programme budget 2002-2003. The regions might combine the areas of work differently, depending on their own structure, but financial reports would be drawn up in the same way at all levels.

The Board had asked for more information on the results of the follow-up and evaluation of activities in 2002-2003 and the activities planned for 2004-2005 to be submitted at its 109th session in January 2002. The Board had adopted resolution EB107.R1 which recommended that the Health Assembly should approve the general programme of work for the period 2002-2005.

Mr EINARSSON (Iceland), speaking on behalf of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), said that the shorter period covered by the general programme of work — four years as opposed to six — and its closer links with the Proposed programme budget would help to make that budget a stronger instrument of policy orientation. The Nordic countries welcomed the emphasis in the general programme of work on the health of populations and communities. The core functions and strategic directions defined in the document would form a logical basis for the identification of more specific areas of work in future years.

The Proposed programme budget 2002-2003 was built on the same policy framework as the general programme of work, set out in nine groups of priorities with a budget structure covering 35 areas of work. The Nordic countries welcomed the fact that the regional committees had been given the opportunity to comment on the budget as a whole and on the strategic directions of the organization-wide proposals, as well as matters specific to their own regions. He also welcomed the emphasis on results-based budgeting. The international community needed to respond to the widening gaps in health status in different countries and give more people the opportunity to benefit from economic developments and scientific advances: the changes that had been made would help WHO in that task. He commented that the general programme of work must be followed up and evaluated regularly, with the Health Assembly receiving a report on its implementation.
Dr LARIVIÈRE (Canada) welcomed the proposed general programme of work, which reflected the corporate strategy endorsed by the Executive Board at its 105th session, and made WHO's programme policies more consistent. However, his delegation would have liked to see an assessment of global health needs for the period 2002-2005 and a small number of key targets. The Proposed programme budget might provide part of that information, but if the general programme of work was to serve as a medium-term plan for WHO's activities, it should include the key elements of a medium-term plan, such as quantified goals and targets. The appropriate tools to evaluate the implementation of the general programme of work should be decided upon before the end of 2005. There was enough time to do that before the evaluation, which should be carried out early in 2006 and the results conveyed to the Health Assembly. His delegation supported the draft resolution recommended by the Executive Board in resolution EB107.R1.

Dr NOVOTNY (United States of America) said that his country supported the proposed general programme of work for 2002-2005, and welcomed its inclusion as part of the core framework of the next programme budget. Linking organization-wide priorities directly to budgetary resources would facilitate action on and implementation of those priorities.

His Government agreed both with the criteria used to identify the priorities and the list of priorities itself, which reflected the challenges facing developed and developing countries. The list included major challenges and disease burdens, as well as areas where significant advances could be made in terms of improved health outcomes and health systems. The United States' technical agencies remained committed to working closely with WHO and Member States in the priority areas that had been identified.

His country encouraged a focus on child health, which it understood to be implicitly included in several of the identified priority areas. Applying the Organization's own criteria for priority setting actually reinforced WHO's leadership role in global children's health. Early interventions in children's health and nutrition could result in significant changes in the burden of disease, could influence national policy and programme interventions, and could have a major impact on future socioeconomic development and sustainability. His delegation applauded WHO's vision and leadership, as demonstrated in the corporate strategy and the general programme of work.

Dr VIOLAKI-PARASKEVA (Greece) welcomed the new brief format of the general programme of work and, in particular, its closer links with budget allocations, the clearly limited and identified priorities and the criteria used for priority-setting. However, there were still some difficulties in matching the priority areas to the current organizational structure, particularly in the regions. It would be important to ensure that the general programme of work was evaluated at an early date. Her delegation supported the draft resolution contained in resolution EB107.R1.

Mr DEBRUS (Germany) welcomed the brevity and clarity of the document outlining the general programme of work. He agreed particularly with the emphasis on the priority area of cancer, cardiovascular disease and diabetes. Referring to paragraph 14 of the document, in the section entitled "Health systems", he asked what was meant by "tools and methods for assessing and comparing health systems". Was the intention to build up some kind of global reporting system?

Mrs TAPAKOUDI (Cyprus) welcomed the new short format of the general programme of work and its focus on broad strategic directions and the core functions of the Organization. The document reflected WHO's intention to translate policy into practice through the general programme of work and related operational plans of action. Her delegation supported the strategic directions designed to build healthy populations and communities and combat ill-health, and the core functions that would allow WHO to carry out its activities. It also supported the overall Organization-wide priorities for 2002-2003, as presented in the document. Her delegation supported the draft resolution contained in resolution EB107.R1.
Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the general programme of work 2002-2005 was the first major product of the new WHO corporate strategy. The document, which dealt with substantive aspects such as changes in international health activities, strategic directions, core functions and Organization-wide priorities, would be an important tool in the planning of regional and global activities and a reference for countries to identify the results to be achieved in all areas of work in the period 2002-2005. Only by defining the aims of the Organization-wide priorities could the world’s most pressing health problems be addressed.

WHO had declared poverty to be one of the causes of ill-health, but poverty had not been included as one of the Organization-wide priorities. More scientific evidence was required to show the ways in which health could contribute to the economic development of nations. Although health promotion aspects could be identified in every one of the defined priorities, health promotion itself should be designated an Organization-wide priority in the next general programme of work.

As a result of globalization and privatization, health systems were becoming more complex; activities that had previously been conducted by State institutions were now being entrusted to private bodies. The State must maintain its leadership in the areas of standard-setting, methodology and monitoring, in order to ensure that increasing privatization did not have adverse effects for the most vulnerable population groups.

Health, which was a fundamental human right, was still denied to more than one-fifth of humankind. WHO must devote its efforts to ensuring that that right was enjoyed by everyone.

Dr ADAM (Kenya) said that his delegation supported the contents of the general programme of work, which reflected the general thrust of national priorities, including those of his country. The challenge was to provide institutional arrangements capable of implementing the mission and vision.

Mr WARRINGTON (United Kingdom of Great Britain and Northern Ireland) said that his delegation welcomed the document, particularly for its brevity and for its compatibility with the Proposed programme budget 2002-2003. The Organization, through the Executive Board, had endorsed a corporate strategy; the question, in that connection, was whether both a corporate strategy and a general programme of work were required, although the latter was indeed a formal requirement under the Constitution. Apart from some difficulty in understanding how the many strategic directions, core functions and Organization-wide priorities were related, his delegation supported the document.

Dr MOSOTHO (Lesotho) said that his delegation approved the general programme of work, the value of which had been enhanced, although clearly much more work needed to be done. He paid tribute to the efforts of the Executive Board in bringing the task to fruition and in ensuring that it reflected adherence to the Constitution.

Dr ASAMOAH-BAAH (Executive Director) recognized that more work was needed on the programme and welcomed the Committee’s constructive suggestions. The shortened framework for the general programme of work made it easier to incorporate suggestions. In particular, although the policy framework was not an actual plan, it would be useful for reaching globally agreed targets. Closer linkages between areas of work and organizational arrangements, especially at the regional level, would continue to be explored. He would heed all suggestions for speedier evaluation, including those relating to reviewing priorities; shortening the periods of review would be a target, particularly in the light of the rapid evolution of international health concerns.

The CHAIRMAN invited the Committee to consider the draft resolution recommended to the Fifty-fourth World Health Assembly by the Executive Board in its resolution EB107.R1.

The draft resolution was approved.¹

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA54.1.

Part I. Policy and budget for one WHO

Dr THIERS (representative of the Executive Board) said that the Board had appreciated the new format of the Proposed programme budget 2002-2003, especially the presentation and the overview of funds from all sources. The Board had welcomed the “One WHO” format which, for the first time, brought together headquarters and the regions in shared objectives. The presentation of goals, objectives and expected results with related performance indicators had been commended, although it had been considered that greater focus was needed on some indicators prior to presentation of the budget to the Health Assembly. Some concern had been voiced at the growing imbalance, noted over several bienniums, between regular budgetary and extrabudgetary resources, which threatened to undermine the authority that the Health Assembly and the Board should be able to exert over the budgetary process. Various opinions had been expressed on matters such as whether inflation and currency fluctuations should be dealt with by adjustments or absorbed into the regular budget at its nominal minimum level of US$ 842.7 million, as in the two previous bienniums; however, no consensus had been reached.

Some members had voiced disquiet about regular budget allocations to regions in relation to application of resolution WHA51.31, which, the Board had noted, recommended presentation to the Fifty-seventh World Health Assembly in 2004 of a thorough evaluation of the model used for allocations, which was based on UNDP’s human development index.

Recalling the strategic nature of the Proposed programme budget and operational plans of action, the Board had accepted that a detailed breakdown of expenditure would not be meaningful at the current stage but looked forward to itemized expenditure details at its session in January 2002. Following a general discussion, the Board had turned its attention to technical programmes relating to each of the 35 areas of work proposed for the next biennium.

He personally welcomed the incorporation, in the revised version of the Proposed programme budget 2002-2003, of certain observations by the Board on specific technical programmes. Lastly, the Board had considered document EB107/INF.DOC./1 on the Director-General’s intended approaches with regard to cost increases and exchange rate adjustments for 2002-2003; in that connection, it had noted a proposal to limit application of the exchange rate facility to headquarters and the Regional Office for Europe. It had also noted the suggestion to provide exchange rate insurance in the form of a foreign exchange option and to use independent external sources to assess the impact of inflation, rather than relying on in-house estimates. A summary of cost increases and currency adjustments was given in document A54/5, which had been reviewed by the Board’s Administrative, Budget and Finance Committee. He proposed that Committee A might perhaps prefer to examine the subject of cost increases and exchange rates separately.

It was so agreed.

The CHAIRMAN invited the Director, Budget and management reform, to introduce the Proposed programme budget 2002-2003 in more detail.

Mr LARSEN (Budget and management reform) referred the Committee to document A54/INF.DOC./8 relating to the Proposed programme budget 2002-2003. The proposed budget was the first in which the Director-General had been involved from the outset and was thus a cornerstone for the Organization’s entire policy framework, as well as of progress towards “One WHO”. He drew attention to some significant differences from the previous biennium’s programme budget, such as use of the principles of results-based budgeting, joint preparation by regional offices and headquarters and the fact that it was a global programme budget which had been reviewed in draft by all regional committees and their comments incorporated. A main focus was to produce a common draft based on
WHO's corporate strategy. A key concern was how to apply the new focus while making clear to Member States how the process was linked to the elements of the previous biennium's budget. The managerial framework was being extensively reviewed. Consideration of the corporate strategy elements would give impetus to strategic planning relating to the 35 areas of work, WHO's objectives and the expected results. The next stage, closer to implementation, would be operational planning, which would embrace products and activities. That would be followed by the implementation stage, involving tasks and resources, and by subsequent monitoring and evaluation. The long-term goal and objectives would reflect WHO's planned contribution with other partners, whereas the expected results reflected that for which the Secretariat could be held directly accountable. As such, they should be seen as statements of intent by the Director-General relating to the application of budgetary resources for the coming biennium. Later in 2001, detailed work plans would be developed in which the expected results would form a common denominator between strategic and operational plans. Each of the 35 areas of work was presented in a two-page spread in the Proposed programme budget 2002-2003, together with the relevant budget figures and summary tables.

A special feature was the strong focus on the priorities endorsed by the Board. In order to make a preferential allocation of resources, the Director-General had initially withheld allocations for all programmes and regions and then reoriented resources. As a result, priority-area resource allocation from the regular budget had risen from US$ 108 million to US$ 131 million, an increase of 21%, the corresponding increase in total resource allocation being from US$ 329 million to US$ 593 million, an increase of 80%.

In addition to the direct allocations to the 11 priority areas, an effort had been made in the Proposed programme budget to indicate estimated contributions from other areas of work. The expenditure plan for all sources of funds was based on zero growth of the regular budget; however, the growth in allocations from all other sources represented an increase of 26%, giving an overall total increase of 15%. Given the advance of public health to the forefront of the development agenda, the figure of US$ 1380 million from other sources was thought to be a reasonable estimate. The interim financial report to be considered by Committee B provided financial highlights (document A54/INF.DOC./9) which supported that view.

The CHAIRMAN suggested that the Committee should first discuss the policy framework and overall resource context before proceeding to a substantive discussion on the various appropriation sections. He therefore invited discussion on pages 11 to 16 inclusive of the Proposed programme budget 2002-2003.

Mr JOHANSEN (Norway), speaking on behalf of the five Nordic countries, welcomed the new budget forecast, which was in line with efforts to achieve a unified Organization. It was especially important that the budget planning process had been consolidated between headquarters and the regions. The Proposed programme budget was greatly improved in terms of the transparency, accountability and effectiveness of the WHO financial system. He also highlighted the importance of systematic monitoring and evaluation of results, which had been properly reflected in the budget document.

It was noted that WHO was maintaining zero nominal growth in its regular budget for the forthcoming biennium, but that it had been necessary to forecast an increase of 26% in other resources. It was unreasonable to continue to apply the concept of zero nominal growth in the regular budget, and his delegation supported zero real growth as a minimum. It was the collective responsibility of all Member States to finance the United Nations system, including WHO. There was a growing recognition globally of the importance of health in combating poverty and securing lasting development. Health issues were rising on the international agenda, and the new initiatives being taken to finance efforts to combat disease and ill health were commendable. The Health Assembly should take its responsibility seriously and ensure that WHO had sufficient funding to play its part in that global effort, particularly in those areas where it was best qualified. The Nordic countries argued that zero nominal growth had become increasingly detrimental to reform; it made it very difficult to fund
priority activities and meet new challenges. As long as regular budgets were subject to the principle of zero nominal growth, the United Nations system would become increasingly dependent on voluntary contributions from a disappointingly small group of countries. He believed that it would be unfortunate to tilt the resourcing balance further in the direction of voluntary contributions. In the near future, the aim should be to enable activities that were clearly within the core mission of WHO to be better and more predictably funded through the regular budget.

The Nordic countries would make available and informal document summarizing why they believed it was time to review the zero nominal growth policy. In their view, specialized agencies that used their relative advantages and were efficient and effective should be fully compensated for inflation and cost increases in their regular budgets. He therefore supported the proposals in documents A54/5 and A54/5 Corr.1, as well as A54/6 and A54/6 Corr.1. WHO should take fully into account cost increases and inflation in the regular budget as well as using miscellaneous income for the benefit of the Organization.

Mr THOMPSON (United States of America) said that the United States was strongly committed to supporting WHO in its goals to improve global health. His country also supported the overall budget level which, including extrabudgetary resources, showed an overall increase of 15%. It was, however, a strong advocate of budgetary discipline and thus supported maintaining the regular budget at zero nominal growth, as reflected in the Proposed programme budget. WHO was projecting an increase of 26% from extrabudgetary resources, reflecting the fact that it was an attractive organization to donors; 25% of that extrabudgetary revenue came from the United States. While it was gratifying that increased resources were expected, vigilance was also required. The Board and the Health Assembly set the strategic priorities for the Organization; all its resources needed to be devoted to WHO's priorities and to be subject to monitoring and evaluation.

The budget proposal outlined the strong integration of extrabudgetary resources, an important achievement that must continue as such contributions increased. The United States was unable to support cost increases as outlined in document A54/5 and was opposed to any increases in the regular budget to account for exchange rate fluctuations and inflationary cost increases, believing that any net increases could and should be absorbed within existing regular budget resources. He noted that both the internal and external auditors' reports had identified new areas where further efficiency could be achieved. He looked forward to WHO's response to those reports.

The Organization had done an admirable job in preparing a results-based budget. He believed that continuous monitoring would achieve greater efficiency, transparency and accountability. Additionally, the United States encouraged continued efforts to place greater emphasis on programme evaluation to determine the continued relevance of WHO programmes. He recognized that good progress was being made in that area and expressed strong support for it. His Government commended WHO for its ability to attract extrabudgetary resources and did not object to the programme increases in the overall budget financed by such resources.

In conclusion, he referred to the legislation adopted by the United States House of Representatives to withhold the last payment of United States' arrears to the United Nations, including payment for WHO. President Bush was committed to paying all the United States' arrears and opposed the action taken by one part of the United States' Congress. The President would work hard to ensure that the United States fulfilled its obligations to the United Nations and to WHO.

Mr CHERNIKOV (Russian Federation) commended the Proposed programme budget 2002-2003 for its integrated nature, its clear reflection of the Board's defined priorities and a modest redistribution of funds from administrative to substantive programmes and from headquarters to regional and country levels. His delegation stressed the importance of priority programmes, such as maternal and child health and communicable and noncommunicable diseases, which would assist Member States in revealing factors that adversely affected their demographics and in formulating clear indicators of the economic effectiveness of public health activities. Global surveillance of communicable diseases likewise deserved more resources. The budget format should be improved,
however, as the allocation for each item was not always clear. His delegation, while respecting the strategic nature of the document, asked for more detailed information at least in time for the Board’s session in January 2002.

The current Health Assembly should refine the expected results and the indicators outlined. He noted with pleasure incorporation of some of the indicators proposed by his delegation relating to governing bodies and its suggestion concerning the preparation and distribution of documents in time for those bodies’ meetings.

His delegation was disappointed by the proposal for the overall level of the budget for 2002-2003; it had expected the regular budget to be at the level of that for the current biennium, with zero nominal growth. The proposal for an extra US$ 51 million, an increase of 6%, was not nominal but real growth. His delegation could not agree to that proposal. The document failed to show why the proposed programme of work could not be carried out without any increase; on the contrary, the current level of resources was clearly more than enough. For instance, under development funds of the Director-General and the Regional Directors, a request was being made for an investment of more than US$ 7 million in new initiatives which might at some future time be included in the programme of work. If the spending could not be effected on the basis of zero growth, it was hard to see why an increase in real terms should be requested. His delegation was not convinced by the comments on currency fluctuations and inflation and failed to understand why in most regions, including Africa, inflation rates were discussed in terms of United States currency. Surely, the problem could be dealt with through an overall budget absorption, using existing reserves if necessary. His delegation was puzzled by the section dealing with miscellaneous income. It had expected US$ 35 million to be returned to Member States or used to finance approved programmes - in other words, an indirect reduction in contributions. It could not agree with the approach in which such alternatives were subsumed by a higher budget level. That level did not depend on income but should also be defined by the programme of work. As a result, his delegation saw no grounds for approving a budget at a level that exceeded zero nominal growth of expenditure.

Mr MACPHEE (Canada) commented that the proposed budget was a strategic one with results-oriented objectives, provided a basis for assessing value for money and was transparent regarding the actual resources required to achieve results. He welcomed the emphasis on priorities that were of concern to Canada, namely tobacco use, communicable diseases and health systems surveillance, and encouraged WHO to place increased emphasis on nutrition and reproductive health. Rigorous budgetary discipline and focused use of resources continued to be crucial components of good governance in the broader context of United Nations reform. His delegation supported a regular assessed budget of US$ 842.7 million for the forthcoming biennium. Although he was aware of increasing demands on WHO resources, he was not convinced that additional resources were required for the regular assessed budget. Rather, the quality of the budget should be improved by rigorous prioritization, efficiency savings and the identification of obsolete activities. Careful rationalization of regular budget resources could lead to further savings without adversely affecting WHO’s programme of activities. In that connection, his delegation welcomed the report of the internal auditor, which included more than 20 recommendations for improved efficiency and economic use of the Organization’s resources.

His delegation noted that the proposed regular budget plus the expected voluntary contributions (which were projected to increase by 26%) together provided a total budget exceeding US$ 2200 million, an overall increase of 15%. His country was fully committed to improving global health and would continue to support WHO through active participation and through voluntary contributions to programmes such as vaccines, child and women’s health and institutional renewal.

Dr SANOU (Burkina Faso) said that the Proposed programme budget 2002-2003 reflected the unity of WHO as well as the common objectives and the efforts that would be made at various levels of the Organization. She expressed some hesitation, however, about the corporate strategy that required that resources be assessed before the objectives were set. It was difficult for WHO to foresee
extrabudgetary resources for the coming two years, particularly since efforts were being made to attract increased voluntary resources for programmes. She asked for clarification about the mobilization of resources which formed the basis for setting the objectives.

Dr LEFAIT-ROBIN (France) said that her delegation appreciated the presentation of the results-based Proposed programme budget 2002-2003. Care should be taken to ensure, however, that application of the results-based principle did not prevent Member States from receiving full information on, for example, ratios, extrabudgetary resources and assessed contributions. Her delegation did not consider zero nominal growth to be a reasonable option and therefore supported the statement on that subject made by the delegate of Norway. She did, however, approve the presentation of Miscellaneous income as set out in document A54/6. Furthermore, her delegation endorsed WHO's concern about the growing imbalance between the regular budget and extrabudgetary funds, and she asked that care be taken to ensure that a return to growth of the regular budget was accompanied by a decrease in voluntary contributions. In that respect, she noted the intention to regulate extrabudgetary contributions in accordance with the priorities set by the Executive Board and the Health Assembly.

Dr STAMPS (Zimbabwe), referring to pages 11-16 of document PB/2002-2003 and alluding to document A54/5, said that the question of cost increases and exchange rates was increasingly problematic for many countries in Africa that were suffering from hyperinflation, which was not necessarily subsumed under changes in exchange rates. If it was, there was pressure on local currencies which, itself, encouraged inflation. It was therefore difficult to understand why headquarters and the European Regional Office had applied the forecast inflation rates for Switzerland and Denmark, respectively, to their budgets, whereas that facility was denied to all other regional offices. He would appreciate an assurance that that would not imply a real decline in the allocation of funds regionally. His second concern related to the bar graph on page 16 of document PB/2002-2003. In his country, HIV/AIDS was considered to be the world's greatest public health challenge, and yet the estimated expenditure on that problem was half of that applied to malaria and poliomyelitis. The figures gave the world an incorrect message about the degree of commitment of WHO to HIV/AIDS. Referring to Table 2 on page 11, he stressed that economic advisers constantly urged a move towards decentralization in attaining better health for all. Indeed, the philosophy of WHO had been to put money at country level, where it was considered to be most effective, yet the nugatory percentage changes shown did not reflect a determination to decentralize activities. The same rules should hold good for all. Any shortfall in resources should affect headquarters' rather than countries' allocations.

Dr VIOLAKI-PARASKEVA (Greece) welcomed the new format of the Proposed programme budget 2002-2003 for its clarity and the overview of the sources of funds. The fact that the regional offices had participated in preparation of the proposed budget and had reviewed it ensured its representativeness. Efforts to improve transparency should continue, and further information should be provided, in particular regarding programmes at the national level, so that Member States formed a realistic idea of the support they could expect in practice. She commended the approach of allocating funds on the basis of the objectives of each of the 35 areas of work. She reiterated the concern of the French delegation about the growing imbalance between the regular budget and extrabudgetary funds.

Dr KIM Won Ho (Democratic People's Republic of Korea) noted that the proposed budget had been formulated in line with the perspective of world health development. He also welcomed the fact that the principle of results-based budgeting requested by Member States had been fully incorporated and that the preparatory work had been carried out by both headquarters and regional offices. That would help to ensure that targets were met. The redistribution of the regular budget allocations for headquarters, the regional offices and countries was a positive initiative for consolidating cooperation among Member States. In regard to extrabudgetary resources, which had drastically increased compared with past years, donor countries and companies should be encouraged to continue their action.
Mr WASLANDER (Netherlands) commended the performance of WHO and the Proposed programme budget, in which results, indicators and sources of funds were well presented and transparent. He approved the integration of regular and voluntary contributions and of the objectives of headquarters and regional offices into a single budget. More clarity was needed, however, in regard to how the US$ 330 million would be spent at country level. Evaluation mechanisms and feedback to Member States on how well the objectives had been met ought to be improved, so that countries had a clearer view of the value they were deriving from investment in WHO. His delegation approved the Proposed programme budget but maintained that it could have been more ambitious: real growth in the regular budget was needed to give WHO the necessary stability. His delegation therefore supported the proposal for a 1.9% increase in the level of the regular budget to compensate for cost increases and approved the suggestion that other sources of funding be sought for priority programmes.

Dr FERREIRA SONGANE (Mozambique) commended the new strategic, programme-based budget. In regard to the allocation of funds, also referred to by the delegate of Zimbabwe, he pointed out that about 50% of the money allocated for malaria was expected to be spent at headquarters. Programmes were run at country level, and the most affected regions should receive the most funds. That issue required clarification: it should be shown that resources were being allocated where they were most needed. He also endorsed the view of the delegate of the Netherlands that the increase in WHO’s budget should be used for development in countries. It was not clear how funds were allocated nationally. The existing mechanisms for access to funds were not always compatible with the systems in the various countries that needed them. Action should be taken to improve that situation. Referring to the chart on page 16, he wondered whether the relatively small amount devoted by WHO to HIV/AIDS was due to the existence of UNAIDS, which, he emphasized, did not have an operational mandate but one for advocacy. WHO should have an operational unit to address HIV/AIDS and play a central role in fighting that scourge.

Mr TASAKA (Japan) welcomed the concise presentation in the proposed programme budget of objectives and goals in each programme area, in line with Organization-wide priorities. His delegation was in favour of maintaining zero nominal growth in the budget and was concerned about the negative consequences of increases in assessed contributions. WHO should be able to cover the necessary cost increases by redirecting efficiency savings generated by reforms, while maintaining the same levels of programme activity. The efforts within the regular budget for 2000-2001 to improve efficiency throughout management indicated that WHO could absorb cost increases through efficiency measures. With regard to the increases in costs, his delegation was not convinced by the estimate of the impact of inflation, which appeared to lack a firm basis. It did not justify an increase in the proposed budget of almost 2%.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) noted that the Proposed programme budget 2002-2003 was based on lessons learnt in preparing previous budgets and marked important changes in both its content and its preparation. It defined the policies and priorities of WHO clearly and would be useful for planning, programming and evaluation. Although 11 of the 35 work areas had been identified as global priorities, they were not reflected as priorities at regional level; for example, no funds had been allocated for HIV/AIDS in the Region of the Americas. The fact that the majority of the Organization’s funding for the coming biennium would be derived from extrabudgetary funds, as in 2000-2001, resulted in a situation in which WHO’s policy was directed not by the Member States, who provided the regular budget, but by the donor countries. He noted that, despite the identification of poverty as one of the main causes of poor health, the programme of work for the period 2002-2005 did not address that issue.

Dr SOARES MARQUES DE LIMA (Sao Tome and Principe), recognizing the merits of the revised process of preparing the Proposed programme budget, of its presentation and of the increased
allocation of resources to priority areas, nevertheless raised some concerns. First, despite the significant increase in the regular budget over that of the previous biennium, the allocation for HIV/AIDS was still not commensurate with the threat to development represented by the epidemic, especially in Africa. Secondly, referring to the decrease of 10% in regional office budgets and drawing attention to the decline in regular budgetary resources allocated to priority areas such as malaria and immunization in the African Region, he asked whether there had actually been a decline in the resources for that Region in the Proposed programme budget 2002-2003.

Mr HAN (Republic of Korea), recalling his Government’s commitment to Roll Back Malaria and citing the donation of goods to the value of US$ 500 000, noted the broadening of the scope of its cooperation with WHO and its contribution of further substantial funds to support the framework convention on tobacco control in 2001 and 2002. The FIFA World Cup 2002, hosted jointly by his country and Japan, would be a tobacco-free event.

He suggested that WHO should increase the budgetary allocation to both scientific and administrative aspects of traditional medicine, given the desire of many countries to reduce their health care expenditure and the growing international interest in such forms of medicine. He informed the Committee that the 11th International Congress of Oriental Medicine would be held in Seoul, Republic of Korea, in October 2001, and invited participation by Member States.

Dr SHIVUTE (Namibia) welcomed the revised format and structure of the Proposed programme budget. He noted with satisfaction the improved allocation to the Regional Office for Africa, although further resources were needed for both the Regional and country offices, given the heavy burden of diseases such as HIV/AIDS. Future allocations of the regular budget should go to benefit countries, especially developing countries, and regions rather than headquarters.

Professor RATSIMBAZAFIMAHEFA (Madagascar) praised the way in which the proposed budget reflected the new global priorities, with resources allocated accordingly, in a results-based budgeting process. She associated herself with the remarks of previous speakers concerning the elements to be improved in the Proposed programme budget. In particular, she echoed the concern of the delegate of Burkina Faso about reliance on extrabudgetary funds, with a view to a proper complementarity with regular budget funds. She looked forward to further clarification of the methods for allocation of resources at country level, of the mechanisms for follow-up and evaluation of the actual use of the resources foreseen and for facilitation of the procedures for their optimal use.

Mr VARELA (Argentina) expressed his appreciation of the new format of the document under discussion, with its use of indicators and expected results, which would lead to greater transparency and efficiency. The inclusion of regional office management in a single budget was especially appreciated in that regard. Referring to the concerns expressed by other speakers over the growing imbalance between the sources of funds for WHO, he said that any such problem might be resolved through the understanding that WHO would execute its programmes within the framework of the goals and objectives defined by its governing bodies. That issue, which had structural implications, could be dealt with in greater depth by the Executive Board prior to review by the Health Assembly. Finally, his Government favoured zero nominal growth in the budget with further cost-efficiency savings.

Dr BATCHASSI (Togo) praised the results-based budgeting and the integration and centralization of health problems by zone. His delegation asked that, during the budget process, a financial report on the level of implementation of programmes be made that would permit technical units in the countries to forecast the income and expenses that could be expected. There was a concern that, despite the increases made, the budget might be inadequate for the scale of the disease problems facing Africa in particular and the war against poverty in general.
Mr COSTI SANTAROSA (Brazil) commended the results-based approach but expressed concern at the overall level of the Proposed programme budget. Brazil's current economic situation did not allow it to support initiatives that would result in an increased assessed contribution. He therefore endorsed the position of previous speakers that zero nominal growth should be maintained.

Mr WARRINGTON (United Kingdom of Great Britain and Northern Ireland) commended the document under discussion, observing that WHO had become an acknowledged leader in the field of results-based budgeting and was a model for much of the rest of the United Nations system. The new format aided transparency and provided a real framework for the programme of work. The identification of goals, objectives, results and indicators was welcomed, as was the integration of regular budget and other sources in one document. The input of regional offices and the regional governing bodies was valued. The increase in funding of 80% for priority areas was also welcomed. His Government did not share the concern expressed by some other delegates over a lack of balance between extrabudgetary and regular budget funds. The 40% increase in extrabudgetary funding over the past year was, he believed, a testimony to the visionary leadership of the Director-General and the renewed sense of strategic purpose within the Organization. Extrabudgetary funding was valuable when the donations conformed to the agreed objectives of the Organization, when excessive earmarking was avoided and efforts were made to ensure its predictability. His delegation agreed with others that efficiency savings were important in directing more resources to priority areas and that, where necessary, obsolete programmes should be dropped. There should be a greater focus in debates on the quality of programming rather than on the budgetary level. Evaluation mechanisms were important, as the delegate of the Netherlands had indicated. The overall level of funds available from all sources, cost increases, exchange rate fluctuations and the use of miscellaneous income should be reviewed all together. His Government also supported zero nominal growth.

Mr ASLAM (Pakistan), while recognizing the long-term vision of WHO reflected in the Proposed programme budget, noted the 17.4% decline in funding for the important area of work of communicable disease prevention, eradication and control. Such diseases, especially hepatitis B, were present in epidemic proportions in certain areas of his country and were a major public health hazard. Exacerbated by the high rate of inflation in the country and the high cost of vaccine against hepatitis B, immunization was beyond the reach of his population. He therefore requested the Director-General to reconsider the allocation to that area of work accordingly.

Dr ALAOUI (Morocco) was of the opinion that objectives should be carefully defined and indicators selected that supported the attainment of those objectives. The regular budget as a whole had not increased, although there were increases in certain areas, but there had been no increase for the Eastern Mediterranean Region; that might need to be reconsidered. With regard to documents A54/5 and A54/5 Corr.1 on cost increases and exchange rates, it was essential to focus on activities. The 11 priority areas of work were important, and the budgetary allocations proposed for them were acceptable. The increases showed the efforts made to rationalize budgetary allocations and to assign them to specific priorities. He called on WHO to increase resource mobilization wherever possible, particularly in respect of important areas of work such as malaria, tuberculosis and HIV/AIDS. Those areas had received an overall increase in funding in comparison with the previous biennium, but there had been a decrease for the Eastern Mediterranean Region. That situation was not acceptable. He also observed that the way in which extrabudgetary funds would be distributed among regions was not clear.

Mr Li Changming (China) remarked that the Proposed programme budget was very different in form and content from its predecessors. He said that he was pleased to see that major areas of work such as tuberculosis, HIV/AIDS and safer pregnancy still received due attention. The resources allocated to country activities had increased somewhat, which showed that WHO was still committed to strengthening technical cooperation with countries.
The process of formulating the budget had changed radically, and that would prove a challenge for people working at country level. He could foresee problems arising from the new format and timetable. One major objective of the Proposed programme budget was to strengthen national planning capacity. He hoped that WHO would provide practical advice on ways in which the new formulation process could improve national planning.

The Proposed programme budget gave several projected outcomes for each area of work but only one overall budget figure. His country could therefore not ascertain the detailed budgetary allocations for areas in which it was particularly interested, such as immunization as a means of controlling communicable diseases, development of a vaccine against HIV or traditional medicine. He asked for more information than that shown in Tables 3 and 4 (document PB/2002-2003, pages 13-15) in that regard and, in particular, about the footnote in Table 4 which stated that "substantial resources will continue to be allocated to the priority area 'investment in change'."

Mr LARSEN (Budget and management reform), responding to queries, said that the need for predictable funding referred to by several delegates was also a major concern of the Executive Board and of the Director-General. With static regular budgets, extrabudgetary funds had to be pursued vigorously. Opportunities to make further efficiency savings were rapidly diminishing. The Organization had been instructed, through resolution WHA52.20, to save over US$ 50 million through efficiency measures. Current projections indicated that about US$ 35 million of that figure could be saved by the end of the 2000-2001 biennium. He confirmed that the estimated funds from other sources for malaria, tuberculosis and HIV/AIDS had increased since the subject was discussed by the Executive Board at its 107th session.1 Child health, a concern raised earlier by the delegate of the United States of America, had received an additional reallocation of US$ 800 000 under the regular budget. Although it was not one of the 11 priority areas, child health, along with environment and health, had received preferential allocations in response to interventions made during the 107th session of the Board.

It was not possible to comply with the request for more detailed itemized expenditure at the present stage of strategic budgeting; an itemized expenditure plan based on work plans would be prepared and presented to the Executive Board in January 2002. In reply to a point raised by the delegate of the Russian Federation, he explained that the allocation to the Director-General's and Regional Directors' development programme and initiatives had actually been decreased by US$ 4 million. In reply to the point raised by the delegate of Zimbabwe concerning exchange rate mechanisms, he pointed out that only headquarters and the European Region had opted to participate in the exchange rate facility; all the other regions had opted out, predicting that the local currencies in their countries would devalue against the US dollar, which would be to their advantage in the course of 2002-2003. The African Region in particular stood to gain from that decision. With regard to expenditure on HIV/AIDS, a substantial increase was projected for the next biennium. Referring to Table 3 in document PB/2002-2003, he confirmed that a significant part of the extrabudgetary resources would be spent at country level. He agreed that little information was provided on country level programming; the point raised by the delegate of the Netherlands in that regard had been well noted and would be taken into account in the preparation of the next budget proposal. The detailed planning would come after approval of the Proposed programme budget but would be closely aligned with the policy framework in the budget document. The comment of the delegate of China regarding the relationship between national planning and the budget process was also relevant to that point. In line with a policy agreed upon by the Board and the Health Assembly, with a view to a more consistent Organization-wide programme, country programmes should be based on collectively agreed policies, in consultation with the respective regional offices. That topic would be considered by the regional committees later in 2001. The query of the delegate of Mozambique on the allocation of resources to malaria applied only to regular budget funds. The funds from other sources had not been

1 See document EB107/INF.DOC./4.
broken down by regions, but a tentative outline of funding existed: of the US$ 110 million projected to come from other sources, about half (US$ 52 million) was expected to go to the African Region. By contrast, less than one-fifth of those funds was expected to go to headquarters.

The delegate of Cuba had referred to the allocation of 0% for the Region of the Americas for HIV/AIDS in the summary table of resources on page 59 of document PB/2002-2003. Mr Larsen explained that the tables did not include the large resources of PAHO. In response to the comments of the delegates of China and the Republic of Korea concerning traditional medicine, he noted that, in response to similar concerns raised by the Executive Board at its 107th session, the area of work on Essential medicines (pages 74 and 75 of the document) included mention of the integration of traditional medicine into health systems. The expected results with respect to traditional medicine would be operationalized and resources allocated over the coming few months. In reply to queries raised by the delegates of Madagascar and the Netherlands on strengthening the mechanisms for evaluation and follow-up of programmes, he noted that a report on that difficult management issue was being prepared for submission to the Executive Board at its session in January 2002. Finally, resolution WHA51.31 on regular budget allocations to regions included a model for regional, intercountry and country allocations in future programme budgets. That resolution also requested the Director-General to present a thorough evaluation of the model by 2004. The delegate of Morocco, who had queried that aspect, could be assured that a full report would be presented to the Health Assembly at that time.

The meeting rose at 17:45.
SECOND MEETING
Wednesday, 16 May 2001, at 9:40
Chairman: Professor S.K. ONGERI (Kenya)

PROGRAMME BUDGET: Item 12 of the Agenda (continued)


Part I. Policy and budget for one WHO (continued)

Dr OMI (Regional Director for the Western Pacific), replying to questions raised by several Member States concerning the impact of the new results-based budget on the development of each country's programme budget and on the budget process at regional and country levels, spoke of his Region's experience in the matter. In February and March 2000, the regional offices and headquarters had jointly developed a global strategic framework, based on discussions in the Executive Board, that had included global priorities. In September 2000, at a session of the Regional Committee in Manila and in line with the global strategic framework, regional targets had been identified and discussed. In the light of specific regional situations, indicative country planning figures based on objective methods had been presented. Early in 2001, Member States had started to develop the country programme budgets within the framework of the global and regional targets and in the context in each country. After the present Health Assembly, individual countries and the Regional Office would complete their proposed programme budgets and submit them to the Regional Committee in September 2001 for final consideration. That process would allow Member States to address country-specific issues but also to contribute to WHO's overall objectives.

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

Part II. Strategic orientations 2002-2003 by area of work

The CHAIRMAN invited the Committee to continue its consideration of the Proposed programme budget (document PB/2002-2003) by reviewing Part II, section by section.

Communicable diseases

Dr PRETELZARATE (Peru) noted with pleasure that Peru was no longer considered one of the 22 countries accounting for 80% of the world's cases of tuberculosis. That major success for his country, which had made significant progress in the past 10 years to attain the goals set by the Health Assembly in 1990, had been due to strong political support by the Government, which had decided that all health services should provide treatment for tuberculosis free of charge and implement the DOTS (directly observed treatment, short course) strategy. The latter facilitated long-term surveillance of all cases diagnosed and helped to avoid resistance. Peru had also organized an efficient diagnosis campaign, which had brought to light around 97% of all patients known to have the disease, of whom over 93% were receiving treatment.

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Dr STAMPS (Zimbabwe) expressed some disappointment at the presentation on research and product development for communicable diseases. Regular budget allocations seemed to have declined for headquarters, Africa and South-East Asia, while a small amount had been earmarked for the Americas. The largest portion of funds for research and product development was identified as coming from “Other sources”. He asked whether those sources were pharmaceutical organizations or non-aligned budget allocations.

Dr HEYMANN (Executive Director) congratulated Peru on its success, which had been due to its Government’s strong commitment to deal with tuberculosis in an integrated manner that provided for both diagnosis and treatment of new cases. Research and product development for communicable diseases was done within the UNDP/World Bank/WHO Special Programme on Research and Training in Tropical Diseases, which was funded mainly by bilateral donors. Thus, most of the funds for research and product development represented support by donor governments for the Special Programme.

Noncommunicable diseases and mental health

Mr BRODRICK (Australia) expressed support for WHO’s efforts to develop results-based budgeting. An excellent start had been made in the document before the Health Assembly, concerning which he agreed with the United Kingdom delegate’s assessment. He looked forward to further development of the monitoring, evaluation and reporting mechanisms as well as the reinforcement of a culture of performance at headquarters and, just as importantly, in each region. In Australia’s view, the proposed programme of work closely reflected the priorities accorded to key issues such as malaria, HIV/AIDS and tobacco control. His country was particularly gratified by the priority given in the budget to tobacco control and the increased allocation for that work in the proposed regular budget for 2002-2003. He noted the inclusion of the development and adoption of the draft framework convention on tobacco control as one of WHO’s indicators of performance and urged that that normative activity be funded from the regular budget in order to ensure that the framework convention developed out of a neutral and transparent process.

Dr HANSSEN (Norway) observed that the preparation of the framework convention on tobacco control was regarded as an expected result under the section on tobacco. He commended the excellent work in developing the convention. The process involved a heavy workload, with numerous meetings of the Intergovernmental Negotiating Body. The efforts made should be properly reflected in the budget and treated as a separate item entirely financed from the regular budget and with a separate budget line in order to guarantee the neutrality of financial support for the work.

Dr SADRIZADEH (Islamic Republic of Iran) welcomed the new format for the Proposed programme budget 2002-2003. With regard to health promotion, however, he noted that, although the total budget for 2002-2003 represented a 37% increase over 2000-2001, the sum allocated in the regular budget had fallen by some 30%. That could prove of great concern if the funds from other sources were not forthcoming.

Dr STAMPS (Zimbabwe) welcomed the increased interest in the surveillance, prevention and management of noncommunicable diseases. Africa suffered from both communicable and noncommunicable diseases and was experiencing a dramatic increase in reproductive tract cancers, which evidence suggested was related to the HIV epidemic. He also welcomed the renewed interest in oral health, which was a fundamental factor in a healthy life. He commended the increased emphasis on surveillance, and especially the long-term commitment to primary prevention, which represented a major challenge to countries with high rates of infection and urgent disease problems but where civil disturbances tended to take the limelight. Zimbabwe fully supported the draft framework convention
on tobacco control and was confident that provision would be made to support countries such as Zimbabwe in which tobacco production was a major contributor to the economy.

Professor GRABAUSKAS (Lithuania) welcomed the new format of the Proposed programme budget 2002-2003 and noted with satisfaction that noncommunicable diseases had at last been placed on the global agenda. Among the 11 priorities identified by WHO, three directly concerned noncommunicable diseases which were no longer limited to affluent countries. However, his country was concerned at the considerable fall in regular budget allocations to noncommunicable diseases, especially in the European Region, although the reduction had been offset by funds from "Other sources". The allocations for other programmes closely related to noncommunicable diseases, and especially their causes, had also been reduced in the regular budget. Lithuania fully supported the draft framework convention on tobacco control and considered that the time had come, within the broad context of health promotion, to deal similarly with other important subjects such as nutrition and physical activity. However, the decline in regular budget funding in all WHO regions except Africa called for innovative approaches to raise funds for such important activities. Lithuania strongly supported WHO's efforts to cover noncommunicable diseases as a regular activity of the Organization.

Dr ABUDAJJAH (Libyan Arab Jamahiriya) commended the new presentation of the Proposed programme budget 2002-2003 but pointed out that one cause of many lost lives had been overlooked, namely, traffic accidents, possibly because they could be classified neither as communicable nor noncommunicable diseases. Yet, they were a source of great concern to many countries, in particular because they affected the most active members of the population.

Dr TEMU (Papua New Guinea) joined in welcoming the Proposed programme budget with its results-based approach. He observed, however, that the biennial programme appeared to include rather too many priorities, given the budgetary constraints. There was a danger that the limited resources would be spread too thinly and the goals not achieved. Although the global figures appeared sizeable, the funds available at country level were small making it difficult to implement the programmes. Almost every programme or disease appeared to be treated as a priority. WHO should concentrate on the priority concerns of developing countries with very limited resources, such as malaria, tuberculosis, HIV/AIDS, diabetes and health systems. With regard to noncommunicable diseases, diabetes was a subject of major concern in the Pacific Island countries, where the rates were steadily rising. He therefore welcomed the increase in resources devoted to the surveillance, prevention and management of noncommunicable diseases, even though the allocations at country level were small.

In health promotion, his country was moving towards a "healthy islands vision" in which health promotion and health protection would play a most important role. Such programmes were critical to all attempts to improve the health of the population of Papua New Guinea and other Pacific Island nations. The healthy islands programme, which the Western Pacific Region was hoping to coordinate, was one such programme. He noted the small increase of 6% for health and environment. Nations in the Pacific were greatly concerned that a number of important areas of work were receiving very small increases. He welcomed the mobilization of support for priority programmes from other sources and looked forward to the fully itemized budget, which would be the key to successful implementation of the next biennial programme budget and the test of its capacity actively to target resources to essential activities with the greatest impact.

Dr VIOLAKI-PARASKEVA (Greece) stressed the importance of mapping the emergence of noncommunicable diseases and identifying priorities in order to reduce premature mortality, morbidity and disability. She welcomed the study of gender issues in the prevention and control of common noncommunicable diseases.

Dr TROOP (United Kingdom of Great Britain and Northern Ireland), noting that expenditure on tobacco control was not broken down by source, asked to what extent the draft framework convention
on tobacco control, which the United Kingdom strongly supported, would be funded from the regular budget and how much would come from extrabudgetary funds. The United Kingdom felt strongly that the convention should be seen to be entirely transparent and not susceptible to undue external influence. It should therefore be funded exclusively from the regular budget. Obviously, that would not rule out the use of extrabudgetary funds for other activities within that area of work and for implementation of the convention.

Mr VOIGTLÄNDER (Germany) said that many health promotion strategies, campaigns and action programmes in developing and developed countries alike were not based on sound evidence. He recalled that the Executive Board, at its 107th session in January 2001, had reached consensus on the need to base health promotion on sound evidence as a matter of priority. Yet the evidence base was not mentioned in the corresponding objectives box of the Proposed programme budget. He urged that the omission be rectified.

Dr MOETI (Botswana) welcomed the new format of the Proposed programme budget. Referring to the disability/injury prevention and rehabilitation area of work, he asked whether the reduced allocation for the African Region in 2002-2003 compared with the previous biennium reflected a reduction in perceived needs or whether additional funds would be available from other sources. Although communicable diseases were undoubtedly a major challenge in the Region, disabilities and injuries were imposing a major and growing burden on developing nations.

Dr AL WAN (Management of noncommunicable diseases), responding to questions raised about tobacco control, said that the draft framework convention was being funded by a mixture of regular budget and extrabudgetary resources, with some funds coming from transfers. He fully agreed with the delegates of Australia, Norway and the United Kingdom of Great Britain and Northern Ireland on the importance of neutrality; every effort would be made to increase the regular budget component.

Regarding the reduced country allocations under the regular budget for the surveillance, prevention and management of noncommunicable diseases, emphasis had been placed under the current programme of work, both at headquarters and in the regional offices, on supporting country activities as much as possible and on sharing resources between headquarters and countries.

He assured the delegate of Zimbabwe that reproductive tract cancers, particularly those related to HIV infection, were a major priority of the cancer programme at headquarters and in regional offices, especially in the Regional Office for Africa. During the current biennium, two important consultations had been held on the subject, and there was close inter-cluster collaboration in WHO on implementation.

With regard to the point raised by the Lithuanian delegate, headquarters and the Regional Office for Europe collaborated closely on noncommunicable diseases and health promotion. The priority given to nutrition and physical activity under the current programme of work would be increased further in the next biennium.

Road traffic accidents, to which the delegate of the Libyan Arab Jamahiriya had referred, were a major priority for the 2002-2003 biennium. WHO had initiated work on injuries and violence since 2000, and a global consultation had taken place in April 2001 to develop a global strategy in that area.

Responding to the delegate of Papua New Guinea, he said that diabetes was one of the four priorities of the global strategy for the prevention and control of noncommunicable diseases endorsed by the Fifty-third World Health Assembly, and a priority of the programme budget for 2000-2001 and that proposed for 2002-2003.

A significant proportion of the resources available for noncommunicable diseases would be used to support health promotion. He fully agreed with the German delegate on the importance of evidence-based interventions for health promotion. The methods used for developing strategies and guidelines had been changed for the specific purpose of placing more emphasis on the evidence base and on public health considerations. Joint work on evidence-based interventions was due to start in the near future with the International Union for Health Promotion and Education.
Ms JAKAB (Regional Office for Europe), replying to the delegate of Lithuania, emphasized that, notwithstanding the figures, noncommunicable diseases and mental health would remain a priority in the European Region. The decline in the allocations was attributable to several factors. At the time of the preparation of the Proposed programme budget, the country funds had not yet been distributed. Secondly, during the 2002-2003 biennium the largest shift in the history of the Region from regional funds to country funds would add an additional US$ 4.2 million to the country allocations, bringing the total to US$ 11.7 million, part of which would be distributed for noncommunicable diseases. Thirdly, staffing and organizational changes in the European Office had led to a reduction in the allocation for health promotion, as the director post for that activity had been abolished. The health promotion area would be substantially strengthened, however, through the establishment of a health promotion centre in Venice, Italy.

Mr LARSEN (Budget and management reform) confirmed that the total of US$ 336 million for country programmes under the regular budget was in the process of being attributed to the various areas of work. As he had mentioned the previous day, it was the policy of the Director-General that the country programmes should take their inspiration from the endorsement by the Health Assembly of the programme budget, not vice versa. Furthermore, a large component of the funds from other sources would eventually be programmed at country level. The results of the country programming exercise for the regular budget and other sources of funding would be presented to the regional committees in September 2001.

Family and community health

Dr WIUM (Norway) said that people living with AIDS needed access to care for opportunistic infections, in particular tuberculosis. He requested the addition of a further expected result in the section on HIV/AIDS to read: “Support to countries to improve the care for AIDS patients with opportunistic infections in general, and tuberculosis in particular”.

Dr SADRIZADEH (Islamic Republic of Iran) requested clarification concerning the decline of more than 65% in the funds allocated to the Eastern Mediterranean Region in 2002-2003 under research and programme development in reproductive health.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) commented that countries with already low rates of infant mortality would find it difficult to meet the goal of reducing the rate by two-thirds by the year 2015, as set out in the section on child and adolescent health. Instead, the goal should be fixed in relation to countries’ current rates.

Dr FERREIRA SONGANE (Mozambique) cautioned against over-concentration on mother-to-child transmission of HIV at the expense of other aspects, such as social support and care for mothers with opportunistic infections. To what extent were those aspects being coordinated? He recommended separating child and adolescent health, to avoid the risk of neglecting the latter. Appropriate care of adolescents was an important aspect of making pregnancy safer, for example to prevent unsafe abortions.

Dr TÜRMEN (Executive Director), commenting on the newly established HIV/AIDS department, said that the funds and human resources within the cluster were being used to start a major public health programme on HIV/AIDS with a view to increasing WHO’s efforts in that area. Consequently, the budget did not truly reflect the support given to the HIV/AIDS area of work. In reply to the Norwegian delegate’s remarks on the importance of care for patients with opportunistic infections, she confirmed that those issues would be incorporated into the relevant plans. As to the delegate of Mozambique’s question on coordination of activities in making pregnancy safer, maternal
health and HIV infection, she further confirmed that there was close collaboration within WHO between reproductive health and research and HIV/AIDS; resources were being provided to ensure that emphasis was placed not only on maternal-child transmission but also on care of the mother and on other interventions that had been shown to have an impact. More details would be given during the discussion of HIV/AIDS under agenda item 13.6, together with information on means of promoting the health and well-being of adolescents, particularly in sexual and reproductive health, with special focus on HIV/AIDS.

Sustainable development and healthy environments

Dr SADRIZADEH (Islamic Republic of Iran) asked why, despite an increase of 12% in all funds, the resources allocated to the Eastern Mediterranean Region for sustainable development had been decreased by some 25%.

Mrs ADAM (Switzerland) considered that the health and environment area of work was an important long-term activity and welcomed the addition of US$ 2.2 million since the Executive Board’s discussion in January 2001 to raise the headquarters regular budget total to US$ 10.8 million. She asked how the additional funds would be spent.

Mrs KERN (Executive Director) said that the additional funds would be used mainly to explore the long-term implications of climate change on health and issues relating to effects on health of and protection from radiation.

Dr SALEH (Assistant Regional Director for the Eastern Mediterranean) said that the reduction in allocation noted by the delegate of the Islamic Republic of Iran was largely attributable to the overall decrease in the budget for the Eastern Mediterranean Region. However, the allocations reflected the budget for the Regional Office. The budget allocations for countries had yet to be determined through joint planning, when efforts would be made to find means of compensating for the decrease in funds at the Regional level.

Health technology and pharmaceuticals

Evidence and information for policy
External relations and governing bodies
General management
Director-General, Regional Directors and independent functions

The CHAIRMAN noted that there were no comments on the budget allocations for the last five sections of Part II. He suggested that the question of cost increases and exchange rates be discussed under agenda item 12.3.

Miscellaneous income budget: Item 12.3 of the Agenda (Documents A54/6, A54/6 Corr.1 and A54/38)

Professor ZELTNER (Switzerland), speaking in his capacity as Chairman of the Administration, Budget and Finance Committee (ABFC), introduced the question of cost increases and exchange rate adjustments for 2002-2003 (documents A54/5, A54/5 Corr.1 and A54/37). The Committee had noted that the method used for calculating the proposed cost increases followed the recommendations made by the Executive Board in January 2001. The resulting proposed cost increase amounted to a net figure of US$ 16.1 million, which consisted of the two elements of US$ 25.8 million for inflation in 2002-2003 and a reduction of US$ 9.7 million for negative currency adjustments. The cost increase for inflation was based on independent flotation forecasts for Switzerland and Denmark for headquarters and the Regional Office for Europe, respectively, and the inflation forecast for the US dollar for the
other regional offices for the spending in those offices that was based on the US dollar. The currency adjustment for headquarters and the Regional Office for Europe was based on the latest United Nations rates of exchange, given that those offices were to remain in the exchange rate facility. There was no currency adjustment for the other regional offices, although there was a cost increase proposal for the component of expenditure, amounting to 70%, that was linked to the US dollar. The local currency portion would no longer be in the exchange rate facility and would therefore benefit from the devaluation of local currencies against the US dollar, which would offset the effects of inflation.

Turning to the question of the Miscellaneous income budget under agenda item 12.3, he said that the Committee had noted that 2002-2003 was a transition biennium in terms of implementation of the new Financial Regulations and Rules and that, in future, miscellaneous income would be integrated into the regular budget. The Committee had also noted that two amounts of US$ 10 million had been mentioned in document A54/6. The first amount was for priority programmes, about which further information had been requested. The second amount was potentially available in the event that the US$ 19 million requested for the exchange rate facility and for the hedging thereof was not required in its entirety. In the discussion on the inclusion of a net amount of US$ 16 million for cost increases, one member of the Committee had noted that the inflation should be absorbed by rationalization of working methods and elimination of redundant activities.

Ms WILD (Financial services), commenting further on the question of cost increases and exchange rate adjustments, said that document A54/5 had been prepared by the method considered by the Executive Board in January 2001. The inflation forecasts and exchange rates used in that document had, however, changed in May 2001. The figures revised accordingly were shown in document A54/5 Corr.1, in which connection she pointed out that the amounts of the cost and net increases indicated in the Annex should read US$ 2 995 000 instead of US$ 2 685 000 for the Regional Office for South-East Asia and US$ 2 685 000 instead of US$ 2 995 000 for the Regional Office for the Eastern Mediterranean. Similarly, the proposed budget amounts indicated in the Annex should read US$ 96 017 000 instead of US$ 86 075 000 for the Regional Office for South-East Asia and US$ 86 075 000 instead of US$ 96 017 000 for the Regional Office for the Eastern Mediterranean.

Inflation had been forecasted on the basis of data averaged from over 250 forecasts gathered from banks and organizations such as the World Bank and OECD. Such data were publicly available and had not been specially prepared for WHO by the organization concerned. The forecasted inflation rates shown in document A54/5 Corr.1 were for the biennium. The annual inflation rates were therefore 1.3% for headquarters, 2% for the Regional Office for Europe and 2.3% for all other locations. Currency adjustments had been made on the basis of the United Nations rate of exchange as of 1 May 2001 in order to change the basis for the programme budget from that for the 2000-2001 biennium. Only headquarters and the Regional Office for Europe would participate in the exchange rate facility; the currencies of both locations strengthened and weakened over time in comparison with the US dollar, and the exchange rate facility provided a stabilizing mechanism which ensured that the value of the budget remained constant, irrespective of the movement of the US dollar in relation to the local currencies concerned, thus providing protection when the US dollar weakened. Gains that occurred when the US dollar strengthened would flow into Miscellaneous income for future disposition by Member States. Other regions did not participate in the exchange rate facility because the local currencies of such locations weakened over time in comparison with the US dollar. In previous years, transfers to the exchange rate facility had taken place, but there had been no compensation for the related local currency inflation. In those locations, 30% of the expenditure was in local currency, and the remainder was in US dollars or was affected by US dollar inflation only. By excluding those regions from the exchange rate facility, the local currency portion of the budget was automatically protected from both devaluation and inflation. There was therefore no currency adjustment for those locations, although inflation was calculated for that portion of the budget that was related to the US dollar. Thus, for headquarters and the Regional Office for Europe, inflation for the biennium 2002-2003 was calculated at 2.6% and 4%, respectively, with a negative currency adjustment on the basis of the May 2001 rate of exchange. In the other locations, the US dollar
inflation forecast of 4.6% was applied to 70% of the budget, which was equivalent to an adjusted inflation rate of 3.2%, reflecting the expenditure pattern in those locations. The overall cost increase was therefore US$ 25.8 million, or 3.1%, the total negative currency adjustment was US$ 9.7 million, or 1.2%, and the net cost increase was US$ 16.1 million, or 1.9%.

Turning to Miscellaneous income, she said that the Proposed programme budget reflected a transition from the former casual income process to the new process incorporating miscellaneous income. In January, when the new Financial Regulations and Rules providing the framework for Miscellaneous income had come into effect following confirmation by the Executive Board, the programme budget, which had not then included miscellaneous income, had already reached an advanced stage of development. Document A54/6, as amended by document A54/6 Corr.1, which updated the figures for cost increases and currency adjustments, reflected that transitional approach. Annex I of the document showed the way in which estimated miscellaneous income had been calculated, Annex 2 detailed the proposed expenditure to be included in the Proposed programme budget 2002-2003 by reason of inclusion of miscellaneous income in the budget process, and Annex 3 integrated all the elements of the proposed regular budget. The proposed expenditure included provision for the exchange rate facility and the cost of hedging that facility, the Real Estate Fund and the financial incentive scheme, all of which had in the past been financed by appropriation from casual income. Those items were now being brought into the regular budget process.

The amount of US$ 10 million proposed for priority programmes was, as stated by the Director-General in her address, linked to the ongoing reform process in the Organization and would be used, for example, to strengthen the capacity and the contribution of work at country level. As the Chairman of ABFC had noted, a second amount of US$ 10 million might become available for priority programmes in the event that the full amount of US$ 19 million was not required for the exchange rate facility and for the hedging thereof. However, since the availability of such an amount would not be identified until the second year of the biennium and its size was impossible to predict, it would not be prudent to consider it as currently available. The effect of the proposal contained in document A54/6 would be to allow that particular source of surplus miscellaneous income to be used sooner than the date provided by the Financial Regulations, which in the current case was 2006-2007. Miscellaneous income would in future be fully integrated into the regular budget process.

Mrs ZIKMUNDOVA (Belgium) said that for several years her country had favoured a rigorous and disciplined budgetary policy for international organizations and considered that that policy must be maintained. The concept of zero nominal growth had been useful in obliging organizations to review their priorities, adopt management reforms and seek efficiency savings, and Belgium had in the past pleaded for adherence to that concept without regarding it as sacrosanct. However, zero nominal growth, despite the savings it achieved, had reached its limits in some organizations, and, in the case of WHO, programmes had begun to suffer as a result. Moreover, adherence to zero nominal growth for the regular budget often led to increased recourse to extrabudgetary contributions, resulting in a lack of transparency and control and a risk of dependence on contributors. Belgium therefore considered it appropriate to adopt a more flexible approach in favour of zero real growth in certain cases and under certain conditions. Such an approach was justified in the light of the transparency of WHO's budget management, the clarification of its priorities and objectives and its adoption of results-based budgeting. The Organization must nevertheless continue to strive to make savings, particularly in areas offering the greatest potential for them, such as general services and travel, and the relevance of its ongoing activities should be regularly assessed.

In view of the significant progress achieved in recent years by WHO in the area of budgetary management, Belgium was ready to modify its position and to agree to a zero real growth of US$ 16 million, an increase of less than 1.9%.

Mr CHERNIKOV (Russian Federation) said that his intervention the previous day had been misinterpreted. He had in fact asked why, if the Organization had a sum of US$ 7 million as yet unearmarked, it was requesting a further US$ 10 million. His delegation was gratified to learn that, in
response to its request that Member States should be provided with relevant information when taking decisions on the budget, a breakdown of categories and items of expenditure would be submitted to the Executive Board at its 109th session in January 2002. His delegation, like a number of others, had also expressed the hope that a staffing breakdown would be made available at that session. He was grateful for the responses given to questions raised by other delegations, especially to that posed by the delegation of Zimbabwe, and in particular for the confirmation that the inflation rates forecast for the regions had been exaggerated.

In summary, the replies given had served to confirm his delegation's view that there was no justification for departing from the zero nominal growth principle in the budget. He proposed that in the table contained in document A54/6 Corr.1, lines 2, 3 and 4 should be deleted.

Ms BLACKWOOD (United States of America) expressed appreciation for the work on budget issues and the efforts made to incorporate the new miscellaneous income concept, in line with the revision of the Financial Regulations. The budget could be fully realized on the basis of zero nominal growth and increased extrabudgetary resources. She supported the proposal that non-recurring expenditures, such as those from the Real Estate Fund and the financial incentive scheme, should be financed from Miscellaneous income to give the Organization stability in the face of exchange rate fluctuations. There were certain options that might be pursued under the exchange rate facility: for example, other agencies used a forward purchasing scheme, which could be appropriate for WHO given the current economic outlook.

However, the United States was concerned at the proposal to use US$ 10 million of miscellaneous income to fund undefined priority programmes. That proposal required clarification. While her delegation supported the application of available miscellaneous income balances to finance the budget for the next biennium, it considered that WHO should proceed cautiously and should not budget for full expenditure from the Miscellaneous income account in case the total amount of projected income did not materialize.

Mr WASLANDER (Netherlands) said that the global importance of health justified a substantial increase in the Organization's regular budget. Referring to miscellaneous income and cost increases, he said that recent positive developments, such as the achievement in 2000 of the highest rate of collection of assessed contributions in 15 years, the decrease in internal borrowing and the substantial income obtained by the Working Capital Fund, should allow the Organization at least to maintain its current purchasing power. He therefore considered that the 1.9% increase in the regular budget was necessary.

With regard to miscellaneous income, while he welcomed the proposed allocation of US$ 10 million to priority programmes, the programmes that were to receive that allocation should be specified. In his view, part of the proposed sum should be devoted to HIV/AIDS, malaria and tuberculosis and part to the reform of human resources management.

With regard to the possible reallocation of US$ 10 million from funds not required for the exchange rate facility, he asked why the Organization could not increase the allocation for exchange rate hedging from the current US$ 4 million to a slightly higher amount in order to offset possible exchange rate fluctuations and to provide a clearer view of how much money would be left over and used to fund priority programmes. He expressed doubts about the usefulness of the proposed financial incentive scheme; the US$ 3 million provided for that purpose should also be devoted to priority programmes. While he accepted that such provision was required under the current Financial Regulations, he urged the Organization and Member States to review the effectiveness of the scheme, which would be unnecessary if all Member States paid their contributions in time, in full and without conditions.

His country had considerably increased its voluntary contribution in recent years and would continue to do so in the future.
Mr TASAKA (Japan), referring to the proposed cost increases, said that the estimated inflation rates appeared to be high in comparison with those projected by other organizations, notably ILO, and he would appreciate details of the cost estimates for regions other than the European Region. The negative impact of inflation as a result of devaluation of local currency required clarification, and he was concerned about the lack of correlation between cost increases and the inflation rates forecast for the regions of Africa, South-East Asia, the Eastern Mediterranean, the Western Pacific and the Americas. He was also concerned that the Proposed programme budget contained no reference to the proposal contained in the document to appropriate US$ 10 million from Miscellaneous income for priority programmes. He noted that there was a similar plan to appropriate up to US$ 10 million for priority programmes if the exchange rate facility was not entirely used, but the legal basis for the Director-General's authority to implement such a plan was unclear.

Mr BRODRICK (Australia) said that he considered that no case had been made for an increase in the regular budget, particularly since voluntary funds were expected to grow by 26%. Australia supported efforts to achieve long-term efficiency savings in the current budget cycle and expected that targets would be achieved both in headquarters and in the regions. The reports of the internal and external auditors had identified several areas in which further efficiency saving could be made. While his country was a significant voluntary contributor, it strongly believed that there should be no increase in the total assessed amount payable by Member States. Should the draft resolution on the proposed new scale of assessments be adopted, Australia's assessed contribution, along with those of a number of other Member States, would rise.

Turning to the proposals on the use of miscellaneous income, he recalled that the agreement reached by the Health Assembly at its previous session had not been intended to create a precedent, and he reiterated his country's position that surpluses should ordinarily be returned to Member States. He was prepared to accept in principle the application of some miscellaneous income to the regular budget, but insufficient information had been provided to support the proposal for the application of US$ 10 million to priority programmes; such proposals should have been incorporated in the budget document, in accordance with the principles of results-based budgeting. It was, moreover, inappropriate for the Health Assembly to give authority to the Director-General to spend a possible further US$ 10 million on unspecified priority programmes without prior approval by the Executive Board.

Mr CICOGNA (Italy) supported the view expressed by the delegate of Belgium that a flexible approach was required to the issue of cost increases for the 2002-2003 biennium. However, he urged WHO to continue its policy of efficiency savings, transparency and cost-containment. His delegation supported the principle of zero real growth.

Mr VOIGTLÄNDER (Germany) welcomed the improved presentation of the budget document. However, he regretted that the Miscellaneous income budget had not been incorporated into the regular budget, as he had been requesting for many years and which he understood had been agreed. He supported the principle of zero nominal growth, with cost increases being absorbed by WHO, as was the practice in many national budgets. Moreover, the level of the budget should correspond to the outputs proposed. He added that his country's view on the subject of zero nominal growth did not prevent it from providing voluntary contributions to WHO on the basis of an annual cooperation programme which had recently been approved.

Dr SANOU (Burkina Faso) urged the Committee to accept the proposal relating to cost increases set out in document A54/5 and endorsed the statement made by the delegate of Belgium. It was of great importance for each level to achieve results and for indicators to be further refined so that those results could be properly measured. She warned that in a results-based budget the elimination of certain activities would make it impossible to attain the global objectives of the Organization and that cost increases should be taken into account so as to prevent a decrease in the overall level of activities.
She supported the proposal for an increase of 1.9% in the regular budget, particularly since WHO had been rigorous in its stewardship and was constantly improving the transparency of its use of funds.

Dr TSHABALALA-MSIMANG (South Africa) pointed out that, although the level of the regular budget had been stable for the past three bienniums, as a result of currency fluctuations and cost increases there had been a reduction in its real level. Although her Government, like those of other countries, had had to face fiscal constraints and had had to adjust programmes accordingly, she considered that in the light of the huge number of international health needs that remained unmet a reduction in the Organization's budget would militate against the achievement of its mandate. Moreover, such a reduction would occur at the very time when WHO advocacy was approaching its peak. She wondered whether Member States could in good faith request other partners to provide increased resources while at the same time resisting the modest and rational budgetary increase proposed. She therefore supported the proposed increase of 1.9% to preserve the current level of purchasing power.

She joined with other speakers in supporting the allocation of US$ 10 million to programmes such as HIV/AIDS, tuberculosis and malaria, all of which had been identified as urgent priorities. If the international community was being requested to establish a global fund of US$ 10 000 million, it would not be unreasonable to support such a request with a matching contribution of 0.01%, even if that amount was merely symbolic in terms of the total amount that was being sought. Her country's assessed contribution, although a very small proportion of the overall budget, was large for the country and one of the largest contributions of all developing countries. She nevertheless regarded it as money well spent.

Mr WARRINGTON (United Kingdom of Great Britain and Northern Ireland) said that the resource levels of WHO should be seen in the round, taking into account at the same time the level of assessed contributions, the level of extrabudgetary contributions, the level of miscellaneous income and cost increases. In accordance with the principle of zero nominal growth, it was good discipline for international organizations to absorb cost increases through efficiency savings. He nevertheless fully accepted the argument that a higher level of resources should be devoted to the world's major health problems. His Government had significantly increased its extrabudgetary support for the Organization and was prepared to support the proposed global AIDS and health fund.

However, he would have preferred to see the items listed in document A54/6 incorporated in the main budget document, with objectives, results and indicators attached, in line with the principle of results-based budgeting. He acknowledged the transitional nature of document A54/6 and was therefore prepared to allow a certain flexibility in that regard. However, if any of the expenditure contained in that document were to be approved, he would expect some form of report to be issued before the beginning of the biennium, setting out objectives, results and indicators for that expenditure. If the additional sum of US$ 35 million were to be made available to the Director-General, as requested, a breakdown should be provided of the individual components for which that sum was to be used. While endorsing the allocation of miscellaneous income to the Real Estate Fund and to information technology, both of which required funding, he said that he had doubts about the allocation to the financial incentive scheme. Governments should not be rewarded merely for complying with their legal obligations, as was currently the case under the scheme. The money could be better spent in other areas. He expressed a readiness to consider the proposal to allocate US$ 10 million to priority activities, on condition that the activities concerned were clearly identified and objectives and indicators set accordingly, in line with the results-based budgeting approach. One area on which such funds could be spent was the preparation and negotiation of the framework convention on tobacco control.

Turning to the proposal concerning the allocation of US$ 19 million to cover exchange rate fluctuations, either through a hedge mechanism or through a fund within WHO itself, he said that the concept of US$ 10 million being made available for priority activities subject to exchange rate fluctuations raised certain difficulties. Although he was not opposed to expenditure of the funds in
question on such activities, it was incompatible with the principle of results-based budgeting to start a budgetary biennium without knowing exactly how much would be spent. One solution might be to develop a more comprehensive hedge mechanism. It might then be possible to examine the question of whether the remaining funds would be returned to Member States or spent on priority activities. However, any flexibility in the use of the US$ 35 million allocation from Miscellaneous income, including the US$ 19 million allocated to cover exchange rate fluctuations, could be shown only if WHO committed itself to absorbing the remaining US$ 16 million through efficiency savings. That would represent a comparatively modest target in relation to the targets for efficiency savings set for previous bienniums.

Ms WILD (Financial services), responding to questions, said that she would reply to the points raised by the delegate of the Russian Federation outside the meeting. A briefing would be held later in the week to provide more detailed information on the progress achieved during the current biennium in achieving efficiency savings.

On the issue raised by several speakers as to how the level of the budget could be safeguarded against losses due to exchange rate fluctuations, she said that various approaches could be used to hedge or secure the value of the budget, including forward foreign exchange contracts and the purchase of insurance to secure the total amount of the budget against such fluctuations. Both alternatives had certain consequences. Forward foreign exchange contracts meant that the Organization lost any possibility of benefiting from foreign exchange fluctuations, as well as requiring additional accounting operations. Under certain circumstances, such contracts could result in losses for the Organization. With regard to the insurance alternative, current information indicated that the cost of securing the total budget would be in the order of US$ 15 million, which was an expensive way of managing the exchange rate facility exposure. The proposal that had been made in the document allowed a certain flexibility which would make it possible to use the resources available in an economical way. It constituted a middle path, which might cost more than full forward coverage, the option adopted by some other international organizations, but offered the advantage that any benefits would flow into Miscellaneous income for disposition in the future. It would reduce costs from those projected in previous bienniums when the limit of the exchange rate facility had been US$ 31 million.

With reference to questions on the forecasted inflation rates used for the proposed budget, and particularly with reference to the rates used by other international organizations, she indicated that WHO's expenditure pattern differed from that of other organizations. Independent information had been obtained to forecast inflation rates and had been applied to the normal pattern of WHO expenditure by region. Other organizations used a different method, with a composite rate for the whole organization. An attempt had been made to identify the inflation rates that would be applicable in different parts of WHO: for example, in the case of headquarters, the forecast inflation rate of 1.3%, the rate for Switzerland, had been applied. For the regions that would not participate in the exchange rate facility, the United States of America inflation rate of 2.3% per annum, or 4.6% for the biennium, had been applied to that portion of expenditure that was either in US dollars or was affected by US dollar inflation. The 30% of the budget to which inflation rates had not been applied represented local currency expenditure in each of those regions. She explained that, in the past, regions where the currency had devalued had experienced a budget reduction in US dollar terms because of that devaluation, but there had been no compensation for inflation, resulting in a real cut in the spending power of the WHO budget for those regions. The removal of the regions concerned from the exchange rate facility would have the effect of helping to compensate for the effects of inflation. She noted that comparisons made over the past 10 years had shown that over time levels of devaluation and of inflation tended to balance out in broad terms.

Turning to the comments made on the financial incentive scheme, she recalled that the Organization had undertaken to review the scheme's effectiveness, and that a review would be made after the next biennium in order to allow sufficient time for the experience gained to be assessed. The results of the review would be reported to WHO's governing bodies.
Finally, in response to the points raised concerning the use of the US$ 10 million for priority activities, proposed in document A54/6, she said that all the suggestions made would be studied carefully. The second sum of US$ 10 million, which she would categorize as “dream money” rather than “expected money” in view of the uncertainty of its availability, would be used by the Director-General only on the authority of a resolution by the Health Assembly.

The meeting rose at 12:30.
THIRD MEETING

Wednesday, 16 May 2001, at 14:30

Chairman: Professor S.K. ONGERI (Kenya)

1. FIRST REPORT OF COMMITTEE A (Document A54/43)

Mrs POPESCU (Romania), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda

Global strategy for infant and young child feeding: Item 13.1 of the Agenda (Resolution EB107.R16; Documents A54/7, A54/7 Add.1 and A54/INF.DOC./4)

Dr THIERS (representative of the Executive Board) said that the great interest shown in the topic by the Executive Board at its 107th session had been reflected in an open working group that had met for nearly 15 hours to discuss the draft resolution and amendments proposed at the Fifty-third World Health Assembly in accordance with decision WHA53(10). The Board had reaffirmed unanimously the fundamental importance of appropriate feeding practices for infants and young children and commitment to continue support for measures to protect and promote breastfeeding. While acknowledging the risk of mother-to-child transmission of HIV, the Board had expressed concern at the reduction in breastfeeding among mothers whose HIV status was unknown or who were unable to offer a safe alternative to breastfeeding, and considered that both basic scientific and operational research were extremely important in that regard. The Board had emphasized that the essential underpinning of all health policy was solid scientific evidence, as reflected in the meticulous and comprehensive year-long review and analysis conducted by WHO of the published scientific literature concerning the optimal duration of exclusive breastfeeding. Consensus had been reached that a global strategy on infant and young child feeding must be based on the principles of scientific evidence, transparency and participation by all interested parties.

Ms COSTA COITINHO (Brazil) expressed satisfaction at the transparent process followed at WHO headquarters and regional offices in response to Brazil's proposal at the Fifty-third World Health Assembly on the subject under consideration. The current discussion constituted the final step in a series of debates at the previous Health Assembly, the 107th session of the Executive Board and the WHO expert consultation on the optimal duration of exclusive breastfeeding, on which wide agreement had already been achieved. She was in full support of the draft resolution contained in resolution EB107.R16 and urged delegations to limit discussion to the text within square brackets in paragraphs 2(4) and 3(3), which she proposed should be amended to read as follows: “for six months as a global public health recommendation”, with removal of the square brackets, and the

¹ See page 304
corresponding footnote to read: “As formulated in the conclusions and recommendations of the expert consultation (Geneva, 28 to 30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (document A54/INF.DOC/4)”. She looked forward to making progress on the topic of infant and young child nutrition and well-being and on the reduction of global inequalities.

Mrs Wigzell (Sweden), speaking on behalf of the Member States of the European Union, commended the process of broad consultations among Member States, experts and others, which had provided a sound basis for the draft resolution recommended by the Board and for the strategies for implementation proposed in documents A54/7 and A54/7 Add.1, which she supported. She stressed the importance of continuing the process, without reopening the discussion on the text except in regard to that within square brackets just referred to. She proposed a similar amendment: the text in square brackets should be replaced by “for six months as a global public health recommendation, taking into account the findings of the WHO expert consultation on optimal duration of exclusive breastfeeding”, and the corresponding footnote should read “As formulated in the conclusions and recommendations of the expert consultation (Geneva, 28 to 30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (see document A54/INF.DOC/4)”.

Dr Stamps (Zimbabwe) said that he supported the position of Brazil and the European Union but preferred the wording proposed on behalf of the latter. In order, however, to ensure that breastfeeding was carried out from birth, he proposed that the text should read “during the first six months of life” rather than “for six months” so that there was no period of alternative feeding before breastfeeding commenced. His country had made great progress in promoting the International Code of Marketing of Breast-milk Substitutes, with a statutory regulation and an International Code of Marketing committee, which had representatives of the dairy industry and infant formula manufacturers. He fully supported the text of the draft resolution, with its proposed amendment.

Professor Jongjit Angkatavanich (Thailand) commended the efforts made to improve global infant and young child nutrition. With regard to the legislation recommended in the draft resolution contained in resolution EB107.R16, she endorsed WHO’s recognition of the problem related to non-compliance with the International Code of Marketing of Breast-milk Substitutes and considered that it was timely to readress the issue and to reinforce the Code. She suggested the addition of the words “and initiate research to identify the underlying causes of non-compliance both from the government and the commercial sectors and to find ways to alleviate the problem, such as making the Code mandatory in nature” to the end of paragraph 3(2). She further suggested the addition of a new subparagraph under paragraph 3, to read “to be more actively involved in the Codex Alimentarius Commission in taking the International Code and relevant World Health Assembly resolutions into consideration in developing standards and guidelines” in order to complement the statement in paragraph 2(9) concerning the interactive role with the Codex Commission. Lastly, she proposed adding a reference to the problem of overnutrition in the preamble and in the global strategy in order to protect the right of children not only to be adequately fed but also to be appropriately trained in good dietary habits and not be overfed. The emerging incidence of type 2 diabetes in children was an alarming symptom of overnutrition and needed public health attention. Moreover, efforts to solve overnutrition must begin at an early age.

Dr Thakur (India) welcomed the emphasis being given to the global strategy for infant and young child feeding. Discussions on the specific duration of exclusive breastfeeding should come to a definite conclusion, since the expert consultation had clearly recommended that exclusive breastfeeding should be practised for six months and that complementary food should be introduced subsequently alongside continued breastfeeding. The WHO recommendation must be specific, unambiguous and unequivocal; therefore, the text of the draft resolution should contain nothing to
dilute the substance of the expert consultation recommendation. The Government of India had always promoted exclusive breastfeeding, and he urged support for the draft resolution.

Dr MOGUILEVSKY (Argentina) said that the stance of his country was to promote, protect and support breastfeeding exclusively until the age of six months. At that point, suitable complementary feeding began, and breastfeeding continued during the second year of life. He supported the proposals made by the delegates of Brazil, Sweden and India.

Ms FUNDAFUNDA (Zambia) said that a successful conclusion on the topic of infant and young child feeding, which had been debated in WHO since 1994, was essential. Although the Organization had advocated that breastfeeding should continue for between four and six months after birth, science had demonstrated the benefits to both children and their mothers of breastfeeding of infants, not just for six months, but even up to two years or longer, with the addition of appropriate complementary foods. The WHO expert consultation had recommended six months as the optimal duration; that should resolve the controversy over the duration of breastfeeding. In that respect, the Fifty-fourth World Health Assembly was a defining moment for infants—born and to be born—all over the world, who would be free of the hazards of early complementary feeding. It was claimed that manufacturers of breast-milk substitutes would lose sales of over US$ 1000 million if the age for exclusive breastfeeding were raised from up to four to up to six months, but surely the choice should be based on the best public health results worldwide for infants and their mothers rather than commercial profit. Mothers, who chose other options should be able to do so free from commercial influences. She therefore supported unreservedly the experts' recommendation of six months as the optimal period for exclusive breastfeeding and urged all delegates, and the baby food industry, to give unequivocal support to that recommendation. The importance of the draft resolution could not be overemphasized as it was in the best interests of the health of babies throughout the world and would strengthen the International Code of Marketing of Breast-milk Substitutes. In addition, the Health Assembly, in adopting the draft resolution, would be sending a clear message to the forthcoming meeting of the Codex Alimentarius Commission which was scheduled to discuss the labelling of complementary foods for infants. She supported the amendment proposed by the delegate of Brazil.

Professor MATHEWS (Australia) expressed support for measures to ensure respect for the right of every child to the highest attainable standard of health, including measures to protect, promote and support optimal feeding for infants and young children. He also supported the recommendation of the expert consultation on a duration of breastfeeding of six months, on a population basis, as optimal nutrition for infants. The figure marked a small but significant change to WHO's current recommendation. While the new recommendation was relevant for populations generally, it would best be implemented in conditions favourable to the nutrition and support of the pregnant and lactating mother; for some infants, complementary and/or alternative feeding at four months might be necessary. Care should be taken in applying the six-month recommendation to at-risk subgroups of the population, for whom health professionals played an important role in assessing and supporting individual needs. Australia endorsed the rights of individual mothers who might be unable or unwilling to follow the recommendation, and was currently reviewing its own national recommendations on infant feeding to take account of its own context.

He supported the amendment to the draft resolution proposed by Sweden on behalf of the European Union, since it stressed the importance of making a strong recommendation as regards the optimal period of exclusive breastfeeding, while the inclusion of the reference to the recommendation of the expert consultation adequately took account of the needs of at-risk mothers and infants.

Dr VIOLAKI-PARASKEVA (Greece) said that she was pleased to note, some 20 years after she had held the office of President of the Health Assembly, renewed progress being made in discussion of breastfeeding issues within the framework of WHO.
Dr LARIVIÈRE (Canada) commended the work of the expert consultation and welcomed the opportunity to adopt by consensus the draft resolution on infant and young child feeding. His Government recognized the importance of ensuring optimal infant and young child feeding as a means of preventing millions of deaths each year in developing countries and would continue to support efforts, through the Canadian International Development Agency, to protect and promote breastfeeding and the timely introduction of high-quality, micronutrient-rich complementary foods. Canada deplored the lack of consensus that had characterized recent Health Assembly discussions on the optimal duration of breastfeeding, particularly in light of WHO estimates that less than 20% of infants were exclusively breastfed at four months; priority should be given to improving that extremely serious situation.

He looked forward to the results of research into biological and social constraints to exclusive breastfeeding for six months recommended in document A54/INF.DOC./4 and endorsed the draft resolution, together with the amendment proposed by Sweden on behalf of the European Union. However, he was unable at the current juncture to endorse the amendments put forward by Thailand.

Dr SHIMODA (Japan), recalling that Japan had been promoting proper infant and young child feeding since 1975, pointed out that the period of breastfeeding differed greatly from one society to another, possibly as the result of sociocultural factors. It would therefore be inappropriate to conclude on the basis of a limited number of studies that six months was the optimal period for breastfeeding in all circumstances. In promoting proper feeding of infants, account should also be taken of the cultural and socioeconomic status of the mother, rather than imposing uniform standards for the first six months of an infant’s life.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the elaboration of a global strategy for infant and young child feeding must take into account various factors other than exclusive breastfeeding, such as complementary feeding, feeding under difficult circumstances, for example owing to the risk of HIV transmission, and maternity protection at work. It should also take account of technical, political and economic factors and the interplay between them.

The global strategy under consideration went well beyond the scope of initiatives such as the Baby-friendly Hospital Initiative, the International Code of Marketing of Breast-milk Substitutes and the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding. It should be based on recognition of the right to food as a basic human right and be in accordance with the provisions of the Convention on the Rights of the Child.

The fact that brain development was largely completed within the first three years of life underlined the importance of appropriate feeding in infancy. Moreover, exclusive natural breastfeeding offered multiple benefits and provided the first immunization that a child received. Endorsing the view that six months was an appropriate period for exclusive breastfeeding, he stressed the importance of educating mothers about the unrivalled benefits of breastfeeding for as long as possible in the first year of a child’s life.

As a corollary, efforts should continue to ensure the implementation of and dissemination of information about the International Code of Marketing of Breast-milk Substitutes, particularly in light of the intense promotion of substitutes by the industry, including through the Internet. Furthermore, States should provide HIV-positive mothers with financial support to avoid transmission of the virus to their infants and should ensure maternity protection at work, extending maternity leave to one year, as had recently been done in Cuba.

Governments and international organizations had a responsibility to ensure that producers of breast-milk substitutes complied with the provisions of the International Code, while professional health bodies should design and develop research that would provide scientific evidence to support the global strategy. Civil society should improve its intersectoral activities in order to assist in the identification of risky behaviour in communities.

He supported the draft resolution with the amendment proposed by the delegate of Brazil.
Dr KIM Won Ho (Democratic People's Republic of Korea) expressed support for WHO's efforts to protect mothers from hazardous agents, to increase the length of maternity leave and to reinforce the entitlement to paid breastfeeding breaks. In his country, maternity leave was granted for 150 days, while a period of six months was recommended for exclusive breastfeeding. Complementary feeding practices should be improved through the use of locally available and affordable food. He supported the draft resolution.

Dr SADRIZADEH (Islamic Republic of Iran) noted that most recent studies provided evidence against the general use of complementary foods between the ages of four and six months, since they provided no growth advantage for most infants and babies took less breast milk when given complementary foods, resulting in a net loss of nutrients. Moreover, morbidity rates, particularly as a result of acute respiratory infections and diarrhoea, and the risk of malnutrition were more marked in the presence of early complementary feeding practices. He therefore fully supported the recommendation of the expert consultation that infants should be exclusively breastfed for six months, with introduction of complementary foods and continued breastfeeding thereafter.

Dr EL-SHAFAI (Egypt) expressed support for the conclusions and recommendations of the expert consultation and for the amendment to the draft resolution proposed by Brazil. Egypt was trying to provide support to breastfeeding mothers at the national level but recognized that issuing recommendations was not enough. Mothers needed material support from a social and nutritional point of view, particularly in poor countries where access to breast-milk substitutes was not an option. Implementation of the recommendations was predicated on the provision of information and education to mothers in the first months of their infants' lives. Women should be given an opportunity to continue breastfeeding after six months. Health care workers should receive appropriate training to enable them to provide the necessary information and advice. He urged governments to implement the International Code of Marketing of Breast-milk Substitutes. Effective implementation of recommendations concerning micronutrients was vital to ensuring the mental and physical development of children.

Dr OULD HAMED (Mauritania), welcoming the draft resolution, pointed out that an additional benefit of recommending a period of six months for exclusive breastfeeding would be the potential extension in birth spacing. He suggested that the Baby-friendly Hospital Initiative might be strengthened through a baby-friendly community initiative, since most deliveries in Mauritania, for example, were assisted at home, by traditional midwives.

He appealed to WHO to support countries not only in following up the International Code of Marketing of Breast-milk Substitutes, but also in drafting national codes incorporating the provisions of the Code to facilitate its application at the national level. Greater subregional cooperation was also needed to ensure implementation.

Dr KOUNANDY (Côte d'Ivoire) agreed with earlier speakers that discussion of the draft resolution should be limited to those parts of the text appearing in square brackets. It was not up to national regulations, let alone a Health Assembly resolution, to set standards for individual cases, which should be left to the relevant health care professionals. The twentieth anniversary of the International Code of Marketing of Breast-milk Substitutes offered the Health Assembly an opportunity to adopt a clear and specific resolution which would lead to real progress in the promotion of optimal and safe breastfeeding and infant feeding practices, free from commercial pressures and the promotion of artificial products, which had already inflicted enough damage on developing countries.

Ms PHUMAPHI (Botswana) applauded the effort that had gone into reaching consensus on a matter that could benefit millions of babies throughout the world. The adoption and implementation of the draft resolution could help save many lives. Botswana supported the content of the amendments
proposed by the delegates of Brazil and Sweden and would find either text acceptable. In her view, however, Thailand's proposals had come too late for consideration.

Professor AKIN (Turkey) also commended the efforts made under the leadership of WHO and with the collaboration of other international organizations to ensure protection, promotion and support of optimal feeding practices for infants. Since over one million children died each year of malnutrition, the nutritional needs and related problems of infants and young children remained as important as they had always been. She therefore endorsed the draft resolution. Evidence-based policies, the participation of all stakeholders, the changing health environment and the importance of research into HIV transmission and breastfeeding were all crucial to the success of the recommendations.

Ms COSTA COITINHO (Brazil) said that in the interests of achieving consensus she was willing to accept the wording suggested by Sweden on behalf of the European Union. She reiterated her view that any changes to the text should be limited to those parts in square brackets.

Dr AL-HAWASI (Saudi Arabia) expressed concern that WHO might be perceived as suggesting that breastfeeding should continue for six months only, by using the phrase “optimal duration of breastfeeding”. The phrase should perhaps be reworded in order to ensure the understanding that longer periods of breastfeeding, with the addition of appropriate complementary foods, were not precluded.

Mr JARAMILLO NAVARRETE (Mexico), referring to paragraph 3(2) of the draft resolution, suggested that the phrase “free from commercial influence” should be replaced by “free from conflicts of interest”. After all, the aim was to conduct a dialogue with all interested parties, of which the commercial sector was one.

Dr UPUNDA (United Republic of Tanzania) supported the amendments proposed by the delegates of Brazil and Sweden. He also preferred the wording “during the first six months of life” suggested by the delegate of Zimbabwe, which would be more in line with the spirit of the Baby-friendly Hospital Initiative and previous WHO recommendations.

Mr ASLAM (Pakistan) said that Pakistan had launched a health education campaign to promote breastfeeding, although its efforts had been hampered by the promotion of breast-milk substitutes. For the past 10 years, the Government had been working towards adoption of an ordinance for the protection of breastfeeding and young child nutrition, but it had met with considerable resistance from the manufacturers of breast-milk substitutes. He called upon WHO to mobilize public opinion and increase the pressure on those manufacturers to implement the International Code, and to motivate Member States to put a stop to the unethical promotion of breast-milk substitutes.

Dr KHAZ'AL (United Arab Emirates) said that her country's infant and young child nutrition policy, adopted in February 2000, encouraged exclusive breastfeeding for six months, continuing at least into the child’s second year, complemented by appropriate solid foods. Mothers were encouraged to feed their children fresh, locally available and home-made foods, and health workers monitored children’s weight regularly to ensure that they were adequately nourished. She supported the amendment to the draft resolution proposed by the delegate of Sweden. Lastly, she stressed the importance of improving training of health professionals, especially nurses and midwives, in order to increase the access of mothers to accurate information and to skilled help if required.

Dr RIAZANTSEV (Russian Federation) said that the best definition of the optimal period for exclusive breastfeeding was that recommended by the WHO Regional Office for Europe, which stated that all children should be exclusively breastfed from birth to the age of about six months, and at least
for the first four months of life. That recommendation made allowances for individual differences among infants and also for the nutritional status of the mother, which might affect the quality of her breast-milk. Babies born to HIV-positive mothers should be fed with breast-milk substitutes from birth, since experts considered that it was not possible to evaluate the risk of transmission of HIV from mothers to infants in the first three months of life.

Dr TEE Ah Sian (Malaysia) said that her country had made considerable efforts to promote optimal infant and young child feeding practices. Comprehensive national policies and plans of action were needed to define the roles and responsibilities of the various parties concerned and to establish appropriate partnerships without conflicts of interest. Governments needed consistent and evidence-based recommendations about optimal feeding practices. The Health Assembly must make an authoritative pronouncement about the optimal duration of exclusive breastfeeding: she therefore supported the draft resolution.

WHO should take firm action in cases of non-compliance with the International Code of Marketing of Breast-milk Substitutes and help countries to monitor implementation of the Code at national level.

Professor ZELTNER (Switzerland) endorsed the amendment proposed by the delegate of Sweden, welcomed the acceptance of that proposal by the delegate of Brazil and called upon other delegates to confine their suggested amendments to the phrases in square brackets in the draft resolution. He expressed the hope that WHO would adopt a similar evidence-based approach in determining exact procedures for the introduction of complementary foods.

Mr ROKOVADA (Fiji), Mr BOIT (Kenya) and Dr TOUYÁ (Uruguay) supported the draft resolution, agreeing with the recommendation of six months as the optimal duration of breastfeeding.

Dr LEVENTHAL (Israel) supported the draft resolution, as amended by Brazil, but considered that it might be difficult to implement. Furthermore, the term “breast-milk substitute” was ambiguous; mothers might think that it implied that such substances were an adequate substitute for breast-milk, and it was even used by manufacturers in their advertising. He would prefer to see the term “complementary food” or “baby nutritional compound” in the draft resolution.

Mr HAN (Republic of Korea) said that exclusive breastfeeding should continue for four to six months, since delaying the introduction of complementary foods might restrict a child’s growth.

Mrs MADZIMA (Zimbabwe) withdrew the amendment proposed earlier by the delegate of Zimbabwe and supported the draft resolution with the amendments proposed by Sweden. The points raised by the delegate of Thailand did not need to be addressed in the draft resolution, since they could be decided at regional or national level.

Mrs TAPAKOUDI (Cyprus) said that her country fully appreciated the importance of breastfeeding as a means of preventing child malnutrition, and promoted the Baby-friendly Hospital Initiative. She supported the draft resolution, with the amendments proposed by Sweden.

Dr TEMU (Papua New Guinea) said that his country had adopted an act to promote good infant nutrition 20 years earlier. He supported the draft resolution with the amendments proposed by Sweden. Referring to the comments by the delegate of Australia, he suggested the addition of a new subparagraph following the present paragraph 2(4): “to provide adequate social and nutritional support to lactating mothers unable to follow the six-month recommendation”.

Ms DJAMALUDDIN (Indonesia) supported the view that exclusive breastfeeding should continue for six months. However, the specific needs of individual mothers and infants must be taken into account. Accordingly, she suggested that a sentence should be added to that effect to paragraph
2(4). She further proposed that the global strategy should address in a balanced way the timely introduction of adequate, safe and appropriate complementary foods in conjunction with continued breastfeeding, and also the empowerment of the family. The global strategy should develop a new concept of intervention by means of regulatory and legislatory measures. More attention should be paid to protecting consumers from inappropriate and misleading information, labelling and advertising, as well as unethical marketing practices.

Dr NOVOTNY (United States of America) said that the challenge of infant and child nutrition must be considered in the context of sound scientific evidence and changing health environments. It was important to consider the full range of essential nutritional requirements for infants and children. More effective strategies were needed, including identification and assessment of specific micronutrient deficiencies and a better understanding of culture-specific practices and community standards of maternal and infant feeding.

The document before the Committee (A54/INF.OOC./4) made it clear that the recommendation of the expert consultation could not be extended beyond the population level. The available evidence did not exclude the risk that exclusive breastfeeding for six months might increase the risk of faltering growth and iron or other micronutrient deficiency in high-risk infants. The report emphasized the need to support mothers who could not, or chose not, to breastfeed exclusively for six months in ensuring the best possible nutrition for their child. Member States would need to balance population-based strategies against the needs of individual infants and mothers at risk.

The process of negotiation of the draft resolution at the 107th session of the Executive Board had been a challenging one, which had, however, benefited from the participation of a large number of Member States. It was important to achieve consensus quickly, and he therefore called upon delegations to confine their proposed amendments to the phrases in square brackets in paragraphs 2(4) and 3(3). He supported the version proposed by the delegate of Sweden.

Dr MACHATINE (Mozambique) said that, for the past 20 years, her country had advocated exclusive breastfeeding for four months and the continuation of breastfeeding until the child was 18 months old. However, in the light of the research described in the reports, she supported the draft resolution with the amendments proposed by Sweden.

Dr KIENENE (Kiribati) supported the draft resolution with the amendment proposed by Brazil. It was important to state specifically that infants should be breastfed for the first six months of life.

Dr HETLAND (Norway) welcomed the emphasis on human rights in the draft resolution and the importance it placed on strengthening growth monitoring and improved nutrition. The new international growth reference curves mentioned in the report of the expert consultation would be of great importance in monitoring infant health. He supported the draft resolution, with the amendments proposed by Sweden.

Dr SULEIMAN (Oman) said that a great deal of negotiation had been required to arrive at the text of the draft resolution, and he hoped it would be approved unanimously. He preferred the wording “exclusive breastfeeding during the first four to six months of life”, since any less precise reference might be interpreted as meaning only two or three months. He shared the concerns expressed by the delegate of Saudi Arabia: there was a danger that the draft resolution might be misinterpreted as advocating breastfeeding for six months only.

Dr SHIVUTE (Namibia) supported the draft resolution as amended by the delegate of Sweden. He emphasized the need for further research on the risks of transmission of HIV from HIV-positive mothers to their infants through breastfeeding, as called for in the draft resolution.
Mr GUILLEN (Peru), expressing support for the draft resolution, said that he would join the emerging consensus on the recommendation of an optimal duration of six months for exclusive breastfeeding.

Dr TSHABALALA-MSIMANG (South Africa) supported the draft resolution with the amendments proposed.

Dr KOUNANDY (Côte d'Ivoire), agreeing that comments should be confined to the text in square brackets, expressed a preference for the amendment proposed by Brazil, since it reflected more accurately than the amendment proposed by Sweden the conclusions of the expert consultation. The provisions of the draft resolution should remain general and be directed to the population as a whole rather than to individuals.

Dr LÓPEZ (Chile) said that, although she supported the recommendation of six months as the optimal duration of exclusive breastfeeding in view of the clear health benefits to both mother and child, she was concerned about the impact that the draft resolution might have on women, given their large contribution to the world of work and their role in society.

Mr OULEDI (Comoros) supported the draft resolution. Exclusive breastfeeding during the first six months of life would help infants, in particular those in developing countries, to develop healthily and give them a fighting chance against external hazards.

Ms INGÓLFSDÓTTIR (Iceland) agreed that discussions on the draft resolution should focus on the bracketed wording, and said that Iceland, for its part, fully supported the recommendation of the expert consultation regarding an optimal duration for exclusive breastfeeding of six months.

Dr FALL (Senegal) expressed support for the amendment proposed by Brazil which would further the interests of the infant within the framework of public health.

Ms KONDOLO (Zambia) said that, despite the fact that the delegate of Brazil had withdrawn her proposal, she remained in favour of wording which read as follows: “for six months as a global public health recommendation”. That wording was clear, and the amendment proposed by the delegate of Sweden was in her view superfluous.

Dr KELLOU (Algeria) said that, in the light of the conclusions and recommendations of the expert consultation, he supported the proposal that exclusive breastfeeding should be for the first six months of life.

Ms LAVIOILLE (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that her organization had noted with satisfaction the outcome of the systematic review of the optimal duration of exclusive breastfeeding. It, too, advocated the recommended duration of six months, and she urged Member States to support that recommendation.

Her organization welcomed a science-based approach to any discussion of infant feeding. The fact that only 35% of infants worldwide were exclusively breastfed for the first four months of life indicated a tremendous need for promotion and support of breastfeeding. She therefore urged Member States to become fully involved in formulating the new global strategy for infant and young child feeding, to be submitted to the Health Assembly in 2002. In addition to practical help to breastfeeding mothers all over the world, the Association was also able to offer technical support that governments might require in order to implement the new global strategy.

Ms GASKELL (La Leche League International), speaking at the invitation of the CHAIRMAN, said that her organization too had been delighted at the results of the WHO expert consultation on the
optimal duration of exclusive breastfeeding, which it also considered to be six months. She recalled that the Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding had provided momentum for the global breastfeeding movement in the 1990s: much had been done to make hospitals baby-friendly, to implement the International Code of Marketing of Breast-milk Substitutes and to increase support for breastfeeding in the workplace. Mother-to-mother support had proven efficient in many cultural settings, and 70% of the mothers enrolled in such a programme in Bangladesh had breastfed exclusively for five months, as compared with 6% in the control group. Maternal support in breastfeeding had been a challenging initiative to implement, and should receive priority attention at the international, national and local levels and funding under the WHO global strategy on infant and young child feeding. She endorsed the draft resolution with the inclusion of a recommendation of six months for the optimal duration for exclusive breastfeeding and looked forward to participating actively in the WHO global strategy for infant and young child feeding.

Dr BRAAK (Medical Women’s International Association), speaking at the invitation of the CHAIRMAN, said that malnutrition and micronutrient deficiencies, which often began in infancy, contributed to blighted mental and physical development and were a widespread cause of morbidity and mortality in later life. The nutrition of infants and young children was a key issue that was linked to the rights of both children and women. Women had the right to full and reliable health information, to choice and decision-making in health care, reproduction and infant feeding, and to the benefits of scientific progress. She urged WHO to continue to ensure that those critical rights were protected, promoted and respected.

Science was making rapid progress, and the accepted facts and assumptions of yesterday should be relinquished and replaced as newer and better information emerged. In order to make the best, most informed choices about the nutrition of infants and young children, each woman must have unrestricted access to full, accurate and updated health information and to confidential, honest and unbiased counselling. The report of the 1998 UNICEF/UNAIDS/WHO technical consultation on HIV and infant feeding1 recognized the right of a woman to make decisions about infant feeding. Her choices in that regard were complex and included a mental health dimension. All too often, a major factor in her choice was the fear of stigma, discrimination and violence if she could not, or chose not, to breastfeed. Mother-to-child transmission, which was responsible for more than 90% of paediatric HIV infections worldwide, also presented a mental health hazard, exposing the mother to severe psychological traumatic stress that might deprive the infant of the psychosocial stimulation normally associated with feeding.

Her Association welcomed WHO’s continued efforts in the area of infant and young child nutrition and urged the Organization to ensure that all parties involved were actively engaged in a dialogue, that a gender perspective was integrated in all policy, research and recommendations, and that infants, young children and their mothers benefited from scientific progress.

Ms LHOTSKÁ (Consumers International), speaking at the invitation of the CHAIRMAN, recalled that the International Code of Marketing of Breast-milk Substitutes had been adopted by the Health Assembly 20 years previously, despite the strong opposition of powerful infant food manufacturers and some governments. Throughout its existence, the Code had been a constant threat to the entire corporate community. The Code was still alive and well, thanks to the efforts of the governments that put the well-being of children before profit and consumer groups that had assisted in its implementation and monitoring, and to the continuous support of UNICEF. Although the Code had been implemented in full in 24 countries and 31 countries had incorporated most of its provisions into national legislation, violations were still widespread. Monitoring and implementation of the Code had

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become even more critical in the face of the HIV pandemic, since it also protected babies of HIV-positive mothers who chose not to breastfeed; commercial misinformation and manipulation must not interfere in their choice of replacement feeding.

She welcomed the recommendation for exclusive breastfeeding and expressed the hope that WHO would use its good offices to have that recommendation reflected in the draft Codex Alimentarius standards on infant formula and on cereal-based complementary foods. Infant food manufacturers should consequently change the recommended age of introduction on the labels of all their complementary foods.

The International Baby Food Action Network, of which Consumers International was a founder member, was pleased that two different recommendations were no longer being advocated, thus avoiding confusion and a waste of resources. Having assured the Committee that Consumers International would continue its collaboration in technical and policy development areas in infant and young child nutrition, she expressed the hope that the draft resolution with the recommendation of six months for exclusive breastfeeding would be adopted.

Dr BRONNER (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN and on behalf of the International Association of Infant Food Manufacturers (IFM), said that the food industry was committed to improving the health and well-being of infants and young children through proper nutrition and devoted considerable resources to the research and development of nutritionally balanced foods. It was also committed to developing a global strategy on infant and young child feeding, and was convinced that the process launched the previous year by WHO in conjunction with UNICEF would result in a comprehensive strategy and plan of action for implementing sound nutritional policies for infants and young children. It looked forward to participating constructively in the activities in that regard.

IFM welcomed the fact that the results of the WHO systematic review of the optimal duration of exclusive breastfeeding took into account the specific nutritional needs of the individual infant as well as prevailing environmental, cultural and other risk factors, and provided concrete recommendations for continued research in that regard. It also welcomed the report on the global strategy on infant and young child feeding, which highlighted the need for comprehensive national policies on the feeding of infants and young children.

IFM was proud to have taken an active part in the formulation of the International Code of Marketing of Breast-milk Substitutes, and continued to support governments in its implementation and monitoring. Individual manufacturers had worked with governments and civil society to help increase the percentage of mothers who exclusively breastfed their infants in the early months of life and had provided other assistance such as setting up Code compliance committees and widely distributing the Code to health care professionals. Lastly, IFM continued to support WHO's scientifically-based policies aimed at ensuring that all infants and young children were adequately fed, and it remained committed to playing a responsible and constructive role in infant and young child feeding.

Mr BAILEY (Save the Children Fund (UK)), speaking at the invitation of the CHAIRMAN, said that, although much progress had been made in the current year, the International Code of Marketing of Breast-milk Substitutes and relevant Health Assembly resolutions were far from being implemented globally as a minimum standard, as envisaged by the Health Assembly in 1981. Little more than a quarter of Member States had legally enforceable measures for implementing the relevant provisions, which were still being violated around the world. His organization welcomed the outcome of the expert consultation on the optimal duration of exclusive breastfeeding; such scientific confirmation should lead to clarity and consistency and would provide a needed opportunity to revitalize support for the Code's implementation. Save the Children urged WHO to support Member States actively in developing and implementing national legislation to reflect the Code's provisions, to take an active part with regard to reported violations and to advise manufacturers, distributors and marketers of breast-milk substitutes, bottles and teats on how to comply with the Code and relevant Health Assembly resolutions, including internal arrangements to monitor marketing and report
transparently on such monitoring. WHO should be careful to avoid partnerships that might conflict with the Code.

The slow progress made in implementing the Code over the past 20 years had been partly due to WHO's lack of leadership and its reluctance to support independent monitoring—a situation that could henceforth be changed. The global strategy for infant and young child feeding should highlight the importance of the Code in ensuring optimal infant health and survival and make clear, as the Code did, that compliance depended not on civil societies alone but on governments in coordination with WHO. Save the Children urged WHO to endorse the interagency operational guidance for emergency relief staff and policy-makers on infant and young child feeding in emergencies, formulated under the auspices of the ACC Sub-Committee on Nutrition and already endorsed by many United Nations organizations and other agencies, bilateral donors and nongovernmental organizations. WHO should seize the current opportunity for more practical involvement in infant-feeding issues at country and global levels. Save the Children was committed to the protection of the rights of children in relation to feeding and would continue to work with WHO in that area.

Mrs TEN HOOPE-BENDER (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said that her organization, which had always promoted exclusive breastfeeding, welcomed the report on the global strategy for infant and young child feeding. While commending the systematic review, the number of studies analysed had been small. She therefore urged WHO and its partners to support further research, particularly in developing countries, given the many complicating factors and small resources in such settings. It welcomed the clarification that some mothers might be unable or unwilling to breastfeed exclusively and in some cases should not be urged to do so.

Her organization endorsed the draft resolution and the proposal to adopt six-months as the global public health recommendation for exclusive breastfeeding. It also supported the recommendations relating to research, believing that successful exclusive breastfeeding depended on sound preparation during pregnancy and that data for the requisite guidelines were needed. Midwives played a crucial role in that regard; as health care providers during childbearing years, they had insight into many aspects of women's lives and could be a constant source of information and inspiration to those who wished to breastfeed. Her organization reiterated its commitment to exclusive breastfeeding and to working with WHO and other partners in further development of the global strategy.

Dr THIERS (representative of the Executive Board) recalled that there had already been a lengthy process of consultation and debate; a satisfactory conclusion should be reached.

Dr TÜRMEN (Executive Director) thanked speakers for their support for the global strategy for infant and young child feeding and for the draft resolution. The implementation of the global public health recommendation would involve important challenges, including increasing the frequency of exclusive breastfeeding to six months and promoting adequate, safe and complementary feeding. Exclusive breastfeeding was still infrequent; data available from the Latin American and Caribbean region and sub-Saharan Africa showed that less than 20% of infants were being exclusively breastfed at the age of four months. Information from Bangladesh, Brazil and Mexico, however, indicated that suitable investment and promotion could lead to rapid increases in breastfeeding. Further, many families lacked the knowledge and resources to prepare adequate complementary foods and adopt suitable feeding practices, in particular in the critical period from 6 to 24 months of age. To transform the findings of global research into feasible measures remained a major challenge; in that connection, she welcomed the suggestion made by the delegate of Switzerland regarding the development of science-based guidance on complementary feeding.

The CHAIRMAN, inviting the Committee to consider the draft resolution recommended by the Executive Board in resolution EB107.R16, asked delegates who had raised questions or reservations relating to the text whether they wished to maintain their positions.
Professor JONGJIT ANGKATAVANICH (Thailand), Dr TEMU (Papua New Guinea) and Mr JARAMILLO NAVARRETE (Mexico) withdrew their proposed amendments.

The CHAIRMAN invited the Secretary of the Committee to read out the amendment proposed by the delegate of Sweden on behalf of the European Union and supported by the delegations of Brazil and other countries.

Dr HOLCK (Secretary) read out the amendment proposed by the delegate of Sweden to the effect that the text contained in square brackets in paragraphs 2(4) and 3(3) would be replaced by “for six months as a global public health recommendation, taking into account the findings of the WHO expert consultation on optimal duration of exclusive breastfeeding”, the square brackets being deleted. The corresponding footnote would be reworded: “As formulated in the conclusions and recommendations of the expert consultation (Geneva, 28 to 30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (see document A54/INF.DOC./4)”.

Dr THIERS (representative of the Executive Board) confirmed that the proposed text reflected the conclusions and recommendations of the expert consultation.

Ms PHUMAPHI (Botswana), Dr KOUNANDY (Côte d'Ivoire), Ms FUNDAFUNDA (Zambia) and Dr FALL (Senegal) signified that in the interests of achieving consensus they were willing to support the draft resolution with the amendment proposed by the delegate of Sweden.

The draft resolution, as amended, was approved.¹

The meeting rose at 17:05.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA54.2.
FOURTH MEETING
Thursday, 17 May 2001, at 9:20
Chairman: Professor S.K. ONGERI (Kenya)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

HIV/AIDS: Item 13.6 of the Agenda (Document A54/15)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegation of Brazil, which read as follows:

The Fifty-fourth World Health Assembly,
Having considered the report on HIV/AIDS,¹
Considering that the AIDS epidemic has become one of the biggest threats to public health in the world, having reached pandemic levels and involving over 36 million people and recalling resolution 54/283 of the United Nations General Assembly which recognizes that the poor and developing countries are the most seriously affected by it;
Considering moreover that AIDS has caused the loss of countless human lives, the reduction of countries' productive capacity, the orphanhood of some 13 million children, a serious reduction in life expectancy, and much despair and unhappiness;
Noting that resolution 1308 (2000) of the United Nations Security Council stresses that the HIV/AIDS pandemic may pose a risk to stability and security;
Recalling that resolution WHA53.14 recognizes that prevention and health promotion activities are as important for combating the epidemic as those focusing on care and treatment of people living with HIV and AIDS;
Bearing in mind that the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases of the African Heads of State and Government supports the creation by the donor community of a global fund against AIDS with the aim inter alia of assuring access of populations affected by the epidemic to antiretroviral therapy;
Bearing in mind that the Declaration of Quebec City of the Heads of State and Government of the Americas emphasizes that good health and equal access to medical attention, health services, and affordable medical drugs are vital for human development and the achievement of political, economic and social objectives;
Recognizing that new techniques, especially those related to antiretroviral drugs, must be considered as a human rights issue and, as such, should be accessible without discrimination to all people living with HIV and AIDS, as set out in resolution 2001/33 of the 57th Session of the Commission on Human Rights;
Considering that treatment of HIV/AIDS provides a positive incentive for individuals to submit to voluntary counselling and HIV testing, which in turn dramatically increases the efficacy of HIV prevention and education efforts necessary to retard the advance of the pandemic;
Considering that HIV/AIDS affects women with special severity;

¹ Document A54/15.
Considering that levels of international aid to support HIV/AIDS programmes in poor countries approximately US$ 5 annually per HIV-infected person, has been greatly incommensurate with the prevalence of the infection;

Emphasizing the key role that WHO has performed at world level, especially in developing and least developed countries to establish and implement policy initiatives centred on health promotion, on prevention of related diseases, on organization of services, on assembling and making available appropriate information to assist the formulation of health policies, on technical and financial support for national health services, and on devising ways and means of negotiating better prices for the procurement of medical drugs;

Commending the action of UNAIDS in combating the AIDS pandemic, through its support for national AIDS programmes, including for the least developed countries, in the organization of the special session of the United Nations General Assembly on HIV and AIDS, and especially in the drafting and dissemination of documents which have facilitated thoughtful appraisal of the most relevant issues concerning the pandemic,

1. URGES Member States to express their support:
   (a) for the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases of the African Heads of State and Government, which support the creation by the donor community of a global fund against AIDS with the aim inter alia of assuring access of populations affected by the epidemic to antiretroviral therapy;
   (b) for the Declaration of Quebec City of the Heads of State and Government which emphasizes that good health and equal access to medical attention, health services and affordable medical drugs are vital for human development and for achievement of political, economic and social objectives;
   (c) for resolution 2001/33 of the 57th Session of the Commission on Human Rights which recognizes that access to medication in the context of pandemics such as HIV/AIDS is a fundamental element for realizing the right of everyone to the highest attainable standard of health;

2. CALLS UPON Member States:
   (1) to make every effort to guarantee that access to antiretroviral drugs and those for treating opportunistic infections should have as its point of reference the principle of equity, thus guaranteeing supply and prices compatible with the social and economic circumstances of individual countries and with the extent of HIV prevalence in each country;
   (2) to make every effort to guarantee access of the population to currently available techniques in the areas of health promotion, of prevention of the main AIDS-related diseases, and of care and treatment, with a view to reducing the negative impact of the HIV and AIDS epidemic throughout the world;
   (3) to seek all available ways and means at both international and national levels to increase access of populations to antiretroviral drugs and those for treating opportunistic infections;
   (4) to establish health policies which promote access to drugs through:
      (a) policy initiatives which embrace the right to use technical and intellectual capacity for local production of AIDS drugs, under the auspices of the agreements reached within the bounds of international law, such as the Agreement on Trade-Related Aspects of Intellectual Property Rights;
      (b) support for the establishment and financing of an international fund for promotion of access to antiretroviral drugs and those for treating opportunistic infections, based upon the principle of equity;
COMMITTEE A: FOURTH MEETING

(c) facilitation of the supply of drugs, including the production and distribution of generic drugs and the negotiation of prices with pharmaceutical drug companies, in line with the social and economic development profiles of each country;

(5) to ensure participation of people living with HIV and AIDS in the formulation of national policies on access to drugs;

(6) to promote social control at national level so as to ensure better quality control of antiretroviral drugs;

(7) to provide international aid to combat HIV/AIDS in the form of grants, not loans, to the least developed countries;

3. REQUESTS the Director-General:

(1) to provide support for, and to participate in, the creation of an international fund to ensure access particularly of poor and developing countries to antiretroviral drugs and those for treating opportunistic infections such fund to make drugs available at differentiated prices in line with social development indices and according to the prevalence of HIV in different regions and countries, so that the principle of equity can be attained;

(2) to establish an expert committee with an expanded membership of physicians, scientists, public-health practitioners, and nongovernmental AIDS advocates (including people with AIDS), drawn from both developed and developing Member States, to review and assess on a case-by-case basis the scientific, medical and operational feasibility of proposals submitted by developing Member States for support from the international fund;

(3) to reject any proposal which would entail financing from the international fund on the basis of interest-bearing loans, rather than outright grants, to least developed Members States or other Member States needing significant financial support because of the scale of the HIV/AIDS epidemic in relation to their domestic resources;

(4) to create a data bank on drug prices, containing the information on drug procurement and manufacturers needed for management of national policies on access to antiretroviral drugs and those for treating opportunistic infections;

(5) to establish parameters jointly with the Member States and the pharmaceutical drugs industry, including producers of generic drugs, in order to frame a global policy of differentiated prices for drugs according to social, economic and epidemiological indicators, with the principle of equity as the basic point of reference;

(6) to devise ways and means to permit better monitoring and quality control of antiretroviral drugs;

(7) to foster intercountry exchanges and international technical and legal cooperation, with a view to framing a global policy for the production of generic drugs, and to implementing policies for care, treatment and prevention of AIDS, which implies the strengthening of links between public authorities and civil society;

(8) to accord access to antiretroviral drugs and those for treating opportunistic infections the highest priority, and to frame policies:

(a) for reducing the suffering of men, women and children living with HIV and AIDS throughout the world;

(b) for reducing mortality caused by AIDS, especially in the socially and economically less developed countries;

(c) for increasing life expectancy, particularly in those countries where it has been falling as the result of AIDS;

(d) for restoring the process of social development in poor countries by helping to maintain productive capacity and the labour force.
Dr BODZONGO (representative of the Executive Board) said that the Board, at its 107th session, had noted the information contained in document EB107/29 which described a restructuring of WHO's work in the area of HIV/AIDS so as to strengthen its leadership in the fight against the global epidemic. Owing to the lack of time available for in-depth discussion and in view of the continuing problem of HIV/AIDS, the Board had recommended that the issue be fully debated at a later stage.

Mr TEIXEIRA (Brazil) said that the HIV/AIDS pandemic and the numerous problems deriving from it required a global response to contain its spread and alleviate the suffering of the 36 million people affected, the majority of whom lived in the world's poorest countries.

Brazil, whose own policy in regard to HIV/AIDS was based on the principles of international solidarity and mutual assistance, had put forward several proposals related to HIV/AIDS at the global level: establishment of an international fund to finance the acquisition of antiretroviral drugs; negotiation of differentiated prices, according to social development indices, for antiretroviral drugs for poor and developing countries; strengthening the process of inter-country cooperation, especially South-South; encouraging public and private institutions to provide incentives and funds for research into, and development of, new drugs; promotion of international technical support in the use of antiretroviral drugs; support for measures to guarantee compliance with international agreements covering in-country production of strategic drugs and those drugs needed for use in specific situations such as in the HIV/AIDS pandemic; fostering broad access to prevention resources, especially male and female condoms and injecting equipment; establishment of a data bank detailing the prices of antiretroviral drugs, to be monitored by WHO; and development of worldwide strategies to guarantee the basic rights of people living with HIV/AIDS and of the population groups most vulnerable to the epidemic.

Those proposals focused on access to care, as less had been achieved worldwide in that area. However, the Brazilian response to HIV/AIDS, fully recognizing that care and prevention should go hand in hand, emphasized large-scale prevention programmes based on the empowerment and involvement of communities, alongside the universal provision of care. Brazil's national response to HIV/AIDS had achieved reasonably positive results, although enormous commitment, a high degree of political will, clear priorities and substantial financial investment had been required. Brazil was willing to share the fruits of its experience with any interested countries or institutions.

Mrs WIGZELL (Sweden), welcoming WHO's determination to participate actively in scaling up the response to the HIV/AIDS pandemic, said that the Organization was well placed to play a normative role, provide technical support and help to mobilize additional resources. She noted with satisfaction that the Director-General, in her address to the Health Assembly, had emphasized a broad approach encompassing all stakeholders in civil society and the international community. She fully endorsed the priorities for support to Member States' HIV/AIDS programmes set out in document A54/15.

Recent advances in drug treatment should not be allowed to obscure the importance of continued support to primary prevention, with a special focus on young people and reproductive health, voluntary counselling and testing, reduced mother-to-child transmission of HIV and care and support for people living with HIV/AIDS. Support for the development of preventive measures, such as vaccines and microbiocides, should be reinforced.

New HIV drugs had appeared, and the possibilities for making them available to large groups of infected patients were truly revolutionary. However, experience over decades with low-cost treatment of tuberculosis had shown that drugs were not the only solution. A functioning delivery system, which reached the periphery, such as the DOTS system (directly observed treatment, short course) used in tuberculosis control, was also required to optimize access to new drugs. WHO would be called upon to

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1 Document A54/3.
provide guidance, technical support and training in that regard. Sweden would continue, within the framework of its bilateral cooperation, to support intersectoral programmes to develop strong, effective and sustainable national health systems. She therefore strongly supported the long-term perspective advocated by the Director-General in her address to the Health Assembly. Specific resources should therefore be set aside for strengthening the delivery system.

In Sweden's HIV/AIDS strategy, the global situation was closely linked to broad development issues. That situation could no longer be seen only as a health issue, notwithstanding the need for increased efforts within the health sector itself. Equity and equality should be high on the agenda if the most vulnerable in society were to be helped. Sweden would participate in global partnerships, including contributing to an appropriate global HIV/AIDS and health fund.

As the country that currently held the presidency of the European Union, Sweden intended to propose a draft resolution on HIV/AIDS.

Professor CHURNRURTA KARNCHANACHITRA (Thailand), welcoming the report and the many activities described therein, which responded to resolution WHA53.14, expressed her appreciation for WHO's commitment to and continuing cooperation in the area of combating HIV/AIDS. She endorsed WHO's priority areas of work and urged the Organization to continue to make every effort to encourage primary prevention. She noted in particular the promotion of the use of condoms; information, education and communication campaigns; empowerment of young girls and women; fostering of life skills among young people; and promotion of safer sex.

She said that her country had been wrongly cited in paragraph 8 of the report, as it could not afford to provide antiretroviral drugs to all people with HIV/AIDS. Although her Government was spending 63% of its total HIV/AIDS programme budget on care and treatment, the amount was sufficient to benefit only the 2100 HIV/AIDS patients who had enrolled in clinical trials of combination antiretroviral drugs. If Thailand expanded its coverage to all the 100 000 reported cases of HIV/AIDS in the country and the price of antiretroviral drugs remained constant, the annual cost would be equivalent to 2000% of the HIV/AIDS programme budget, or nearly half the overall health budget. Even under an optimistic scenario of a significant drop in the cost of generic drugs and voluntary price reductions by pharmaceutical companies, the figures would be 650% and 15%, respectively. Such a substantial transfer of public funds would entail reductions in other activities, including the prevention programme. She therefore supported WHO's endeavours to obtain the lowest possible prices for antiretroviral drugs through negotiations with the pharmaceutical industry.

People had a right to be protected from HIV infection. She urged WHO to encourage Member States, when introducing antiretroviral drugs, not to compromise by shifting resources from prevention to care; to maintain a functioning preventive programme, including voluntary counselling and testing; to provide comprehensive care and support for people living with HIV/AIDS; to take the economic situation into consideration so as to ensure the affordability and long-term sustainability of care; to strengthen the health care infrastructure so that it could use antiretroviral drugs; and to provide information on the cost and outcome of interventions for the purpose of policy monitoring and evaluation.

The delegation of Thailand was unable to support the draft resolution proposed by Brazil, as it focused mainly on drugs and could lead to the medicalization of HIV/AIDS, whereas the AIDS situation required a comprehensive approach encompassing prevention, care and support, and impact alleviation. Resolution WHA53.14, she affirmed, was more comprehensive than the draft resolution and had already recognized the right of every individual to be protected from HIV infection.

Dr FERREIRA SONGANE (Mozambique) stressed the need to reconsider the question of who should lead efforts to combat the HIV/AIDS pandemic. All Member States were agreed that the problem should be tackled through a multisectoral approach, but the current superstructure created by the establishment of national committees at the highest levels was depriving ministries of health of their rightful role as leaders. The number of and level of participation in international forums on HIV/AIDS had given ample proof of high-level commitment. The time for talking was now over – the
time had come for action, before it was too late. An operational structure along the lines of that for Roll Back Malaria should be established at WHO.

He keenly awaited more information on the global AIDS and health fund proposed by the United Nations Secretary-General and on its goals and functions. However, discussion on funds for access to antiretroviral drugs was distracting attention from the most important aspect of efforts to combat AIDS, namely prevention. While such drugs were necessary, what was essential, above all in poor countries, was the strengthening of basic services so as to prevent the spread of infection, especially among young people and adolescents. In Mozambique, most HIV-infected people were aged between 24 and 40. Steps must be taken to ensure that in future more young people would not be infected through ignorance, as at present. In his country, more than 50% of hospital beds were occupied by HIV/AIDS patients, which placed a great strain on an already over-stretched health system. So, while he welcomed the greater availability of antiretroviral drugs and important programmes such as those on the prevention of mother-to-child transmission, it was important not to lose sight of the main objectives in the fight against HIV/AIDS: preventive action, strengthening of health care systems and returning the leadership role to ministries of health.

Dr UPUNDA (United Republic of Tanzania) said that he concurred with the statement by the delegate of Mozambique. Recent trends in the HIV/AIDS pandemic were placing health care systems under extraordinary strain. That situation called for scientifically tested information to be made available so as to allow for a swift and accurate response to the problem. WHO was the natural ally of health ministries; however, the Organization did not have the necessary resources to scale up its HIV/AIDS activities in accordance with Member States’ national priorities. Notwithstanding the multisectoral approach adopted at national level, and the activities undertaken by UNAIDS, WHO’s capacity to support health ministries still needed to be improved. To ensure a strong HIV/AIDS programme and to maintain its comparative advantage, WHO must provide useful guidance and technical support to the health sector.

Mr SKURATOVSKYI (Ukraine) said that HIV/AIDS differed from other epidemics: the prevalence, speed of infection and discrimination surrounding those affected by the disease created a unique social and psychological situation calling for joint action. For that reason, the Ukraine had been one of the proponents of the special session of the United Nations General Assembly on HIV/AIDS to be held in June 2001, which, it was hoped, would prove to be decisive in curbing the epidemic. He acknowledged the important role played by WHO and UNAIDS in the global efforts to combat HIV/AIDS. He also welcomed the work undertaken pursuant to the terms of resolution WHA53.14. The global health-sector strategy to combat HIV/AIDS and sexually transmitted infections would be one of the central themes of the United Nations system’s strategic plan for HIV/AIDS for 2001-2005. The priorities outlined by WHO to support Member States in their HIV/AIDS programmes were in line with the requirements. He also stressed the importance of the consultations under way between WHO, UNAIDS and other United Nations bodies with pharmaceutical companies with a view to improving access to HIV/AIDS treatment.

Over the past few years, the epidemiological situation in the Ukraine had deteriorated: about 75% of HIV-infected persons were injecting drug users. The epidemic was spreading, with an increase in the numbers of pregnant women and children infected with the virus. Particularly alarming was the fact that most HIV-infected people were young adults (20-39) or adolescents. Given the absence of a cure or a vaccine, measures to prevent the spread of infection must be given priority. In his country, the matter was being dealt with at the highest political level. Pursuant to a presidential decree, the Ukrainian Ministry of Health had devised an all-State programme for prevention of HIV/AIDS for 2001-2003, aimed _inter alia_ at reducing the number of cases of HIV infection contracted through blood transfusions and during medical treatment. With the assistance of international organizations, work to prevent mother-to-child transmission had also begun. A Government committee on HIV/AIDS prevention comprising Members of Parliament, representatives of United Nations agencies and nongovernmental organizations had been set up to coordinate action to prevent the spread of the
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epidemic and, it was to be hoped, to reduce prevalence and mortality rates as well as to ensure epidemiological surveillance.

Dr SHIMODA (Japan) said that he welcomed the Organization’s efforts to launch discussion on guidelines for standardized antiretroviral therapy in resource-constrained countries. While he understood the need for WHO to strengthen its activities at national and international levels, he cautioned that duplication of efforts with those of other relevant agencies such as UNAIDS should be avoided. Regarding the proposal to strengthen health systems worldwide in their measures to combat HIV/AIDS, he stressed the need for consistency with WHO’s earlier policy in the area of health system strengthening. As for measures to prevent HIV/AIDS in developing countries, aside from increasing accessibility to HIV/AIDS drugs it was also essential to develop public health infrastructures and to ensure appropriate medical facilities and personnel. The problem of the availability of HIV/AIDS drugs must nonetheless be resolved, hence the need to continue efforts towards a consensus on suitable measures in the light of the joint WHO/WTO workshop held in Høsbjør, Norway, in April 2001 on differential pricing and financing of essential drugs.

Dr KALITE (Central African Republic) said that his country was among the 10 nations most seriously affected by AIDS, with an HIV prevalence rate of 14%. The situation was compounded by poverty, and national efforts to combat the disease undertaken thus far, focused mainly on preventive measures, had been unable to stop the devastating loss of lives. More than ever, international solidarity was required to halt the epidemic. In that connection, he thanked WHO, UNAIDS and other international partners for their support. He fully supported the draft resolution proposed by Brazil, in particular with regard to access to treatment and the preference for grants instead of loans, given that the Central African Republic was one of the world’s most heavily indebted nations. Access to treatment, including to low-cost antiretroviral drugs, was an essential component of any HIV/AIDS programme as preventive measures based on education were not sufficient; it would significantly improve other programmes, such as voluntary HIV testing, which were also preventive measures.

Dr MASSE (Canada) welcomed WHO’s leadership in its global action against HIV/AIDS and endorsed the comprehensive report (document A54/15), which would serve as a basis for important work in the future. The task currently facing WHO was to step up its efforts to combat HIV/AIDS by building on past experience, and to launch a strategic attack against the disease, in view of its far-reaching and devastating consequences. The current situation was untenable. WHO’s much-needed global health-sector strategy against HIV/AIDS must be properly coordinated with other plans in the United Nations system’s strategic plan for HIV/AIDS for 2001-2005. He welcomed the new vigour in programme focus, giving priority to identifying gaps in knowledge and disseminating up-to-date information to those in need. It must be recognized that prevention and treatment formed an integral part of a holistic approach to the disease. For instance, preventive action that took account of gender disparities and educational campaigns targeted at the most vulnerable sectors of the population reduced the risks for infection in those groups.

The economic and social costs of the epidemic could not be reduced as long as effective treatment and care were lacking, thereby preventing infected people from continuing their roles, such as family carers or health workers. The crucial element of the cost of treatment was deservedly receiving increased attention. Most of the millions of people affected by HIV/AIDS had no access to treatment. His Government therefore supported the Organization’s efforts with others to continue to accelerate access to care and to improve the availability of medicines against HIV/AIDS at affordable prices. The report referred to the link between AIDS and poverty, and in that context Canada was concentrating its efforts on improving the health of those living in poor and marginalized communities. Much remained to be done. However, if the measures described in the report were implemented effectively and rapidly, WHO would be able to make a major contribution to the fight against the HIV/AIDS pandemic.
Dr VAN SCHOUTEN (Netherlands) expressed satisfaction with the information, analysis and suggestions for action on HIV/AIDS contained in the report. Its strong points were its emphasis on prevention as the most crucial element in stopping the further spread of HIV/AIDS, on strengthening health systems in developing countries as an essential means of providing adequate care to HIV/AIDS patients, on psychosocial and social support for people living with AIDS, and on the clear connection between HIV/AIDS and other sexually transmitted infections.

There were, however, some weak points. The Organization's approach to HIV/AIDS was confined to its medical aspects, to the detriment of the broader developmental aspects and the consequences of the pandemic.

WHO had, however, identified some priority areas in which the HIV/AIDS programme should be strengthened. Such activities as the prevention of HIV transmission among young people should focus on gender equity and empowerment of girls and women. He was concerned that the report contained no reference to the global strategy for infant and young child feeding, which was also on the agenda of the Health Assembly. Moreover, no attention had been given to the relationship between nutrition and the immune response to infections such as HIV. In that context, no clear priority had been given to research on the link between mother-to-child transmission of HIV and nutrition or the role of nutrition generally in health care.

He requested clarification of some aspects of the report. Referring to paragraph 9, which mentioned the need to strengthen WHO's offices at national level, he asked how many additional staff at both national and international level would be recruited to deal specifically with HIV/AIDS. In the context of the human resources policy, WHO should take the lead in tackling the mental health of and the effect of stigmatization on HIV-positive people, following the outcome of the round-table discussions held on mental health. Referring to the draft progress report mentioned in paragraph 10, he asked whether it would be compiled in association with other United Nations organizations or solely by WHO.

He stressed the importance of intensifying efforts to build up an adequate infrastructure in countries affected by HIV/AIDS in the hope that they would in the near future have access to treatment such as antiretroviral drugs. The similarity of the treatment required for HIV/AIDS and tuberculosis made extension of tuberculosis programmes to include HIV/AIDS action a logical step.

WHO should recognize that HIV/AIDS was not only a medical problem but linked to issues of development. In that context, WHO needed to define its role, particularly vis-à-vis the functions of UNAIDS and other organizations involved in the control of HIV/AIDS.

Mr GUDMUNDSSON (Iceland) said that prevention of HIV transmission was the key to overcoming the pandemic. Efforts should be focused on young people in order to prevent sexually transmitted infections, on mother-to-child transmission of HIV, blood safety, safe injection practices, and on protecting vulnerable groups. It was a human right for people with AIDS to have access to care and support, including access to drugs and antiretroviral therapy, management of major opportunistic infections, palliative care and psychological and social support. That goal could be achieved only through an effective primary health care service. Surveillance was essential in order to evaluate the spread of infection and the result of interventions. Voluntary counselling and testing for HIV infection needed to be strengthened. Research into social behaviour and vaccine and drug development should be supported in particular. The role of affluent nations in that context was crucial.

Mr THOMPSON (United States of America), commending the report for reflecting the major issues of HIV/AIDS, said that the priority areas for strengthening WHO's work and the priorities for technical cooperation with Member States were appropriate. Additional information, however, was needed on the relationship between WHO's HIV/AIDS programme, the programmes of other United Nations specialized agencies, Bretton Woods Institutions and the efforts of major nongovernmental organizations. He noted that much of the planned work stemmed from the direction given by resolution WHA53.14.
He commended the report's emphasis on prevention, which his Government believed was cost-effective and the key component of an integrated strategy. National prevention campaigns with strong leadership such as those conducted in Brazil, Thailand and Uganda, although often supported by modest resources, had proved to be the most effective defence against HIV/AIDS. Effective strategies to prevent mother-to-child transmission of HIV should be expanded. That would require special investment in related research which was appropriate to local settings and capabilities. Individual and government accountability and culturally appropriate approaches based on changing behaviour and on abstinence should also be part of prevention efforts. The impact of the epidemic on individuals, families and communities could be lessened through collaborative work with faith-based institutions, as shown from experience in his country.

He welcomed the attention given to care, including access to drugs and antiretroviral therapy. Preventive measures could themselves improve access to care, and provision of care provided a crucial entry point for efforts to prevent further transmission. He emphasized the importance of the report's call for evidence-based policy and treatment guidelines for appropriate antiretroviral therapy in resource-constrained settings. His Government looked forward to conducting clinical research with WHO, UNAIDS and Member States to provide the information base for the development of such guidelines.

His Government had been pleased to make a first contribution, of US$ 200 million, to the global AIDS and health fund announced by the United Nations Secretary-General, including action on malaria and tuberculosis. He expressed the hope that the fund would support an integrated approach to reducing the spread of infection, preventing mother-to-child transmission of HIV and providing care for the sick. He looked forward to discussing at the current session health infrastructure development and the training of medical personnel with a view to complementing the treatment-oriented draft resolution proposed by the delegation of Brazil.

While he supported the establishment of a working group to achieve a statement of direction for WHO, he agreed with the delegates of Mozambique, Sweden and Thailand that it should be broadly focused. He stressed that such a working group should not limit the deliberations at the forthcoming United Nations General Assembly special session on HIV/AIDS in June 2001.

Professor GIRARD (France) said that, thanks to cooperation among UNAIDS, WHO and other institutions, international action was growing. That trend was reflected in the fact that, for the first time, the United Nations General Assembly was soon to deal exclusively with a health problem and that an international conference to be held in Dakar on 30 November 2001 would discuss follow-up action so that the control of HIV/AIDS could move into a new phase with facilitated access to drugs.

France had been among the first countries to denounce, in 1997, the scandal of unequal access to drugs; such access was a right of all patients. His country therefore fully supported the setting up of a global fund, which should be operational as soon as possible. Access to drugs, however, presupposed quality control, in which WHO should be involved, as well as developed health systems and inter-hospital forms of cooperation such as "twinning". Although access to drugs was not the sole solution, prevention campaigns had decreased with the advent of triple therapy in 1996.

While his country supported the adoption of a resolution at the current session for the control of HIV/AIDS, it considered that a more global resolution, which would set a landmark in control activities for HIV/AIDS, would be achieved by taking into account the complementary text to be submitted by the European Union and creating a single, unified text.

Dr DUONG HUY LIEU (Viet Nam) reported on a conference held recently in Hanoi on 10 years of HIV/AIDS prevention and control. Most of the major factors necessary for a serious HIV/AIDS epidemic were present in his country. Since 1994, there had been an exponential increase in detected cases of HIV infection, and by the end of 2000, some 32 000 people had been reported to be infected. Women represented 14% of the total infected population. The epidemic in Viet Nam was concentrated among injecting drug users and commercial sex workers, who accounted for 63% and 4%, respectively, of the cases of infection.
Providing an overview of the measures taken in Viet Nam to combat HIV/AIDS, he noted that prevention and control had been given high priority. Following the establishment of surveillance mechanisms in 20 provinces, the information provided had allowed projection and estimation of the progress of the epidemic. Interventions such as peer education and the promotion of condom use had been concentrated on high-risk groups such as injecting drug users and commercial sex workers, as well as youth. Information and education activities had been intensified through the mass media, and measures had been taken to improve the availability of condoms. Recent surveillance had revealed an increase in the rate of HIV infection among military recruits and pregnant women. However, the financial and human resources available were insufficient, and the HIV/AIDS programme had been constrained by a lack of well-trained workers.

A national strategic plan for 2001-2005 based on multisectoral cooperation had been developed which gave priority to information and education activities as well as strengthening HIV/AIDS prevention and control in the health sector, strengthening the surveillance system and training personnel. However, in view of the severe financial constraints in his country, the cooperation and support of external donors were essential for implementation of the plan.

Mr JUNOR (Jamaica) thanked UNAIDS, WHO/PAHO and other partners for their support in his country's struggle against HIV/AIDS. The growth in the epidemic of HIV/AIDS in the Caribbean region was second only to that in sub-Saharan Africa in global terms. A regional strategic plan had therefore been developed which encompassed preventive and care aspects along the lines proposed by WHO. Economists had calculated that it would cost about US$ 250 million a year to make a real difference. He informed the Committee that in February 2001 an HIV/AIDS partnership had been launched in the Caribbean region at a meeting of heads of governments. It was planned to scale up multisectoral response through rapid development and a review of national strategic plans with a view to developing the capacity required to ensure access to care for persons who were already infected. Moreover, traditional societal and cultural rigidity, which had constituted a major obstacle to reducing the stigma and discrimination still experienced with regard to HIV/AIDS, would be addressed more boldly. His country would want to have access to the proposed global fund and he appealed for all Member States to be involved in decisions concerning the manner in which the fund was administered and distributed. Finally, while welcoming the Brazilian initiative in proposing a draft resolution, he indicated his wish to participate in reviewing the draft text.

Dr MELKAS (Finland) welcomed the more systematic, focused and coordinated approach to the evolving HIV/AIDS pandemic set out in document A54/15. WHO's global leadership in strengthening responses in the health sector and its contribution to multisectoral work as an active component of UNAIDS had been well developed. However, even an intensified response had not met the ever-increasing demands of the pandemic. New resources, such as the planned global fund, were therefore welcome and necessary; however, he warned that when new resources became available they should not be wasted on new structures and bureaucracy but should be directed at enlarging and intensifying existing activities. The global strategy prepared and adopted by UNAIDS in 2000 and the strategies of the cosponsors should provide the basis for the efforts undertaken. The key focus in WHO's work should be to support countries in building and developing a health infrastructure capable of facilitating prevention and care.

He emphasized that HIV/AIDS could not be solved with money and technology alone. There was still a need for fundamental social and cultural changes to reduce vulnerability, eliminate poverty, promote education and opportunities for women and allow open discussion of sexual matters. The challenges for WHO and other participants in the struggle were therefore broad and complex. He accordingly supported the proposal of a comprehensive resolution, as put forward by the delegate of Sweden.

Dr KHAZ'AL (United Arab Emirates) recognized that the current period was crucial for WHO's action on HIV/AIDS. In her country, UNDP had provided assistance in combating that lethal
disease. She paid tribute to the efforts made to address the various priorities, including the need to reduce the opportunistic infections it caused. Since the adoption of a national programme in 1995, her country had made progress in reducing the impact of the disease. She welcomed collaboration between headquarters and the Eastern Mediterranean Region in helping to prevent the disease from spreading. She also thanked WHO and UNAIDS for helping her country to understand the true magnitude of the disease and its causes. UNAIDS and WHO should continue working in a similar manner.

Professor KÖLBEL (Czech Republic) indicated that, although HIV/AIDS was not a leading health problem in his country, he fully realized the enormous importance of the pandemic in many countries of the world. He therefore welcomed the well-balanced report. In his country, the priorities set out in the document were covered by plans of action. He expressed appreciation of WHO's intention to adopt a strategic plan at the Fifty-fifth World Health Assembly which could be used by his country to prepare the follow-up to the present national plan of HIV/AIDS action. He also welcomed the fact that HIV/AIDS was the subject of the United Nations General Assembly special session to be held in June 2001; the resulting attention should contribute to raising the awareness of political leaders throughout the world concerning the serious implications of the issues involved and the need to devote more attention and funding to HIV/AIDS. He welcomed the draft text proposed by Brazil and indicated that he would study the Swedish proposal.

Dr ABEBE (Nigeria), while welcoming the report in document A54/15, objected to the phrase in paragraph 8 which stated that sub-Saharan Africa was "home to most people living with HIV/AIDS". She supported the statement made by the delegate of Mozambique concerning the importance of the health sector and of preventive measures in the multisectional response to HIV/AIDS. The health sector should continue to play a leadership role in HIV/AIDS control, focusing on reducing the rate of new infections and providing quality care to people living with HIV/AIDS. The high level of commitment to combating HIV/AIDS in Nigeria was demonstrated by the establishment of a Presidential Council and the development of a national action committee on AIDS, which was a multisectional body responsible for coordinating the various sectoral responses to the pandemic, although the bulk of the response involved the health sector. A comprehensive plan of action for controlling HIV/AIDS in Nigeria had recently been launched by the President, which would align the activities of all partners.

Nigeria had hosted an extraordinary meeting of OAU in Abuja in April 2001 to discuss the issue of HIV/AIDS and related infectious diseases, and a declaration had been signed by the Heads of State and governments, which would be adopted at the ordinary meeting of OAU to be held in Lusaka later in 2001.

The key to reducing the prevalence rate of HIV/AIDS, which was already 5.4% in her country, remained prevention. The problem of access to drugs and the poor state of health systems remained major barriers to HIV/AIDS control in Africa. The provision of affordable antiretroviral drugs in a situation in which health systems functioned poorly was a major challenge. It was important to emphasize that the administration of antiretroviral drugs required support and monitoring facilities to check for adverse reactions. Access to antiretroviral drugs should therefore be accompanied by the provision of laboratory services, in addition to improving the capacity of health workers at all levels of care to administer the drugs.

Dr TEE Ah Sian (Malaysia), supporting the draft resolution proposed by Brazil, emphasized that the previous year the Committee had been informed that multinational drug companies were ready to announce substantial reductions in the prices of antiretroviral drugs for the treatment of HIV/AIDS in developing countries. However, the promise remained largely unfulfilled and millions more people had died since. Although drugs were not the only strategy for HIV/AIDS control, it could not be denied that broader access to drugs could alleviate the suffering of many persons infected by HIV. She therefore urged WHO to coordinate the unilateral efforts of Member States in their quest for affordable drugs. Following the efforts made by certain countries, the Agreement on Trade-Related
Aspects of Intellectual Property Rights allowed for contract manufacturing and parallel importing in situations of emergency, as in the case of the HIV/AIDS pandemic. On that basis, the Malaysian Parliament had amended its Patents Act accordingly. Multinational companies needed to understand that developing nations would take action that was legal and in accordance with WTO rules to save the lives of their peoples. At present, companies could sell only limited amounts of antiretroviral drugs to developing countries because of the high prices. It would therefore be mutually beneficial for all concerned if the prices were significantly reduced.

Dr COLEMAN (Liberia) told the Committee that Liberia was experiencing a rapid and alarming rise in the prevalence rate of HIV/AIDS, from 4.6% in 1997 to 8.2% in 2001. That increase was a consequence of the extreme socioeconomic conditions affecting the people of his country, where 85% of the population lived below the poverty line. Conditions of that nature were conducive to the rapid spread of HIV. The situation was complicated by the state of denial that persisted among the people of his country, which had contributed to the low level of awareness and the decline in prevention activities, as stigmatization and discrimination increased.

In view of the gravity of the situation, the Government, in collaboration with groups from civil society and UNAIDS, had intensified awareness and prevention programmes over the past year, with special reference to young people. He therefore thanked UNAIDS, the United States Agency for International Development and other bilateral donors for their support and welcomed the recent formulation of the Abuja Declaration. In addition, he looked forward to the establishment of the proposed global fund and to affordable retroviral treatment being made available to the many people living with HIV/AIDS. The pledge made at the meeting of Heads of State on HIV/AIDS in Abuja to allocate at least 15% of African national budgets to health, with a view to strengthening the health systems, would definitely reduce the great strain that was being exerted on the Region's weak health systems. His country had begun to implement many of the activities set out in the plan of action that had resulted from the meeting. He expressed the hope that the consolidated efforts of UNAIDS, governments, nongovernmental organizations and civil society would soon bring the pandemic under control. He supported the draft resolution proposed by Brazil, with certain amendments.

Dr AL-JABER (Qatar) said that the worsening HIV/AIDS pandemic called for increased efforts to curb that atrocious situation by all means possible. Everyone was aware that many women had lost their children or husbands. With regard to the approaches used to combat HIV/AIDS and to provide treatment such as antiretroviral therapy, international goodwill was needed for provision of the necessary drugs and to enable the countries particularly affected to produce such drugs themselves. Those countries also needed technical assistance and instruction in how to treat HIV/AIDS patients. His country supported the draft resolution proposed by Brazil. WHO should intervene more decisively so as to enable countries to plan their strategies to combat HIV/AIDS and related diseases.

Dr VIOLAKI-PARASKEVA (Greece) commended document A54/15 and especially the priority areas of work mentioned in paragraph 7, in particular those connected with prevention and blood safety. She also noted the section on the prevention of mother-to-child transmission of HIV (paragraph 17) and said that further research was needed on the transmission of HIV through breastfeeding. In regard to HIV surveillance, Greece was making efforts to collect data so as to obtain the best estimate of the cumulative number of HIV cases. That work was being done in cooperation with AIDS reference centres and the infectious diseases units of hospitals. In her country, HIV and AIDS patients, including illegal immigrants, received free antiretroviral therapy. The surveillance data in Greece suggested that the sexual transmission of HIV was continuing at more or less the same rate as in recent years. The problem was far from being solved, and the epidemiological picture varied considerably in different parts of the world.

Mrs SEFA-DEDE (Ghana) said that Ghana, like other sub-Saharan countries, was grappling with the HIV/AIDS pandemic. It had started a national AIDS programme in 1985 which had
culminated in the formation of an AIDS Commission under the Presidency in 1999. The current prevalence rate was 4.6% and the awareness rate over 98%, but changing behaviour patterns remained problematic. Her country’s approach was multisectoral and was coordinated by the Ministry of Manpower and Employment. The private sector had been involved, mainly through the Private Enterprises Foundation. One area of activity that had been given priority was professional development and motivation, in order to recruit enough personnel to provide the necessary services. Health financing had been used to develop a risk-sharing approach in order to improve care access and use, especially for those unable to afford health care. Owing to the free movement of people, it was difficult to apply a purely local or individual approach. An international approach to HIV/AIDS was therefore necessary, and she called on all countries and organizations to give the United Nations Secretary-General’s important plea the necessary support to achieve the proposed targets. Ghana considered that the global fund, once established, should be used flexibly so that beneficiary nations could apply the resources to both investment and recurrent needs in the fight against HIV/AIDS.

Professor ANWAR (Egypt) thanked WHO and its experts at both headquarters and the regional offices for all their efforts in the fight against HIV/AIDS. Even though the prevalence of HIV/AIDS in the Eastern Mediterranean Region was low, her country’s Ministry of Health had established a national programme to combat the disease which embraced all forms of prevention and awareness-raising activities, especially among the most vulnerable groups. Egypt supported the draft resolution proposed by the delegate of Brazil, especially in its urging Member States to support the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases. Medicines for such diseases needed to be developed. All countries and organizations should join ranks to combat the pandemic.

The CHAIRMAN, noting that many speakers remained on his list, suggested that the drafting group that was to meet to discuss and formulate a consolidated version of the draft resolution might provide an appropriate forum for many of the interventions, once all the texts were available in the appropriate languages.

Mr NOGUEIRA VIANA (Brazil), rising to a point of order, stated that his country had officially handed in its draft resolution on the previous Friday and had had to wait until the present Thursday for it to be distributed. He wondered if it would be possible to speed up the process by having the drafting group meet that afternoon. It would of course be open to receive contributions from all Member States. It would be preferable not to delay the matter, since many delegates had to travel to New York at the weekend to prepare for the United Nations General Assembly special session on HIV/AIDS.

The CHAIRMAN said that the draft resolution submitted by Sweden on behalf of the European Union was not yet available in all six languages. The drafting group could not meet until that text had been properly distributed. However, there was nothing to prevent delegates from meeting unofficially in the meantime in order to reach a sound level of understanding as to the best way of achieving a text acceptable to all.

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

The meeting rose at 11:10.
FIFTH MEETING

Thursday, 17 May 2001, at 14:40

Chairman: Professor S.K. ONGERI (Kenya)
later: Dr C.T. OTTO (Palau)
later: Professor S.K. ONGERI (Kenya)

1. SECOND REPORT OF COMMITTEE A (Document A54/45)

Mrs POPESCU (Romania), Rapporteur, read out the draft second report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

HIV/AIDS: Item 13.6 of the Agenda (Document A54/15) (continued from the fourth meeting)

The CHAIRMAN, responding to a request from Professor GIRARD (France) for interpretation during informal consultations on the text of the draft resolution proposed by Brazil, stressed that the consultations were purely informal and non-binding in nature. Delegations would in any case be able to express their views fully on the draft resolution, with the benefit of interpretation, once the revised draft came back to the Committee.

Dr AL-HAMAD (Bahrain) underlined the vital importance of prevention in the fight against AIDS, particularly as far as young people and adolescents were concerned. Governments should intensify awareness programmes for that group, in mosques, schools and youth clubs. Her own country had already stepped up its activities in that area, offering public talks and counselling services to both patients and their families. More committees of health professionals should be set up and more financial resources provided to help combat the scourge of HIV/AIDS. Both nurses and doctors needed training in how to treat the disease. The problem of HIV infection in pregnancy deserved a more comprehensive research effort.

Her delegation welcomed the work of the United Nations in the field but wanted WHO to take a leadership role in implementing programmes aimed at the prevention and treatment of HIV/AIDS. She supported the draft resolution proposed by the delegation of Brazil.

Dr TEMU (Papua New Guinea) welcomed the fact that WHO would, working with UNAIDS, resume leadership for the health components of HIV/AIDS control. That was vital, as both governments and UNAIDS needed technical input for implementation in several priority areas.

With strong support from WHO, UNICEF, the Australian Government and the European Union, Papua New Guinea was just beginning to implement strategies against HIV/AIDS that had proven effective elsewhere, in order to combat the exponential increase in incidence. For 14 years, the country had been unable to help people with AIDS and related diseases, largely because it had been unable to

¹ See page 305.
pay for antiretroviral drugs and because of weaknesses in its health system. It therefore looked forward to finalization of a strategic framework that would improve the level and amount of care and support available to people living with HIV/AIDS, and welcomed the training modules designed for clinicians and national AIDS control programme managers on standardized antiretroviral therapy. All health promotion and prevention strategies should go hand in hand with access to affordable therapeutic modalities and strengthening of weak health systems. His delegation therefore urged the United Nations and WHO to facilitate the establishment of the proposed global AIDS and health fund to support access by poor and developing countries to antiretroviral drugs. The world had learnt a hard lesson from its failure to respond in a timely manner to the HIV/AIDS pandemic. His delegation called on all States, particularly development partners, to contribute to the fund as a matter of urgency.

Professor AKIN (Turkey) said that, although significant progress had been made in dealing with many aspects of HIV/AIDS, not least thanks to the efforts of WHO among others, the problem remained serious. Although the report contained in document A/54/15 was clear, it failed to mention the important fact that women were biologically and socially more vulnerable to HIV infection and had less favourable outcomes. Furthermore, the prevalence of the disease was rising among women to surpass that among men. The empowerment of women should also be considered a priority in combating the epidemic. Turkey supported the establishment of an open-ended group to discuss the draft resolution.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) stressed the necessity of action to deal with the global AIDS epidemic, so as to avert disaster in some countries and to avoid a reversal of the development process. Negotiations should be undertaken to reduce the cost of antiretroviral drugs, to assist countries that were able to do so to produce their own drugs at lower cost and to secure greater financial support from developed countries to ensure universal access to existing drugs and knowledge about how to avoid becoming infected. Research into an effective vaccine and more effective, safer drugs should be accelerated, and education of the public should be improved to make interventions more useful. Preventive interventions should be implemented in densely populated areas where the prevalence of the disease was still low. Effective methods of prevention and treatment of sexually transmitted diseases should be guaranteed, since such diseases contributed to the transmission and acquisition of HIV.

His delegation supported the proposal put forward by the delegation of Brazil.

Dr ENDZANZA (Congo) lauded the global partnership of the United Nations bodies to combat HIV/AIDS and welcomed the initiative of the Secretary-General of the United Nations to create a global AIDS and health fund to benefit poor and developing countries. The African Heads of State had confirmed their personal commitment to the fight against AIDS through the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases adopted in April 2001. For its part, Congo was also involved in coordinating efforts at subregional level, particularly with regard to the HIV Drugs Access Initiative. His delegation supported the draft resolution proposed by Brazil, particularly with regard to promotion of local production of drugs to treat AIDS and opportunistic infections. That initiative would imply an honourable partnership with the major pharmaceuticals companies in verifying the quality of locally produced drugs. He would propose an amendment in writing that would ensure subregional initiatives.

Dr RIAZANTSEV (Russian Federation) said that the report clearly outlined the priorities for work against HIV/AIDS. He supported the proposed creation of a global fund for AIDS and health, which would doubtless make use of the valuable experience of both WHO and UNAIDS. The fund should be open to any country that asked for assistance and must be based on the principles of transparency and accountability. His country was already considering how it could best contribute to the establishment of future activities of the global fund. He thanked WHO and UNAIDS for their
assistance in the fight against HIV/AIDS in his country and looked forward to WHO continuing its leadership role.

Professor OMASWA (Uganda) said that, as countries intensified their efforts to combat HIV/AIDS, they should remember that it was possible to treat the disease successfully. That fact should be mentioned in the draft resolution. He urged caution with regard to expectations from the proposed global fund, since funds would not become available immediately and the amounts quoted were far too small for actual needs and could easily be absorbed by one African country alone. Welcome as the initiative was, its existence should not make States complacent about the need to mobilize funds as a matter of urgent priority. He suggested that WHO be mandated to guide and monitor the allocation and use of global resources available for health.

He supported the proposal of the delegates of some African countries that the central role of the health sectors must be stressed in the control of HIV/AIDS through multisectoral approaches.

Dr SANOU (Burkina Faso) noted that the report addressed all aspects of HIV/AIDS, and the proposed actions would strengthen the leadership of WHO. The epidemic posed a major problem to health systems, in terms both of care and support. Failure to treat patients for a long time after the epidemic first broke out had delayed the preparation of care and treatment strategies, and that had diminished the trust between the public and health professionals. Health care systems now needed to be strengthened in terms of both equipment and training.

The problem of HIV/AIDS was usually described in official circles in the context of development, since the most active section of the population was generally that most affected by the disease. However, that fact should not obscure the role of the health sector and the leadership of WHO in helping ministries of health to manage HIV/AIDS-related problems. The global nature of the problem required a global response, and her delegation supported the creation of a global fund to combat HIV/AIDS and related diseases, whose implementation was an urgent priority for the poorest countries.

Dr MILLER (Barbados) commended WHO for increasing its activities in the HIV/AIDS programme. Her country supported the work of UNAIDS and other agencies and welcomed the proposed global fund; it was to be hoped that substantial resources would be contributed to it.

The Caribbean region had an HIV/AIDS prevalence rate second only to that in sub-Saharan Africa. The Office of the Prime Minister in Barbados had assumed responsibility for coordinating an expanded national control programme. It was important for developing countries to have access to affordable drugs for the treatment of HIV infection. Prevention and health promotion were also essential in fighting the pandemic.

Her delegation supported the draft resolution under discussion. It approved the wording “social and economic circumstances” in subparagraph 2(1), and considered that the same wording should be used in the relevant passages in subparagraphs 3(1) and 3(5).

Dr PARASRAM (Trinidad and Tobago) said that his country was keen to work with other Caribbean countries in view of the high regional prevalence of HIV/AIDS. His country recognized the need for access to affordable drugs and other resources and hoped to benefit from the proposed global fund. The fight against the pandemic required a comprehensive approach, combining prevention, counselling and support for affected individuals and their families, as described in the report.

Dr AMATHILA (Namibia) said that her country was implementing a plan of action against HIV/AIDS, drawn up by the members of the Southern Africa Development Community. A sentinel seroprevalence study conducted in one area of the country in 2000 had shown that about 19% of pregnant women attending an antenatal service were HIV-positive. The prevalence appeared to have stabilized over the previous four years in the age group 15-25 years but had increased among women aged 24-29 years. During the past four years, Namibia had implemented a multisectoral response to
the HIV/AIDS pandemic, involving all private-sector industries, including mining. Politicians had been enjoined by the President to start all their discourses with a mention of HIV. Awareness of the problem was high, although that did not necessarily lead to changes in behaviour.

Namibia aimed to strengthen its health system by upgrading its laboratory services and training health workers in the use of new equipment, interpretation of new information, HIV/AIDS counselling and the safe use of antiretroviral drugs.

Her delegation supported the draft resolution in principle, but would look carefully at any amendments that might be proposed.

Dr MAHJOUR (Morocco) welcomed the high-level political commitment and public interest inspired by the problem of access to antiretroviral drugs for people living with HIV/AIDS. Access to those drugs was essential for the success of any HIV/AIDS control programme. His own country had introduced triple therapy in 1998. Developing countries needed effective diagnosis, treatment and follow-up strategies, with particular attention being paid to prevention. The safety of blood transfusions, epidemiological surveillance and management of other sexually transmitted diseases would be more effective if they formed part of a strategy for the treatment of people with AIDS. A multisectoral approach emphasizing the role of the public was essential for any HIV/AIDS control programme. His country was drawing up a national strategic plan to reduce susceptibility to infection, and a situation analysis had been conducted to define susceptibility factors, the obstacles to the control programme and current and future control opportunities.

Mr KRAUS (Switzerland) said that his country supported WHO's efforts to mobilize additional resources to fight the epidemic, particularly those aimed at strengthening health systems and their response to the disease. More needed to be done in terms of prevention of HIV transmission among young persons and from mothers to infants. Switzerland supported the draft resolution presented by Sweden on behalf of the Member States of the European Union (which had not been distributed), since it took account of all aspects of the fight against HIV/AIDS.

Dr Otto took the Chair.

Mr CICOGNA (Italy) said that, as recommended in the report, WHO should focus its activities on certain priority areas of work, particularly prevention of HIV transmission among young people; voluntary counselling and testing; prevention of mother-to-child transmission of HIV; care and support for people living with HIV/AIDS, including access to drugs; and research for vaccine development.

The Italian Government had contributed US$ 8 million to WHO for control of HIV/AIDS in 10 African countries. The programme provided a model for the development and implementation of multi-dimensional and multi-country projects, featuring a country-based approach of support for health systems, with the close involvement of local and international nongovernmental organizations. His country was particularly involved in the support of national health systems in the framework of national plans for sustainable development and the fight against poverty.

At the Okinawa International Conference on Infectious Diseases (Japan, December 2000), the Group of Eight countries had adopted an important strategic document on the control of communicable diseases in developing countries. Italy, which had taken over the presidency of the Group of Eight from Japan, had continued the initiative to launch a global health fund which would bring together various stakeholders – developing-country governments, bilateral donors, international organizations, nongovernmental organizations and the private sector. The fund would cover not only the provision of medicines, vaccines and other commodities but also the strengthening of national health systems, to allow them to invest in staff and logistics to ensure that the available resources were equitably distributed and well used.
Mr Xu Hongkai (China) said that the clear and objective report would increase the awareness and commitment of governments in their efforts to combat the HIV/AIDS pandemic and promote global prevention and control activities. He welcomed the three priorities of the strategy for HIV/AIDS described in paragraph II. It was to be hoped that the proposed guidelines for new standardized antiretroviral therapy in resource-constrained settings would be formulated and implemented as soon as possible. He supported the call for better access to antiretroviral and other drugs at greatly reduced cost and better care and treatment for people with HIV-related illnesses.

He accepted the report’s analysis of HIV/AIDS trends in Africa, but considered that it did not pay sufficient attention to the situation in Asia. Although the prevalence rate in Asia was low, it represented a very large number of cases because of the enormous population of the region. Large-scale migration and the relative poverty of many countries increased the danger that HIV/AIDS would spread quickly. In three to five years' time, the situation might be as bad as in Africa. He called upon WHO to give Asian countries more support in HIV/AIDS prevention and control.

Another area in which greater support was needed was the transmission of HIV among drug users. Injecting drug use was the main means of HIV transmission in eastern Europe and Central Asia and was a major factor in western Europe and the Americas.

Dr Soares Marques de Lima (Sao Tome and Principe) said that, despite general agreement about the potential threat of HIV/AIDS and the need for guaranteed access to care and treatment, the countries most affected by the pandemic were those with the least opportunity to acquire the drugs needed. Richer countries must show greater solidarity with poorer countries in order to ensure that antiretroviral drugs and drugs to treat opportunistic infections were accessible to everyone who needed them. He supported the draft resolution proposed by Brazil.

Dr Al-Kandari (Kuwait) said that HIV/AIDS was not a major problem in her country. Measures had been introduced to prevent the transmission of the virus, treat HIV-related illnesses and take care of the families of people with HIV/AIDS. Kuwait encouraged scientific research into HIV/AIDS, and international conferences on the subject were held regularly. Her country supported WHO's efforts to control the pandemic.

People with HIV/AIDS must have access to appropriate drugs without the restrictions imposed by patenting procedures. It was important to increase the awareness of health workers of HIV/AIDS issues, particularly nursing staff, who were much more numerous than physicians. More use should be made of nursing staff in the fight against HIV/AIDS.

Dr Sok Touch (Cambodia) said that the prevalence of HIV infection appeared to be decreasing in his country, and the number of new HIV infections every year had decreased, particularly among young people. An estimated 169,000 persons aged 15-49 years were infected with HIV, comprising 2.8% of that age group, compared with an estimated 3.9% in 1997. The decrease appeared to be due not to any one factor, such as increased condom use, but to a complex interaction of factors including increased mortality, reduced risk of transmission and changes in behaviour, as well as the energy and commitment of the Government and the good sense of the Cambodian people. A demographic survey undertaken in 2000 showed that 95% of all women in both rural and urban areas knew about HIV/AIDS, and 70% knew that it could be prevented by using condoms.

His delegation supported the draft resolution proposed by Brazil.

Mr Nacuva (Fiji) thanked the delegation of Brazil for submitting the draft resolution under discussion, the delegation of the United States of America for pledging financial and technical assistance for the global AIDS and health fund and the United Nations for planning a special session of the General Assembly on HIV/AIDS. While the numbers of people affected by AIDS varied greatly from one country to another, no country was immune from the epidemic, and the fundamental strategy against AIDS must hinge on the following: first, prevention and promotion of health, with the active involvement of ministries of health; secondly, continuous prevention and care, with an essential role of
the media in destigmatizing the AIDS issue; and thirdly, technical assistance in research and networking. Those countries and regions significantly affected by HIV/AIDS should share their experience with other countries and regions yet to be seriously touched by the AIDS epidemic.

Dr AGARWAL (India) said that the estimated number of cases of HIV infection in India had risen from 3.5 million in 1998 to 3.8 million in 2000. A national global AIDS control programme, which received political support at the highest level, was being implemented to reduce the spread of HIV; the actions undertaken included appropriate vaccine development, ensuring blood safety, intervention programmes to target injecting drug users, prevention of sexually transmitted diseases, voluntary counselling and health awareness campaigns.

With regard to the therapeutic aspect of AIDS control programmes, he said that the impact of international trade agreements, in particular the Agreement on Trade-Related Intellectual Property Rights (TRIPS), on public health and the access to essential drugs was a significant cause of concern. In view of the prohibitive cost of antiretroviral therapy, his Government did not provide such drugs for the management of HIV/AIDS cases; such a step would divert resources from current prevention programmes and might jeopardize efforts to contain the spread of HIV infection. International organizations should continue their efforts to make antiretroviral drugs continuously available to developing countries at highly subsidized and affordable prices. The focus of AIDS control programmes in most developing countries on preventive and behavioural aspects was reasonably effective and affordable. However, a focus on treatment, as advocated in the draft resolution put forward by Brazil, would be advisable only if appropriate funding could be assured in the long term. While he appreciated the spirit of that draft resolution, its approval might present operational difficulties in developing countries. For example, the sustained use of antiretroviral drugs would require intensive monitoring of drug-related side-effects, and clinical laboratory capabilities in the developing countries were very limited. In that connection, he suggested that it was not necessary to proceed with the draft resolution since the matter to which it referred would be discussed at the forthcoming special session of the United Nations General Assembly. Lastly, he reiterated his view that large-scale international funding for appropriate vaccine development would be more productive than a sporadic supply of antiretroviral drugs.

Dr OSMAN (Sudan) said that Sudan, one of seven sub-Saharan countries to suffer greatly from instability and armed conflict, was one of the countries that had been directly responsible for the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases. He welcomed the Secretary-General's initiative to establish a global AIDS and health fund, which he trusted would not be politicized in any way.

Dr TSHABALALA-MSIMANG (South Africa), noting how difficult it was to compile a report on HIV/AIDS, said that discussions at the present juncture should focus on the development of a finite set of policy directives for implementation of the initiatives set out in the report. Her delegation shared many of the Secretary-General's thoughts on the global AIDS and health fund. South Africa might be compared favourably to other countries in Africa in terms of the availability of infrastructure; however, the infrastructure seldom extended beyond the peri-urban areas, and her country's failure to overcome the tuberculosis burden stemmed in part from such a deficiency. In recent years, South Africa had begun the costly exercise of strengthening its tuberculosis control programmes and had also been promoting closer integration of its programmes on tuberculosis, HIV/AIDS and other sexually transmitted infections in order to exploit the obvious synergies that existed. While it was not realistic to expect all the infrastructure to be in place before undertaking any intervention, a certain minimum was required, and she hoped that the fund would give serious consideration to how that minimum could be provided.

She looked forward to being actively involved in finalizing the draft resolution.
Ms PARK (Republic of Korea) said that her country attached great importance to WHO's efforts with respect to HIV/AIDS. Although there were few cases of HIV infection in the Republic of Korea, her Government provided care and support for the infected individuals. There was a strong need to improve prevention of HIV infection. In the Republic of Korea, a law relating to HIV/AIDS had been in existence since 1987, and in 1999 a project had been launched to improve surveillance of HIV and other sexually transmitted infections; sentinel physicians had recently been charged with surveillance of the latter. Many infected individuals went untreated because of ignorance, fear of stigmatization and social and occupational discrimination, and her Government hoped to continue its efforts to decrease the number of unreported cases by offering voluntary counselling and testing, while ensuring respect for human rights. In order to maintain a healthy environment during the 2002 World Cup soccer tournament, her Government was planning new strategies and would implement an educational campaign to prevent the spread of HIV/AIDS. It looked forward to international cooperation in that regard.

Dr HAMUKWAYA (Angola), noting that the large number of displaced persons in Angola exacerbated the danger of the transmission of HIV, said that, although her country welcomed the establishment of a global AIDS and health fund, it was concerned about the mechanisms for tapping into that fund. She fully supported the draft resolution put forward by Brazil but at the same time concurred with the reservations expressed by the delegations of Sweden, Thailand and Mozambique.

Professor AHYI (Benin) supported the ideas set out in the report. He noted, however, that, although much knowledge had been accumulated about effective interventions, the impact on behaviour was inadequate. Considerable efforts had been made to obtain financial resources to deal with the AIDS epidemic, but unfortunately the same could not be said for human resources. In Africa, and particularly in Benin, a wealth of human expertise had been overlooked: persons aged 55 and over had accumulated a lifetime's experience in sexual issues. Older people were respected in African families as repositories of knowledge. In the past, it had been the responsibility of the older generation to pass knowledge and advice on to the younger generation, and that practice could prove very valuable in the fight against AIDS. The failure to combat the AIDS pandemic attested to affective, sexual, spiritual, material, financial and intellectual poverty. In order to succeed, it was essential to take into account cultural sensitivities and to involve the older generation.

Mrs HOAREAU (Seychelles), commending the comprehensive report, welcomed WHO's efforts to increase its HIV/AIDS activities and support countries' programmes. She welcomed the UNAIDS initiatives to combat the AIDS pandemic and looked forward to the special session of the United Nations General Assembly on HIV/AIDS. As a sub-Saharan country, the Seychelles supported the Abuja Declaration and endorsed the draft resolution proposed by Brazil.

Mr KINGDON (Australia) welcomed the strategies proposed in the report to combat HIV/AIDS, in particular the special emphasis that had been attached to prevention and to addressing different modalities of treatment. He noted with pleasure that those strategies were consistent with the first four of the five priorities outlined by the United Nation's Secretary-General in his address to the Health Assembly.

Australia's HIV/AIDS programme had been particularly successful in bringing the epidemic under control, mainly through the provision of community education, prevention activities and patient care. His country had accumulated technical expertise in HIV/AIDS education and research, and the Australian Agency for International Development was providing Australian $200 million in support of HIV/AIDS programmes in countries within its ambit. With international collaboration and goodwill, it would be possible to overcome the AIDS pandemic.

Dr LEVENTHAL (Israel) said that it was encouraging that some countries had reversed the trend with respect to the AIDS epidemic. However, as a result of both legal and irregular immigration,
the problem was bound to spread from one country to another. 75% of the new HIV cases every year in Israel came from abroad. The problem was of global importance, and he urged the delegations of Brazil and Sweden to work together to formulate a consensus resolution that stressed both preventive and curative aspects for combating the HIV epidemic.

Dr TOURE (Côte d'Ivoire), having welcomed the Secretary-General's initiative to establish a global AIDS and health fund, said that the otherwise excellent report contained in document A54/15 should have indicated that HIV/AIDS was a disease of poverty. She supported the draft resolution put forward by Brazil, as her country had benefited from a pilot project on antiretroviral drugs and was convinced that it was feasible for African countries to have access to those drugs. In that connection, financial and technical support should be provided, as it was important for patients to receive comprehensive treatment.

Dr TOUYÁ (Uruguay) said that the prevalence rate of HIV infection in his country was some 0.3%, and the epidemic was moving into vulnerable groups, mainly injecting drug users and women. The rate of increase had diminished. The mother-to-child transmission rate had fallen, in four years, from 28% to under 3%. All patients were given triple therapy with antiretroviral drugs, and the mortality rate among persons being treated for AIDS had been falling.

The United Nations Secretary-General had conveyed a true message of hope in his speech, and international solidarity must be expressed for the establishment of the fund he had mentioned. Its aim should be to embrace all aspects of HIV/AIDS, focusing unequivocally on education and prevention. A strong appeal should be made to the pharmaceutical industry to seek economies of scale, with consequent minimum costs, so that all the world's peoples could have access to medication. His delegation was prepared to take part in drafting an appropriate resolution and firmly supported efforts towards a consensus outcome at the current Health Assembly.

Dr ABUDAJJAH (Libyan Arab Jamahiriya) said that AIDS had not been a major problem in his country until a recent incident in which 400 children in one hospital had become infected. Epidemiological studies had included screening of previous patients and the parents of the infected children, but no other case of infection had been found. As a result, injection with a view to deliberately induced infection was suspected; 16 persons had been charged with offences, which, if proved, would surely constitute one of the most heinous crimes of the 21st century.

His country hailed the proposed international strategy to combat HIV/AIDS. The Head of State had supported the Abuja Declaration and the related campaign and had decided to establish an African institute, staffed by African scientists, to study the problem. He had also decided to promote the production and low-cost availability of antiretroviral drugs to all, as a human right.

His delegation commended the Secretary-General's initiative for a global fund; it congratulated Italy and the United States of America on their promised contributions and hoped that others would follow suit. It hoped too that the fund would focus on care and research, with no diversion to extraneous purposes.

Dr MSA MLIVA (Comoros) said that, although his country had a low seroprevalence rate, it was susceptible to propagation of the pandemic as it was a small insular state whose natural beauty attracted people from elsewhere. Furthermore, because of its low prevalence rate, it did not receive financial support for pilot projects. He reasoned, however, that immediate application of the experience of other countries would help to avoid catastrophe. The current social and political crisis had diverted funds from the combat against AIDS, although a national committee had recently been set up. His delegation requested the help of WHO and UNAIDS in developing subregional projects to combat AIDS in the countries of the Indian Ocean. His delegation wholeheartedly supported the draft resolution submitted by Brazil.

Professor Ongeri resumed the Chair.
Dr. HETLAND (Norway) said that the fight against HIV/AIDS had entered a new phase, reflected in a new sense of awareness, urgency, stakeholder positioning and activity. The severity of the global crisis called for reappraisal by all, at national and international levels. Norway welcomed the report and WHO's intensified support for Member States' efforts. Any HIV/AIDS strategy must combine comprehensiveness, involving all sectors of society, and complementarity, in terms of activities and actors alike; the proposed WHO approach reflected both dimensions.

The health sector's capacity was again in focus: greater emphasis on patient care and support was adding to an already overstretched and under-financed health care system. But responses to realities must be country-led and country-owned, based on access to the best possible information on options, with international support. Emphasis on the health sector provided WHO with new opportunities to advise national public health authorities on the priorities available within their means. In realistic policies, care must be accompanied by fresh approaches to protection and prevention, renewed attention to affordable options, dependable partnerships among public, private and voluntary sectors, and particular attention to the links in services for HIV/AIDS, tuberculosis, child health and reproductive and sexual health. Further international resources were essential, and Norway intended to share in their provision. Reduced prices for drugs and increased capacity for their purchase would not relieve governments of difficult priority choices. The health sector bore the burden of decisions taken about the balance between prevention, protection and care. Stronger guidance from WHO for informed policy choice was therefore essential; the direction outlined in the report would enhance WHO's partnership with Member countries and UNAIDS. His delegation would participate in drafting the relevant resolution.

Dr. FALL (Senegal) endorsed the recommendation in the report to make the health sector the central coordinator of all activities to combat HIV/AIDS. Nevertheless, further emphasis should be given to the close involvement of traditional religious and political leaders in such activities, as his country's experience showed that the response must be global, multisectoral and multidisciplinary. Furthermore, Member States should be more open to external evaluation, which would facilitate the taking of requisite corrective measures. A further requirement was the stability of programme management teams in order to ensure consistent monitoring and subsequent adjustment of programmes. His delegation thanked all United Nations bodies and other development partners that were assisting Senegal in its efforts to combat HIV/AIDS.

Dr. KIENENE (Kiribati) said that, in most developing countries, including the small island nations in the Western Pacific Region, prevention was the only effective way to fight the AIDS epidemic; the basic, but effective tools available included public education, communication and health promotion strategies based on robust studies of social behaviour and epidemiology. His country was grateful for the directions and examples of best practice shown by certain developing countries, such as Thailand and Uganda, that had taken a leading role in that field. Developing countries remained at a disadvantage, however, because lack of resources made it hard for them to avail themselves of the new antiretroviral drugs. The potential benefits of use of such drugs in the prevention of mother-to-child transmission of HIV greatly outweighed the likelihood of side-effects. If, for obvious economic reasons, developing countries could not afford such treatments on the scale required, perhaps they could pool their limited resources, including those available from a global fund. His country welcomed the establishment of such a fund and would like to have access to it. It should be administered in the context of resource constraints and country-specific settings. His delegation looked forward to the eventual availability of antiretroviral drugs at cheaper rates, although they were not his country's first choice in addressing the problem.

Dr. MBAIONG (Chad) welcomed the report on HIV/AIDS and the United Nations Secretary-General's initiative for a global AIDS and health fund for the developing countries in particular. In Chad, HIV was spreading rapidly, the current prevalence rate being 8% to 10%. Its devastating effect on men and women of reproductive age threatened the country's social and economic development.
and heightened the need for antiretroviral drugs. His delegation therefore strongly supported the draft resolution tabled by the delegation of Brazil and wished to participate in the work on its text.

Dr CHILD (Chile) said that her country was tackling the HIV/AIDS problem through associated and complementary activities relating to prevention, sexual health promotion and care for those already affected. The results suggested a stabilizing of the infection rate. Chile had endeavoured to ensure that every patient received the relevant treatment and in that regard recognized the assistance of UNAIDS in providing access to pharmaceuticals. With a view to enhancing the quality of life of people with HIV/AIDS, however, her delegation supported the draft resolution proposed by Brazil and considered that it would be appropriate for the Health Assembly to endorse resolution 2001/33 of the 57th Session of the Commission on Human Rights, as proposed in paragraph 1(c) of the draft resolution.

She proposed that the resources within the proposed global fund should be allocated by a committee that represented the populations affected by the problem, reflecting national policies and, as far as possible, national and regional conditions.

Mrs GARVAL (Denmark) welcomed the increased efforts to combat the HIV/AIDS pandemic. WHO had a vital part to play through its normative work, technical support and mobilization of resources; it could assist Member States with prevention and improved access to care by helping them to establish well-functioning health systems, a necessary prerequisite. Access to treatment, care and drugs should be provided in the best possible way to as many HIV/AIDS-affected people as possible, but little could be achieved without a solid basis, namely a health care system that delivered. A strong WHO at country level was required, and she recommended that special attention be paid to strengthening the Organization in that respect. She fully supported the WHO priorities of prevention among young people and of HIV transmission from mother to child.

Mr MUMBA (Zambia) said that his country was one of those in the African Region most affected by HIV/AIDS, with an incidence rate of about 20%. The social and economic gains of the past 30 years had been completely reversed by its effects: the disease led to poverty, which itself favoured the spread of HIV, creating a vicious circle. All the health sector resources were devoted to the care of patients suffering from the disease. To reverse the trend, the Government had established a council to coordinate a multisectoral response, and, like other countries, had done a great deal to mitigate the effects of the disease. None the less, access to antiretroviral therapy was a critical tool in the fight, and he therefore welcomed the initiatives of the Secretary-General of the United Nations and of Brazil in that respect. His country’s investment in the fight against AIDS was beginning to show results: a random survey had shown that the incidence among young people had fallen to some 16%.

Ms DJONEVA (Bulgaria) confirmed that, as stated by the Secretary-General of the United Nations that morning, there had been a significant increase in the number of HIV cases in eastern Europe. The Government of her country was taking strong preventive measures by developing a national strategy and programme on HIV/AIDS and other sexually transmitted diseases for 2001-2007, implemented by the Ministry of Health, with technical and financial assistance from UNAIDS and UNDP. The strategy laid down the guiding principles and general framework for a multisectoral response, while the programme was concerned with the specific activities of health promotion, epidemiological surveillance, health and social care and treatment. The Government had allocated some US$ 34 million for the seven-year programme; ministries and local governments would develop their own action plans and apply for allocations to support them. In addition, a coalition consisting of 21 nongovernmental, governmental and international organizations had been established to support World AIDS Day activities and to serve as a forum for information exchange and the development of joint activities.
Dr MOGUILEVSKY (Argentina) noted that it was important to emphasize respect for human rights, since that would reduce the vulnerability of people living with HIV; priority should be given to vulnerable groups in access to diagnosis and prevention services. His country had about 130 000 persons infected with HIV and some 30 000 people with AIDS in a population of about 37 million. Injecting drug users were at greatest risk, and harm-reduction policies were needed for that group. A law on sexual and reproductive health and epidemiological surveillance systems had been passed, and the number of voluntary screening centres for sexually transmitted diseases had been tripled. All infected people, even those without medical insurance cover, received treatment. Substantial savings had been made through centralized purchasing of drugs. The quality of medicines gave rise to concern, however, and the effectiveness of all antiretroviral agents had been checked in bioequivalence studies. The efforts made by various countries to increase access to prevention and treatment systems gave hope, as did the proposed establishment of a global fund to aid in combating the epidemic. He considered that the draft resolution proposed by Brazil should stress human rights, prevention policies and the quality of medicines.

Ms PHUMAPHI (Botswana) said the report showed WHO's commitment to the fight against HIV/AIDS and reflected the priorities in her country's national strategy. The disease had provoked a crisis of unprecedented proportions, which crippled all sectors of human activity. She paid tribute to organizations that had provided documentation and promoted best practices as well as legislative, financial and practical frameworks at all levels. Although research into prevention and care had not been highlighted in the report, she trusted that it would not be overlooked. Traditional and faith healing should also be incorporated in health programmes. Botswana's strategy covered community and targeted programmes, education, infrastructure development, training of human resources, counselling and support services, programmes for vulnerable groups and the factoring of HIV/AIDS into development planning. Structure, form and definition were required in the coordination and evaluation of the epidemic at all levels; that required trained personnel as well as financial resources and technical support, and she hoped that the special session of the United Nations General Assembly on HIV/AIDS would crystallize that aspect. She applauded the initiatives of the delegations of Brazil and Sweden and urged the merging of the two proposals in order to attain consensus. She welcomed the proposed establishment of a global fund and urged prudent management, access by all developing countries and careful controls to ensure its optimal use in the fight against AIDS.

Dr STAMPS (Zimbabwe) endorsed the views of speakers who had urged renewed WHO support for a programme to combat HIV/AIDS. His country was unique in that it would be the first developing country in modern times to reach zero population growth, in 2002, by virtue of AIDS, the success of the national family planning programme and migration, the latter two being increased in effectiveness by the presence of HIV: fear of HIV caused migration, and becoming pregnant had become associated with being HIV-positive. His country was probably also unique in having imposed a 3% levy on personal and corporate income taxes to provide funds for the national AIDS programme, raising the equivalent of US$ 20 million in 2000. Since 1985, it had also had a blood safety programme which had probably prevented more than 80 000 cases of infection through blood transfusion. Three innovative activities had been successful. The first was the initiative of a group of schoolboys who had heard that the safe blood programme was under threat because of a lack of safe donors; they had pledged that they would give 25 units of clean blood. A total of 1220 graduates had done so since 1994, and there had been no drop-outs because of unsafe blood donations. That reinforced safe sexual behaviour among young men. Young women had also joined the scheme, and their number now exceeded that of men. The second innovation was protection of young mothers from infection by the promotion of barrier methods for all breastfeeding women, which had been accepted by both mothers and fathers; women who became infected with HIV during breastfeeding were four times more likely to transmit the virus to their infants. The third innovation was community involvement: a disused leprosy colony in a rural area had been converted into an orphanage for children infected with HIV, most of whom had died. The Government had donated 2000 hectares of
land acquired from white farmers in order to develop a programme of self-sustainability. At present, 60 families were managing that land, producing 14 times more than had been produced under the ownership of one white farmer. The project had attracted support from the World Council of Churches and voluntary donations from the WHO office in the country, which he thanked for its help. He would like, however, to see much more done. There seemed to have been no research into the relative virulence of HIV in his country, nor into the susceptibility of persons in the African region as compared with other regions of the world. That research should be carried out quickly. He requested guidance concerning the practice of preserving the confidentiality of HIV-infected persons while they were alive but revealing their HIV status once they died. He supported the Brazilian resolution.

Dr POUTASI (New Zealand) said that her country’s response to the AIDS epidemic had been based on a comprehensive approach of health promotion and disease prevention complemented by medical intervention. A clear decline in the incidence of AIDS had been observed. The need for leadership increased as collective efforts were intensified. There was no room for complacency and all the room in the world for urgency, determination and commitment to long-term efforts in a wide range of interventions to control the epidemic. A traditional Maori saying stressed that people were the most important thing, and indeed it was on people that the focus should lie.

Mrs CABA (Dominican Republic) said that about 2% of her country’s population was infected with HIV, of whom 42% were aged between 14 and 22. Most had contracted the infection by sexual transmission or by mother-to-child transmission, the prevalence of which was increasing. The strengthening of prevention activities, particularly sexual education, and access to cheaper medicines would contribute considerably in reducing HIV infection in her country. She therefore supported the draft resolution proposed by Brazil.

The meeting rose at 17:00.
SIXTH MEETING
Friday, 18 May 2001, at 9:00

Chairman: Professor S.K. ONGERI (Kenya)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

HIV/AIDS: Item 13.6 of the Agenda (Document A54/15) (continued)

Dr PIOT (UNAIDS), speaking on behalf of UNAIDS and three of its cosponsors, UNICEF, UNDP and UNFPA, said that each cosponsoring organization had made good progress towards ensuring that its comparative advantages and complementary expertise were used to the maximum. At the forthcoming meeting of its Programme Coordinating Board, UNAIDS would submit for approval a strategic plan clarifying in detail the role of each United Nations agency within a system-wide multisectoral approach to HIV/AIDS and a division of responsibilities similar to the approaches adopted by many governments.

He welcomed the scaling up of HIV/AIDS activities by WHO, given the enormous amount of work still to be done, especially as care and treatment became more prominent and an integral part of the response to the epidemic. Political leadership at the highest level, which so many people had fought long and hard to achieve, should be embraced. As both the Director-General of WHO and the Secretary-General of the United Nations had commented the previous day, the inclusion of health at the top of the political agenda was one of the most significant developments of recent years. Multilateralism was not easy, but it was not a threat; it was essential and a unique opportunity to expand the resource base for health. The challenges were well understood within the United Nations system, but he recognized that more work was necessary to clarify roles and ease tensions.

UNAIDS and its cosponsors stood ready to work with other partners to take forward the development of a global AIDS and health fund, which was a unique opportunity to increase activities as a matter of urgency. But the impetus would be short-lived, and therefore prompt but inclusive action was required. He welcomed the commitments already made in terms of funding and other support.

While the debate had focused on the availability of and access to drugs, he issued a strong warning against allowing the recent worrying downward trend in the external funding of commodities for HIV prevention in developing countries, especially condoms and their promotion, to continue.

Much progress had been made in the past year in the treatment of HIV/AIDS, many taboos had been broken, and a true partnership was beginning to form among all those who were part of the solution, including governments, pharmaceutical companies and civil society. Some regional approaches had been launched in the negotiations with pharmaceutical companies. However, reducing the price of antiretroviral drugs was the easiest part; the main obstacles lay ahead, namely delivering those drugs, building relevant systems and ensuring that people benefited.

The United Nations General Assembly special session on HIV/AIDS in June 2001 would be a unique opportunity to ensure that not only HIV/AIDS, but health in general, was at the top of the political agenda.

Dr EL ABASSI (UNICEF) welcomed the consensus reached at the third meeting of the Committee on the draft resolution on infant and young child nutrition.\(^1\) UNICEF would continue to

\(^1\) Resolution WHA54.2.
make every effort to increase the proportion of infants being breastfed for the first six months of life and intended to contribute fully to regional and national programme development, in close collaboration with WHO and nongovernmental organizations.

Reaffirming UNICEF's commitment to help countries affected by HIV/AIDS, he said that the fight against the disease was one of the five global priorities set out in the UNICEF Strategic Plan for 2002-2004; increasing importance had been accorded to HIV/AIDS in country programmes in recent years, especially in the worst-affected countries, and the capacity of country offices had been strengthened. UNICEF attached particular priority to the prevention of HIV transmission among young people, the prevention of mother-to-child transmission, access to care and development of support for affected families and children, especially orphans.

UNICEF believed that political mobilization and the local community dimension were essential to achieving progress. It intended to act in coordination with the other cosponsors of UNAIDS and other agencies to scale up efforts to assist countries. The relative advantages that UNICEF could offer within that partnership included a tradition of programme cooperation which was country-focused and managed in a decentralized way, a presence in the field, experience of working with communities and civil society, experience of implementing multisectoral interventions and programmes, experience of communication and advocacy, and experience of and a capability for supplying drugs and other care products.

Mr GIZAW (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, welcomed the increase in HIV/AIDS activities, the holistic approach and the increased focus on youth and on the continuum of care between home and hospitals. However, he hoped that future reports would capture some responses to the impacts of the epidemic.

Since 1988, the Federation had been actively involved in the fight against HIV/AIDS. The focus was threefold: on prevention, especially educational activities; on care and support for people and family members living with HIV/AIDS, especially home care services; and on promotion of human rights in the context of HIV/AIDS. The 52 African Red Cross and Red Crescent national societies, at the 5th Pan African Conference in September 2000, had clearly expressed their commitment in the Ouagadougou Declaration to take all possible measures to intensify and expand interventions against HIV/AIDS. He was gratified to note that the United Nations General Assembly in 2000 had accepted the Ouagadougou Declaration as an official United Nations document. The process of scaling up was under way in Africa as well as in other parts of the world where the epidemic was on the increase, such as Asia, the Caribbean region and eastern Europe. The Federation had also fostered partnerships with WHO, UNAIDS and the Global Network of People Living with HIV/AIDS in order to promote concerted action and facilitate synergy.

The Federation was encouraged by the current global momentum for concerted responses and was actively involved in the preparatory work for the United Nations General Assembly special session on HIV/AIDS in June 2001. The Federation was ready to strengthen further collaboration with WHO in the areas of its competence, in particular in intensifying and expanding prevention, support and care at community level.

Professor IDÅNÅÄ-HEIKKILÅ (CIOMS), speaking at the invitation of the CHAIRMAN, thanked WHO for its continuing valuable support to CIOMS. The CIOMS International Ethical Guidelines for Biomedical Research Involving Human Subjects, issued in 1993 as an update of earlier guidelines, were widely used throughout the world in conjunction with the recently revised World Medical Association Declaration of Helsinki. He acknowledged the substantial support received from UNAIDS and WHO for the current revision and updating of the CIOMS guidelines, which had begun two years earlier. He also thanked the Governments of Finland, Switzerland and the United States of America for their financial support, which was crucial to strengthening the representation of developing countries in the revision. The revision had also benefited from the preparation of the
UNAIDS guidance document on *Ethical considerations in HIV preventive vaccine research*.¹ The draft guidelines, the outcome of extensive consultations, had been posted on the CIOMS website for comments by interested parties. The steering committee of the project had a widely representative international, multidisciplinary and multicultural composition. There continued to be intensive electronic interaction among experts from many WHO Member States and CIOMS. The revision and updating of the guidelines had become necessary primarily because of ethical issues raised by trials of HIV/AIDS vaccines and treatment drugs, as well as by new research and technological advances, mainly in genetics and human reproduction. Another consideration had been the largely concurrent revision of the World Medical Association Declaration of Helsinki, culminating in the adoption of a substantially revised version of the Declaration in October 2000. The revision of the CIOMS guidelines was expected to be completed by the end of 2001 with the endorsement of a final text by an international expert conference.

Dr BALE (International Federation of Pharmaceutical Manufacturers Associations), speaking at the invitation of the CHAIRMAN, said that the research-based pharmaceutical industry was playing an increasingly important role in developing ways to treat people living with HIV/AIDS and to prevent HIV from being passed on from one generation to the next. Over 100 innovative drugs were in development to treat and prevent AIDS and its related conditions, and significant efforts were being made towards developing vaccines to prevent HIV infection. Such research into new vaccines, treatments and cures was by no means limited to HIV/AIDS. Vaccines against malaria were also in development, and there had been many advances in new treatments and cures for diseases that especially affected developing countries. Effective global incentives, particularly intellectual property protection, were essential to ensure further, vitally needed research in those and other areas.

Access to pharmaceuticals was a crucial element of the debate on how best to respond to the HIV/AIDS epidemic. The industry was increasing its work, in partnership with WHO and other United Nations organizations, in that regard, including through the UNAIDS Accelerating Access Initiative. Seven countries had joined in the Initiative, with over 30 more currently in discussions with the United Nations and companies.

He urged WHO to devote attention to the real barriers to access to HIV/AIDS care of adequate quality: lack of financing, the need to build up health care infrastructure and research capacity, the necessity to eliminate prejudice against and ostracism of people living with HIV/AIDS, and other factors, in particular in the field of prevention. Industry was optimistic about developing new, more effective and less expensive drugs and vaccines. He reaffirmed the Federation’s commitment to working with international bodies, responsible actors in civil society and WHO in fighting HIV/AIDS.

Dr TÜRMEN (Executive Director), reviewing WHO’s work in HIV/AIDS over the previous two decades and acknowledging the need to intensify its response, said that WHO had established its Special Programme on AIDS (subsequently the Global Programme on AIDS) in 1987. Nine years later, WHO had been among the first to recognize the need for a multisectoral response and a coordinated United Nations effort. All WHO’s extrabudgetary resources, then about US$ 150 million per biennium, had been transferred to a new cosponsored programme, UNAIDS, launched in 1996, and the Global Programme had been disestablished. WHO had retained a small unit working on HIV and sexually transmitted infections, with regional and country-based staff providing technical support.

On assuming office in 1998, the Director-General had established an initiative on HIV/AIDS with the objective of introducing HIV/AIDS into the mainstream of all WHO programmes. However, it had soon become apparent that that structure was not sufficient to respond to requests for technical support from countries and to fulfil WHO’s normative functions. In December 2000, therefore, the Director-General had established a separate department to address HIV/AIDS, which aimed to

spearhead the intensification of WHO's normative and technical support efforts; harmonize activities in different programme areas; enhance inter-agency collaboration (including in the context of UNAIDS); and support countries in scaling up their health sector response in HIV/AIDS prevention, care and support.

WHO acknowledged the effects of HIV/AIDS on development and the consequent need for a strong coordinated multisectoral response. The Organization's response must engage people and communities at all levels, fostering solidarity and mutual support. WHO's actions were guided by the principles of sound public health practice; equity, especially gender equity; equality and poverty alleviation; elimination of stigma; and reinforcement of human rights.

WHO continued to contribute, as a partner and cosponsor, to the work of UNAIDS, ensuring normative excellence and providing technical support to countries in the health field. The Organization worked closely with partners at global and regional levels, in accordance with the United Nations system's strategic plan for HIV/AIDS for 2001-2005, and contributed actively to international forums and national processes. While acknowledging the importance of multisectoral coordination, WHO must also provide leadership in the health sector, where it had particular responsibility. The Organization was intensifying its support to countries attempting to scale up their responses to HIV/AIDS by building up their health infrastructures and promoting relevant research. While prevention remained essential to the response to the pandemic, the use of antiretroviral and other drugs represented a breakthrough in terms of prolonging life and enhancing its quality. It was, however, incumbent upon WHO to provide guidance on their effective, equitable and safe delivery. WHO continued to strengthen its support to countries undertaking second-generation surveillance and national and regional capacity to monitor the incidence of resistance to antiretroviral drugs. WHO was working with scientists and technical experts in a range of areas, including the development of a global health sector strategy; the forthcoming United Nations General Assembly special session on HIV/AIDS, in which WHO was responsible for a round table on prevention and care and a panel discussion on mother-to-child transmission; the preparation of a technical guide on nevirapine, an antiretroviral drug used for the prevention of mother-to-child transmission of HIV; developing clinical guidelines on HIV in maternity settings, which were available in draft form; and the hosting of a forthcoming international meeting on antiretroviral drugs.

The success of those interventions depended on the existence of viable health systems and sufficient material and human resources. The Organization was therefore endeavouring to strengthen links between relevant health programmes.

In reply to specific comments raised by delegates, she said that due note had been taken of the comments on paragraph 8 of the report made by the delegates of Nigeria and Thailand. She assured the delegate of the Netherlands that WHO was aware of the danger of adopting an overly medical approach to HIV/AIDS and would ensure that its activities in the area were within a broader development perspective. The Organization would also strive to meet the particular needs of young people in relation to sexual and reproductive health and had established a working group to that end. The global strategy for infant and young child feeding incorporated HIV/AIDS concerns, and the Organization would continue to pay particular attention to the nutritional status of women.

In its efforts to increase human resources and technical capacities at country level, WHO was training consultants to work in Africa and Latin America on care issues. In that connection, she expressed particular appreciation to the Government of Italy for its support of action in 10 priority countries in the context of the International Partnership against AIDS in Africa.

WHO was aware that, to succeed in containing the HIV/AIDS pandemic, it would need to focus its resources on activities that worked in various settings. By assuming its responsibilities to the full, WHO hoped to ensure that its response was comprehensive and complementary to the work of its many partners.

The CHAIRMAN said that an informal drafting group had met to discuss the draft resolution proposed by the delegation of Brazil at the Committee's fourth meeting. The group had recommended a draft resolution proposed by the delegations of Brazil and Sweden on behalf of the European Union.
The Fifty-fourth World Health Assembly,

Taking into consideration the report on HIV/AIDS; ¹

Recognizing that AIDS is a crisis of unprecedented proportions that threatens development, social cohesion, political stability, life expectancy and places a devastating burden on many countries and regions;
[to be agreed]

Acknowledging that all countries must continue to emphasize widespread and effective prevention, including education, nutrition, information and services, as well as access to, among other products, vaccines, condoms, microbicides and drugs;

Recognizing that prevention and care are inextricably linked, and that their effectiveness is increased when they are used together;

Considering that HIV/AIDS affects women and children with special severity;

Recognizing that inexpensive and effective drugs to prevent and treat opportunistic infections exist, are urgently needed, and can be made rapidly available;

Acknowledging that the lack of affordable pharmaceuticals and of feasible supply structures and health systems continues to hinder an effective response to HIV/AIDS in many countries and especially for the poorest people;

Recognizing that, where it has been available, antiretroviral therapy has reduced mortality and prolonged healthy lives, that recent reductions in prices create a new opportunity to extend this benefit to those that would otherwise not be able to afford them;

Noting the critical role that health services and systems must play in delivering or scaling up delivery of these responses, and that the health systems in many developing countries are already overstretched by the existing burden of diseases and particularly by the added impact of HIV/AIDS;

Recognizing that in order to implement a comprehensive and multisectoral approach to combat HIV/AIDS, tuberculosis and other infectious diseases will require adequate human and financial resources at national and international levels;

Taking into account the need to implement measures that incorporate HIV/AIDS prevention, care and awareness interventions in humanitarian assistance programmes to ensure that populations affected by conflict, and natural and human disasters - refugees, internally displaced persons and, in particular, women and children - are protected from and [to be agreed] treated for HIV and related infections;
[to be agreed]

Welcoming the work in progress to develop a global AIDS and health fund;

Bearing in mind various regional initiatives, including the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases of the African Heads of State and Government, which recognizes that those epidemics should be tackled as an integral part of the agenda for promoting poverty reduction and sustainable development and the Declaration of Quebec City of the Heads of State and Governments of the Americas, which emphasizes that good health and equal access to medical attention, health services and affordable medical drugs are vital for human development and for achievement of political, economic and social objectives;

Noting resolutions 2001/33 and 2001/51 adopted by the Commission on Human Rights at its 57th session;
Recognizing the role of UNAIDS in leading the global response to HIV/AIDS and its support to national AIDS programmes, the leadership of the United Nations Secretary-General, particularly in the context of the special session of the United Nations General Assembly on HIV/AIDS (June 2001);

Recognizing also the key role that WHO plays in health promotion, prevention of disease, care and treatment, organization of services, dissemination of information to support the formulation of health policies, and [to be agreed] access to affordable drugs and commodities,

1. **URGES** Member States:
   (1) to ensure that HIV/AIDS is one of the highest priorities on the health and development agenda and to allocate sufficient resources for the response to HIV/AIDS;
   (2) to take effective measures, within a supportive environment, to ensure that people everywhere, particularly young people, know how to avoid infection, and to facilitate access to services and methods of prevention;
   (3) to scale up their responses to HIV/AIDS, with particular emphasis on building up partnerships across sectors, strengthening health care systems, nutritional programmes, education and information programmes and developing prevention, treatment and care interventions that involve people living with HIV/AIDS;
   (4) to recognize and act on the need for a society-wide response to reduce stigma and discrimination associated with HIV/AIDS;
   (5) to make every effort to provide, progressively and in a sustainable manner, the highest standard of treatment for HIV/AIDS, including the prophylaxis and treatment of opportunistic infections, and effective use of quality-controlled antiretroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of development of resistance;
   (6) to strive to include participation of people living with HIV/AIDS in the formulation of national policies on HIV/AIDS;
   (7) while taking into account differences of health care systems, to develop appropriate modalities of care such as outpatient services, home-based care, day hospitals in the context of a true continuum of care, so as to ensure sustainable and high-quality diagnosis, counselling, testing, care, treatment and support;
   (8) to support, encourage and provide incentives for increased investment in research related to HIV/AIDS, including social and behavioural research, and in the development of new preventive and therapeutic approaches and technologies, including in particular HIV/AIDS vaccines and microbicides;
   (9) to make every effort to provide financial support and technical cooperation to enable Member States to expand their response to the pandemic;
   (10) [to cooperate constructively in strengthening pharmaceutical policies and practices and in facilitating the development of high-quality local production capacities in accordance with international law, including international agreements acceded to;]
   [in order to increase access to medicines, to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of high-quality [to be agreed] production [to be agreed] consistent with international law, including international agreements acceded to;]
   (11) to support the establishment of a global AIDS and health fund;

2. **URGES** the Director-General:
   (1) to provide Member States and other health and development partners with high-quality, normative, health-related guidance and sustained and comprehensive technical support that will enable countries to intensify their national responses to HIV/AIDS in line with their particular circumstances and priorities;
(2) to assist in the development and implementation of integrated and comprehensive prevention and care strategies;
(3) to expand with urgency support for the development of necessary health system capacities and structures, and to provide normative guidance and technical cooperation in order to enhance clinical management, nursing care, counselling, and social and psychological support to people living with HIV;
(4) to foster research, including through ethical, controlled, clinical trials, on HIV vaccines, microbicides, and new antiretroviral therapies, and on necessary commodities such as testing kits;
(5) to give guidance and support the building of national capacity for surveillance of adverse drug reactions and emergence of resistance in connection with antiretroviral medicines;
(6) to maintain close collaboration with the international community and the private sector with the aim of improving the availability of medicines for HIV, including antiretroviral therapy;
(7) to take an active part, together with other international actors, in the development and establishment of a global AIDS and health fund, including promoting mechanisms for a transparent and participatory governance structure [to be agreed].

Mr NOGUEIRA VIANA (Brazil) ascribed the success in reaching agreement on the text of the draft resolution before the Committee to the address by the Secretary-General of the United Nations the previous day. He thanked those delegations that had taken part in the informal drafting group, in particular those of the Member States of the European Union, and of South Africa, Thailand and the United States of America. He expressed the hope that the draft resolution, together with the proposed additions to be read out, would be adopted at the current session so that it would contribute to the forthcoming United Nations General Assembly special session on HIV/AIDS.

Dr HOLCK (Secretary) read out the proposed amendments to the preamble of the draft resolution. The proposed text to appear as the third preambular paragraph read as follows:

Recalling that the Constitution of the World Health Organization provides that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, and considering that progressive realization of that right should involve access on a non-discriminatory basis to health facilities, prevention, care, treatment and support in the context of HIV/AIDS;

That paragraph would be followed immediately by a further new paragraph that read: “Considering that stigma, silence, discrimination and denial aggravate the impact of the pandemic;”.

In the preambular paragraph beginning “Taking into account the need”, the words “[to be agreed] treated” should be replaced by “treated appropriately”. The third set of square brackets which appeared immediately after that paragraph should be replaced by “Recalling efforts to make drugs available at lower prices to those in need;”, and the set of square brackets in the last preambular paragraph should be replaced by “the improvement of”.

Dr TOUYÁ (Uruguay), referring to the Spanish version, said that in the preambular paragraph that referred to the Declaration of Quebec City of the Heads of States and Governments of the Americas, the word “Delegación” should be replaced by the word “Declaración”.

Professor CHURNURTÁI KARNCHANACHITRA (Thailand) referring to the same paragraph, noted that, while reference had been made to the Regions of Africa and the Americas, there was no mention of the South-East Asia Region, which accounted for some 16% of HIV/AIDS cases. The Member States of that Region, which had met to discuss the draft resolution after the informal consultations, therefore proposed that the paragraph should continue “and the eighteenth meeting of
the Ministers of Health of the South-East Asia Region which emphasized the strengthening of national capacities, the involvement of local communities and making every effort to lower the prices of HIV/AIDS drugs to make them affordable and accessible”.

Dr AL KHARABSEH (Jordan) suggested that it was unwise to reopen the debate on those parts of the text on which consensus had already been reached.

The CHAIRMAN pointed out that the paragraph referred to meetings of Heads of State rather than of ministers and agreed with the suggestion of the delegate of Jordan. He therefore proposed that the wording of the paragraph should remain as originally drafted.

It was so agreed.

Dr FERREIRA SONGANE (Mozambique) proposed that “which should be the mainstay of programmes” should be inserted at the end of paragraph 1(2) and that in paragraph 1(7) the word “hospitals” should be replaced by “care”, as the former term tended to imply larger secondary and tertiary facilities, while HIV/AIDS care was required in facilities at the peripheral level.

The CHAIRMAN said that, in the absence of any objections and given that they were largely administrative in nature, these amendments could be approved.

It was so agreed.

Dr HOLCK (Secretary) continued by saying that it was proposed that the two options placed in square brackets in paragraph 1(10) should be replaced by “in order to increase access to medicines, to cooperate constructively in strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order to promote innovation and the development of domestic industries consistent with international law”, the square brackets being deleted.

Dr STAMPS (Zimbabwe) suggested that the omission of any reference to quality might imply that the domestic industries to be developed would not necessarily be of a high quality.

Dr AL-JABER (Qatar) recalled that the objective was to reduce the prices of drugs produced specifically to treat HIV/AIDS. The text of the draft resolution should therefore indicate that the domestic industry in the most affected areas, and particularly in poor countries, should produce the drugs required by HIV/AIDS patients in their populations.

Dr DONAYRE VALLE (Peru) welcomed the reference to generic drugs. However, rather than referring to “strengthening pharmaceutical policies and practices”, which were raising ever greater obstacles to equitable access to the necessary drugs, it would be more appropriate to speak of adapting or modifying them and of the preferential use of generic drugs in public health services. Moreover, the present draft resolution should be coherent in that respect with the draft resolution on the revised drug strategy, to be considered subsequently. He therefore proposed the inclusion of “and adapting” after the word “strengthening”. He also proposed the addition of “the use of generic drugs,” after the word “promote”.

The CHAIRMAN and Ms STAVAS (Sweden) pointed out that the text of paragraph 1(10) was a delicate compromise reached after lengthy discussions.

Mr NOGUEIRA VIANA (Brazil) added that it would be counterproductive to reopen the debate.
Dr AL-JABER (Qatar) and Dr DONAYRE VALLE (Peru) agreed to withdraw their proposed amendments on the understanding that their concerns would be reflected in the resolution to be adopted on the revised drug strategy.

In the absence of further comments, the CHAIRMAN took it that the Committee found paragraph 1, with the amendment proposed by the delegate of Mozambique and that read out by the Secretary, to be acceptable.

It was so agreed.

Dr HOLCK (Secretary) indicated that the sponsors of the draft resolution had agreed that in paragraph 2(7) "[to be agreed]" should be replaced by "including representatives of civil society".

Ms STAVÅS (Sweden), Professor OMASWA (Uganda) and Ms PHUMAPHI (Botswana) proposed that "HIV" in paragraphs 2(3), 2(4) and 2(6) and the term “AIDS” in paragraph 2(7) should be replaced by “HIV/AIDS”.

It was so agreed.

Dr STAMPS (Zimbabwe) proposed deletion of the word “through” in subparagraph 2(4).

Dr FERREIRA SONGANE (Mozambique) recalled that many speakers in the earlier discussion had referred to the need to strengthen WHO’s HIV/AIDS unit and he therefore proposed the inclusion of a new subparagraph after paragraph 2(6) which would read “to strengthen the HIV/AIDS unit with the focus on operational aspects in the support and monitoring of activities;”.

Ms STAVÅS (Sweden) said that, while it was difficult to include new suggestions that had not been discussed previously, the wording proposed was acceptable, a view with which Mr TEIXEIRA (Brazil) agreed.

Professor OMASWA (Uganda) noted that the issue of prevention was important in relation to people living with HIV/AIDS. That concept should therefore be included in paragraph 2(3). He accordingly proposed the addition of the word “prevention,” after the words “to enhance”, a proposal supported by Dr STAMPS (Zimbabwe).

Dr FALL (Senegal) pointed out that paragraph 2(2) covered all aspects of prevention.

Dr SANOU (Burkina Faso) said that, if the word “prevention,” was included in paragraph 2(3), it should be qualified to indicate whether it referred to primary or secondary prevention.

Dr DRAVE (Mali), recalling the importance of traditional medicine in his own and other countries and the need for traditional medicine to be supported by research, including research by WHO, proposed the addition of the words “and traditional medicinal plants” at the end of paragraph 2(4).

Ms STAVÅS (Sweden), noting that the original text proposed for paragraph 2(4) had been arrived at following extensive discussion, urged the delegate of Mali to withdraw his proposed amendment.

Dr DRAVE (Mali) reiterated the importance of promoting research on medicinal plants but agreed to withdraw his proposal.
In the absence of further comments, the CHAIRMAN took it that the Committee approved the text of paragraph 2, as amended by the delegates of Mozambique, Uganda and Zimbabwe and with the use of the term "HIV/AIDS" as agreed previously.

It was so agreed.

The draft resolution, as amended, was approved.\(^1\)

The CHAIRMAN also took it that the Committee took note of the report.

It was so agreed.

Revised drug strategy: Item 13.8 of the Agenda (Document A54/17)

The CHAIRMAN said that informal consultations following the circulation of a draft resolution proposed by the delegation of Brazil had resulted in the formulation of a revised draft resolution proposed by Brazil and by Sweden, on behalf of the Member States of the European Union, which read as follows:

The Fifty-fourth World Health Assembly,
Recalling resolutions, nominally WHA39.27, WHA41.16, WHA43.20, WHA45.27, WHA47.12, WHA47.16, WHA47.17, WHA49.14 and WHA52.19;
Having considered the report on the revised drug strategy,\(^2\) and bearing in mind the previous report on the subject,\(^3\) that highlight challenges related to international trade agreements, access to essential drugs, drug quality and rational use of medicines, together with the urgent need to improve access to drugs for treating priority health problems such as malaria, childhood illnesses, HIV/AIDS and tuberculosis, among others;
Taking into account that the aforementioned health problems are particularly acute among poor and vulnerable populations, entrapping them in poverty, and substantially allowing the growth of national and international economies to the detriment of all humanity;
Recognizing that enjoyment of the highest attainable standard of health is a human right and that access to medicines is one important element for progressively achieving this right;
Bearing in mind the WHO global framework for expanding access to essential drugs, and its four components: the rational selection and use of medicines, reliable health and supply systems, sustainable financing, and affordable prices;
Taking into account that access to medicines is particularly price sensitive, since most people in developing countries have to pay personally for health care, and that the commitment of governments, organizations of the United Nations system, the private sector, and the civil society is necessary in order to achieve universal access;\(^4\)
Taking into account the urgency of implementing the revised drug strategy in order fully to realize the enormous health benefits that essential drugs can offer to the one-third of the human population now lacking them;
Taking into account the need to increase the current levels of international technical and economic assistance channeled to implementation of the revised drug strategy;

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\(^1\) Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA54.10.

\(^2\) Document A54/17.

\(^3\) Document A53/10.

Recognizing the importance of national drug policies established in accordance with WHO guidelines;

Acknowledging the four main objectives of WHO's medicines strategy, namely, to frame and implement policy; to ensure access; to ensure quality, safety and efficacy; and to promote rational use of medicines;

Commending the strong leadership that WHO has shown in re-emphasizing the essential drugs concept, and the contribution of nongovernmental organizations working in public health to attaining such objectives as the framing of national drug policies and related aspects;

Noting that the impact of international trade agreements on access to, or local manufacturing of, essential drugs needs to be further evaluated in most developing countries;

Recognizing that well-functioning and equitable health systems, including reliable supply systems, are key elements in any framework for expanding access to essential drugs;

Noting resolution 2001/33 on access to medication in the context of pandemics such as HIV/AIDS adopted by the United Nations Commission on Human Rights at its fifty-seventh session,

1. **URGES** Member States:
   (1) to reaffirm their commitment to ensuring public health interests and equitable access to medicines, and to undertake the necessary action within their national health policies, including for priority diseases and pandemics, as an important element for progressively achieving the highest attainable standard of health;
   (2) to take effective measures in accordance with international law and international agreements acceded to in order to ensure improved access to medicines;
   (3) to join efforts to cooperate in the implementation of the resolution 2001/33 of the United Nations Commission on Human Rights;
   (4) to pursue measures directed to expanding access of their populations to essential drugs, including the implementation of resolution WHA52.19;
   (5) to cooperate constructively in strengthening pharmaceutical policies and practices, recognizing the efforts of Member States to expand access to, and local production of drugs, [in accordance with applicable international law, including international agreements acceded to] and facilitating the development of high quality, local production capacity;
   (6) to provide financial support and technical cooperation to enable Member States in need to expand access of their populations to essential drugs;

2. **REQUESTS** the Director-General:
   (1) jointly with Member States, nongovernmental organizations and other partners involved in public health, to keep under review the effectiveness of the current strategy for essential drugs, and to stimulate the development of drugs for diseases whose burdens lie predominantly in poor countries;
   (2) to explore the feasibility and effectiveness of implementing, in collaboration with nongovernmental organizations and other concerned partners, systems for monitoring drug prices and reporting global drug prices with a view to improving equity in access to essential drugs in health systems, and to provide support to Member States in that regard;
   (3) to provide support for implementation of drug monitoring systems in order better to identify development of resistance, adverse reactions and misuse of drugs within health systems, thus promoting rational use of drugs;
   (4) to continue and to enhance efforts to study and report on existing and future health implications of international trade agreements;
   (5) to provide enhanced support to Member States that request support in achieving the priorities set out in the revised drug strategy;
(6) to provide support to Member States to set up efficient regulatory mechanisms for quality assurance that will help ensure compliance with good manufacturing practices, bioavailability and bioequivalence, and especially with national regulators for locally produced drugs;
(7) to report to the Fifty-fifth World Health Assembly on the progress of initiatives taken, globally or regionally, to expand access to essential drugs.

Mr ZEPEDA BERMUDEZ (Brazil), introducing the draft resolution, emphasized the increasing inequity that was arising as a result of the process of globalization, including income concentration, unemployment and the failure of health systems that were exclusively public, so that initiatives by nongovernmental organizations were necessary to increase the direct delivery of health services to the population. For its part, the Brazilian Ministry of Health had adopted several measures to expand the access of the population to health services, and considered provision of essential drugs a vital part of health action in order to ensure the universal right to health. The time had come for a worldwide initiative, under the guidance of WHO, to consider the implications of and contradictions between social policies and trade agreements. It was necessary for all the parties to develop clear positions on the increasingly unfair, uneven and dramatic conflict in those areas.

Brazil's policy of universal access to antiretroviral drugs, diagnosis and prevention, endorsed by the United Nations as a model for developing countries, had reduced the number of deaths from HIV/AIDS by 50% since 1996, as well as resulting in a reduction of some US$ 500 million in the cost of hospital interventions for people living with HIV/AIDS. After a protracted process of technological adaptation, the policy had also encouraged public and local production of drugs. During that process, relations had been maintained with pharmaceutical manufacturers, as demonstrated by the recent agreement to cut the price by 70% of a patent-protected drug produced by a large transnational company. Nevertheless, important health programmes were still suffering the aggression of hegemonic industries defended by government representatives. The Health Assembly could not avoid a clear and open discussion of such an important issue as access to essential drugs. Brazil was sponsoring the draft resolution before the Committee because it considered that developing countries could not remain subject to the interests of pharmaceutical industries without a discussion of the real prices and costs of research, development and the commercialization of products. The recent example in South Africa, where a number of pharmaceutical companies had reached a settlement with the Government, had shown that progress was possible through political and diplomatic discussion. The Health Assembly needed to demonstrate to the world its commitment to universal access to drugs as part of a major effort to ensure that populations, and particularly the poorest, would benefit from solid government policies supported by WHO.

Dr MILTON (Sweden), speaking on behalf of the Member States of the European Union, commended Brazil for bringing the issue of the revised drug strategy to the attention of the Health Assembly and for engaging in constructive consultations with the delegates of the Member States of the European Union in the formulation of the draft resolution before the Committee. Adoption of the draft resolution would strengthen the possibility of cooperation between Member States, nongovernmental organizations and other partners interested in public health and re-emphasize WHO's central role in that process. He urged the Committee to reach a consensus on the draft resolution and thus enable the Fifty-fourth World Health Assembly to issue a positive statement on the subject.

Dr ANTEZANA ARANÍBAR (Bolivia) observed that the draft resolution sponsored by Brazil and Sweden reflected the concerns, interests and expectations of countries like Bolivia in relation to the provision of drugs. However, in line with document A54/17, it would be more appropriate to refer both in the title and the body of the draft resolution to the WHO medicines strategy, the broader concept now used in WHO which covered the illnesses affecting the very poor as well as some of the issues raised in connection with the discussion of HIV/AIDS under item 13.6 of the Agenda. He
further proposed that the preambular paragraph beginning “Acknowledging the four main objectives of WHO's medicines strategy” should become the third preambular paragraph to meet the concerns raised earlier in connection with access to and brand names, quality, safety and efficacy of drugs. He said that he hoped that the draft resolution would be adopted by consensus.

Ms BREMER (Norway) said that one of the four main objectives of the WHO medicines strategy described in document A54/17 was to ensure access to essential drugs. Since the adoption of the current revised drug strategy in 1999, increasing attention had been focused on inequity in the access to essential drugs between low-income and high-income countries. Ensuring access to essential drugs should be a core element of any national drugs policy, although various approaches could be adopted in different countries for the efficient use of resources. Recent debates on drugs had centred on pricing. However, the WHO medicines strategy made it clear that affordable pricing was only one of the many factors involved in ensuring that access to drugs made a real contribution to improving health outcomes. Affordability must be seen in the wider context of rational selection and use of drugs, sustainable financing and reliable health and supply systems. At a WHO/WTO workshop held in Høsbjer, Norway, in April 2001, many had expressed the view that differential pricing was the best way of allowing developing countries better access to drugs, in particular, patented products. The main challenge was to ensure that products sold at preferential prices were not being diverted to richer markets. The matter needed to be given further consideration at national level by patent holders and by their distribution channels. Ultimately, careful and controlled differential pricing should help to lower drug prices in developing countries.

Norway recognized the importance of the safeguard provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in facilitating access to essential drugs. However, in order to obtain access to drugs at affordable prices, purchasers must have the necessary technical knowledge. Norway had therefore donated funds to the WHO project on tackling inequity in access to essential drugs, which it was hoped would raise awareness among Member States about their rights and obligations under the Agreement on TRIPS in relation to access to patented drugs. The availability of essential drugs to developing countries at reasonable prices would considerably improve human welfare, particularly if accompanied by adequate health care systems. That was a joint responsibility which must be assumed with close cooperation between the private and public sectors, from which both society and industry stood to gain. She expressed support for the draft resolution, subject to the amendment of the title proposed by the delegate of Bolivia.

Dr EL-SHAFAI (Egypt) thanked WHO for its support in the reform of the Egyptian pharmaceutical sector, under which all policy components had been incorporated into one comprehensive document and a national master plan had been drafted as part of the overall process of health sector reform. The main objective was to ensure the sustainable availability of high-quality essential drugs at all levels of health care delivery. Essential drugs lists were formulated and regularly updated, and a properly functioning national drug quality assurance system was in place. Efforts were made to promote the rational use of particular groups of drugs, such as antibiotics, to prevent drug resistance. The local drug industry was being encouraged within a regional strategy for self-sufficiency in the production of essential drugs and vaccines. She considered that the last sentence of paragraph 22 of the report (document A54/17) should have highlighted WHO's role in setting international standards for drugs and health-related products.

She expressed support for the draft resolution, subject to the inclusion of an additional paragraph on traditional medicines, to the effect that WHO should lead a process of listing all herbs, their active ingredients and possible actions and side-effects, in order to assess their efficacy and safety. Appropriate guidelines should then be published.

Ms DJAMALUDDIN (Indonesia) expressed appreciation of WHO's efforts to ensure the accessibility of affordable essential drugs, which was still a matter of concern in developing countries, especially large ones such as her own. The situation in Indonesia had been made worse by rapid
decentralization, which had affected the reliability of the supply system in the public sector. Less than half the population was covered by health insurance; the remainder had to pay for drugs. She therefore fully supported the WHO initiative on differential pricing. However, some of the options under the Agreement on TRIPS, in particular with regard to parallel importing and compulsory licensing, were not well understood by all developing countries. The role of WHO in that context should be strengthened; the Organization's observer status on WTO's Council on TRIPS should be on a permanent rather than an ad hoc basis.

WHO should give greater emphasis to preventive action, including the promotion of model laws and regulations on compulsory licensing and other measures to improve access to expensive medicines, and to the provision of systematic legal advice to help developing countries maximize drug availability and protect public health.

She supported the draft resolution in principle and asked that her concerns be reflected in the final text. She emphasized the importance of joint efforts at the global level aimed at ensuring reliable access to essential drugs for most of the world's population. Noting the omission of reference to traditional medicine, she requested WHO to give serious consideration to its important role in health care systems.

Dr ROMUALDEZ (Philippines) expressed satisfaction that the international pharmaceutical industry had decided to cooperate with WHO and Member States to enhance the availability of medicines. However, countries like the Philippines which had long given preference to health over commercial interests could not forget the extreme resistance of many companies, sometimes with government support, to changes in the favour of poor people. He was therefore concerned that certain phrases in the draft resolution appeared to reinforce the pharmaceutical industry's advantage over the health sector, for example, the inclusion, in operative paragraph 1(5), of the phrase "in accordance with applicable international law, including international agreements acceded to". He proposed the insertion at the end of that paragraph of "in accordance with the health needs of people, especially those who can least afford current costs". He further proposed the insertion in paragraph 2(4) of wording to take into account the proposals made by the delegate of Bolivia and, in the discussion of agenda item 13.6, the delegate of Peru, to strengthen the hand of the health care sector in dealing with those considerations. Subject to those amendments, he supported the draft resolution.

Dr ABDESSALEM (Tunisia) said that he too hoped that WHO's status as an observer on WTO's Council on TRIPS would soon become permanent.

He stressed the importance of the registration of new medicines. Tunisia was cooperating with many other African countries, especially within the framework of WHO, to achieve the goal of manufacturing high-quality medicines. Accessibility was a problem for most countries to varying degrees, and Tunisia therefore welcomed the progress made in regard to medicines to combat HIV/AIDS. However, further efforts were needed in respect of some essential drugs, the prices of which had been increased beyond the capacities of developing countries.

Mr FETISOV (Russian Federation) expressed support for WHO's efforts to assist Member States in formulating national drugs policies, pursuant to resolution WHA52.19. In the Russian Federation, materials on standards, methods and information prepared by WHO under the revised drug strategy were widely used, particularly with respect to international generic drugs and in reviewing the national essential drugs list, including the format and contents of WHO's Model List of Essential Drugs. As of the year 2000, the Russian Federation had introduced regulations requiring manufacturing practices along the lines of WHO/European Union Good Manufacturing Practice (GMP) regulations. WHO basic GMP training modules were used for staff training and in setting national standards relating to GMP regulations. WHO materials to combat the spread of counterfeit drugs had also been found extremely useful. As the Russian Federation completed work on its national drugs policy, it would draw on relevant WHO recommendations and the experience of other Member States in the area. In conclusion, he endorsed the draft resolution as amended by Bolivia.
Dr MASSÉ (Canada) said that experience had shown the importance of mechanisms to ensure equitable access to essential drugs to combat diseases such as HIV/AIDS, tuberculosis and malaria. Canada therefore encouraged drug-producing countries and international organizations to continue discussions with a view to improving accessibility for those in need, especially in developing countries. The international agreements in the field of intellectual copyright had been designed to give Member States the necessary flexibility to adopt protective measures in vital sectors such as public health. He supported the efforts of WTO, WHO and others to explore differential pricing as one way of persuading the pharmaceutical industry to pursue research and development by recovering the costs in the richest markets. However, access to medicines involved more than costs; developing countries needed help to establish effective health systems and infrastructures for the procurement and surveillance of essential medical products and therapies. Canada supported the draft resolution but wanted to see the inclusion of the reference to applicable international law and international agreements in paragraph 1(5), as shown in square brackets, which would enable Member States to make use of such provisions while respecting the interests of those for whom the medicines were intended.

Dr ENDO (Japan) stressed the importance of reducing costs for essential drugs in order to improve access but also of ensuring that health systems were able to use them effectively, which raised questions regarding the allocation of limited health resources, to prevention, treatment and infrastructure development. The Group of Eight Summit, held in Okinawa in 2000, had recognized the need to combat infectious diseases that exacerbated poverty by improving access to health services in developing countries. In addition to cost, the quality of drugs was also of great importance. In that connection, Japan was supporting a project on drug quality assurance in the Asian region, which was being conducted under the auspices of its National Institute of Health Sciences.

Ms INGÖLFSDÖTTIR (Iceland) stressed the need to close the gap between the haves and the have-nots; despite the obvious benefits of essential drugs, for millions of people they were unavailable, unaffordable, unsafe, improperly used or of poor quality. Access to such drugs was a basic human right, and she therefore supported the development of strategies to improve accessibility and pricing, and in relation to generic drugs. In view of rising costs and increasing resistance to antimicrobial drugs, it was important for all Member States to implement national strategies for rational drug use, with emphasis on accessibility, quality and affordability, and incorporation of evidence-based clinical guidelines. She supported the draft resolution.

Ms YUWADEE PATANAWONG (Thailand) commended WHO’s efforts to promote the equitable availability and affordability of essential drugs in developing countries through the revised drug strategy. She supported the draft resolution proposed by Brazil and Sweden. Clearly, any mechanisms established by the partners concerned, including national governments, the private sector, civil society, nongovernmental organizations and international organizations, would need to be implemented effectively so as to expand and sustain equitable access to essential drugs, especially for people suffering from poverty-related diseases such as HIV/AIDS. Cost was currently a major constraint to access to drugs. She therefore proposed the addition at the end of paragraph 1(4) of “taking into account the cost-effectiveness of rational drug use as well as affordability for Member States”. She agreed with the delegate of Indonesia that Member States and WHO should be urged to give greater consideration to the use of herbal and traditional medicines and to promote research and development in that field. Lastly, she appealed for strong and consistent support to national governments that wanted to use the safeguard provisions in the Agreement on TRIPS in order to promote, equitable, affordable, accessible and sustainable health care systems.

Dr TSHABALALA-MSIMANG (South Africa) said that the issues under discussion were familiar to her country as a result of its long and sometimes painful experience in attempting to
implement its national medicines policy. WHO had provided valuable support in that process, the document on globalization, trade and health, released in March 2001, having proved particularly useful. It was important to recognize that access to essential drugs and treatment of HIV/AIDS were not limited to access to antiretroviral drugs. South Africa looked forward to the continued support of WHO and others and would be happy to share its own experience and expertise. It was particularly interested in the forthcoming discussions on differential pricing, technological transfer and the local production of medicines. South Africa supported the broad thrust of the draft resolution and expressed the wish to be included as a sponsor.

Dr NOVOTNY (United States of America) commended the efforts made in formulating the draft resolution. While he supported it in general and had no wish to undermine the emerging consensus, he proposed the formation of a drafting group to consider, within a limited time, remaining concerns in relation to the text. He reserved the right, should that prove unacceptable, to take the floor again to propose further amendments.

Dr DONAYRE VALLE (Peru), referring to his intervention during consideration of item 13.6 of the agenda, deplored the omission in subparagraph 1(5) of the draft resolution under consideration of reference to generic drugs, which gave the impression that the recent experience of South Africa in that area had been overlooked by the Health Assembly. He proposed the insertion of a new subparagraph immediately after paragraph 1(5) to read: “to promote the use of generic drugs in the public sector through their preferential inclusion in national lists of essential drugs and through their distribution and exclusive or preferential prescription in public health institutions”. Such a provision would give effective support to countries like Peru that were seeking to create mechanisms to guarantee the use of generic drugs and so reduce the impact of high prices on public and family budgets. Peru endorsed the remainder of the draft resolution.

The CHAIRMAN proposed that a drafting group should be established, under the joint chairmanship of the delegates of India and the Netherlands to consider the points raised during the discussion. He urged the group to refrain from introducing substantial changes to a text that had already been the subject of extensive consultations.

It was so agreed.

The meeting rose at 12:40.
SEVENTH MEETING

Friday, 18 May 2001, at 14:40

Chairman: Professor S.K. ONGERI (Kenya)
later: Dr M. FIKRI (United Arab Emirates)
later: Professor S.K. ONGERI (Kenya)
later: Dr M. FIKRI (United Arab Emirates)
later: Professor S.K. ONGERI (Kenya)
later: Dr M. FIKRI (United Arab Emirates)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Revised drug strategy: Item 13.8 of the Agenda (Document A54/17) (continued)

Ms PHUMAPHI (Botswana) said that access to medicines was essential for the promotion and attainment of the human right to enjoy good health. The WHO medicines strategy was designed to ensure equitable access to drugs, guarantee their quality, safety and efficacy, and promote their rational use. The question of access to medicines could not be resolved by individual countries. It required a global commitment on the part of the pharmaceutical industry, the corporate sector and civil society as a whole. The Global Alliance on Vaccines and Immunization (GAVI) was a major new initiative. However, it still required refinement in order to ensure that all countries participated.

In many developing countries, the essential drugs lists did not include some life-saving drugs or drugs that were critical for health and the control of serious epidemics, or the countries could not provide access to the drugs on their lists. It might even be necessary to redefine the concept of essential drugs altogether, if health as a human right was to be guaranteed. She therefore welcomed the draft resolution under discussion and hoped that it would be fully implemented.

Her delegation endorsed the emphasis on traditional medicines in the report (document A54/17), as most people in the developing world used both traditional and modern medicines. Her country also emphasized the need for equity and the importance of local production, parallel importation and compulsory licensing in improving access to essential drugs.

Ms ORDOÑEZ NORIEGA (Colombia) supported the draft resolution under discussion, which sought to improve access to essential drugs. Some diseases that had posed a public health problem for a long time, such as Chagas disease, could finally be controlled by means of recently developed drugs, while some new diseases could already be controlled: it was possible, for instance, to slow the progression of AIDS and to prevent mother-to-child transmission of HIV.

It was essential that countries' efforts to produce high-quality, reasonably-priced generic drugs and distribute them efficiently should not be restricted. Countries would also need up-to-date information about world drug prices and an early warning system to alert them to negative effects that might result from escape clauses or preferential-treatment clauses in international trade agreements.

Professor CANBOLAT (Turkey) said that his country had adopted its essential drugs list in 1990 to provide safe, locally-available drugs and to promote rational drug use. In April 2001, the Directorate-General of Pharmaceuticals of the Ministry of Health had joined the Collaboration Agreement between Drug Regulatory Authorities in European Union Associated Countries. Turkey was also associated with the European Union, the European Agency for the Evaluation of Medicinal Products, the Food and Drug Administration of the United States of America and WHO in the areas of...
drug manufacture, quality control, drug registration, pricing, transparency and drug monitoring. Despite the success of WHO's Model List of Essential Drugs, almost 30% of the world's population still lacked access to essential drugs, particularly new and expensive antibiotics and antiretroviral agents that were protected by patents. The global framework for expanding access to essential drugs was necessary. WHO was the leading institution in that field. His country was ready to collaborate on WHO's drug strategy with international partners.

Mr RAHMAN (Bangladesh) expressed concern about stringent application of intellectual property rights in the field of pharmaceuticals, which impeded access to essential drugs, increased their cost and effectively restricted the local production of generic drugs. The provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) were interpreted in a way that restricted parallel imports and compulsory licensing. He was concerned about the onerous conditions attached to the application of public health safeguards in the Agreement on TRIPS. Existing patents were often expanded or broadened and patent cover was renewed on old drugs beyond the original 20-year term, even though no substantial innovations had been introduced. Another area of concern was the "TRIPS-plus provisions" dealing with measures more stringent than those laid down in the Agreement itself.

Some of the above concerns were dealt with in the draft resolution under discussion, but others were not. Naturally, some sacrifices had been made in order to achieve a consensus, but, if the draft resolution was eventually adopted by the Health Assembly, its provisions – as far as they went – should be implemented in full. He nevertheless supported the draft resolution.

Dr KHAZ'AL (United Arab Emirates) praised the report before the Committee, particularly the section on expanding access to drugs. Health and access to drugs were basic human rights. Her own country encouraged policies that improved access to drugs, especially those required to combat communicable, endemic and priority diseases, and initiatives that improved access to or local production of drugs within the terms of international agreements. It had established programmes to test herbal medicines and had passed laws and regulations governing their use and distribution. Her delegation supported the draft resolution under discussion.

Mr NGEDUP (Bhutan) said that WHO's essential drugs concept was of great help to developing countries in promoting the rational use, quality and efficacy of drugs. However, it was equally important to establish a sustainable supply system. In 1997, his country had set up a trust fund with the support of the Regional Office for South-East Asia and many bilateral and private donors to guarantee a continuous supply of essential drugs and vaccines. The health fund had obtained funds of US$ 15 million and was now operational. He expressed Bhutan's gratitude in that regard. At present, 80% of the cost of essential drugs was met from the national health budget, and medicines were provided free to the poorest groups in the population and those in remote areas. GA VI was studying the fund as a model for ensuring a sustainable vaccine supply. It was important that the WHO medicines strategy should focus on the sustainability of financing for essential drugs supplies in developing countries, including support for innovative mechanisms developed by individual countries. He joined previous speakers in urging WHO to continue its support for traditional medicine, which represented a long-term, sustainable system.

Dr SILWAMBA (Zambia) thanked WHO for its support in the development of his country's national drugs policy and the establishment of protocols on rational drug use. In countries like his own, with an overwhelming burden of disease, treatment and management also made valuable contributions to prevention. He endorsed the report, which had global public health implications, and hoped that all Member States would support the efforts to streamline the controversial procedures laid down by the Agreement on TRIPS. WHO must assume the leadership in that campaign. He supported the draft resolution.
Mr CHOWDHURY (India) said that the terms and regulations governing world trade had changed considerably during the 1990s, and the tendency was now for all commodities to be treated alike. The Agreement on TRIPS had had a considerable impact on global trade in pharmaceutical products, introducing restrictions on the manufacture of generic drugs and extending the duration of patent rights, which had threatened the availability of new drugs in developing countries. A global consensus was needed on application of the Agreement to the pharmaceutical sector in a way that would ensure the availability of new drugs at affordable prices. That might be achieved in either of two ways. First, a consensus might be reached in the international community to permit the production of new patented drugs in developing countries under restricted patent licences for public, non-commercial use. Alternatively, limited patent rights might be purchased with international institutional funding for the production and use of new drugs for public, non-commercial use in developing countries.

Dr AMATHILA (Namibia) said that sources of essential drugs, their price and the logistics of their distribution were essential factors in ensuring access to such drugs. Her country imported all its pharmaceutical items; however, some consignments of imported medicines had been of such poor quality that the defects were visible to the naked eye. All countries should receive support in establishing quality control facilities for medicines, and she called upon WHO to strengthen Member States' capacity in that area. She supported the draft resolution, particularly paragraph 2(6) which called upon the Director-General to help Member States to set up efficient regulatory mechanisms for quality assurance.

Mrs AL-ANSARI (Bahrain) said that her country had a comprehensive drug policy which ensured a sustainable supply of high-quality medicinal drugs. She informed the Committee that the countries of the Gulf Cooperation Council had had successful experiences with group bulk purchases. The report did not go into detail about research and development as an integral component of national drug policies. She called upon WHO to formulate a clear policy on that issue, including drug development for diseases particularly affecting developing countries and technology transfer to promote national and regional production of essential drugs and vaccines. The Organization should also consider the important role of academic institutions and scientific and professional associations in both developed and developing countries.

Dr HAMUKWAYA (Angola) said that many developing countries had difficulty in keeping track of drugs entering through the black market, which meant that people might be sold poor-quality medicines. She called upon WHO to establish an effective mechanism to reduce the impact of that problem. Resistance to drugs, especially those used to treat malaria and tuberculosis, was a major problem, and alternative drug regimens were too expensive for developing countries. WHO should play a greater part in negotiations with multinational companies to reduce the prices of new drugs.

Dr DAYEH (Syrian Arab Republic) supported the draft resolution. It was important to pay due attention to guaranteeing supplies of drugs and vaccines (including herbal medicines) of high quality and encouraging modern and appropriate methods of manufacture. Paragraph 1(5) of the draft resolution was an important provision, particularly in respect of the local production of drugs.

Professor ABDELMOUMENE (Algeria) supported the draft resolution, and asked that his country be included as a sponsor.

Dr SMITH (OXFAM), speaking at the invitation of the CHAIRMAN, said that her Organization acknowledged the value of the proposed global AIDS and health fund, public-private initiatives and drug price cuts, but believed that they were only a partial answer to the problem. A more fundamental, coherent and sustainable response was needed. Patent protection was important in stimulating research and development. However, pharmaceutical companies failed to invest in research and development
into the diseases of poverty, not because of difficulties with patents, but because there was no market incentive for them to do so. Stricter patent rules would not solve the problem.

Competition from generic drugs played a major role in reducing drug prices overall. Since 2000, pharmaceutical companies had been obliged to make large price cuts in certain products because of the very low benchmark prices of generic drugs. However, the Agreement on TRIPS threatened to undermine the crucial role of generic drugs in price reduction. Countries that tried to enact legislation to implement the safeguards incorporated in the Agreement to ensure the protection of public health were put under strong pressure from the pharmaceutical industry and northern-hemisphere governments, especially that of the United States of America. Brazil and South Africa had suffered that problem among many others.

She called upon the Health Assembly to ask for substantial investment in a global research and development fund for neglected diseases from all countries, according to their means. WHO should take a proactive role on the Council on TRIPS to ensure that public health needs took precedence over commercial interests. WHO should call upon rich countries and pharmaceutical companies to cease their pressure on developing countries that attempted to make use of the "TRIPS safeguards". The Organization should provide more support to help countries to interpret the Agreement on TRIPS in favour of public health and should support countries facing problems because of that Agreement.

WHO should also support a global health fund to strengthen health systems and access to medicines. The fund should be under the aegis of the United Nations system in order to avoid undue corporate influence, and should deal with other public health priorities besides HIV/AIDS. It should operate within an equitable national health policy framework providing comprehensive prevention and treatment services, including antiretroviral drugs, with full transparency and accountability at national and international levels and consultation with civil society. The fund should be open to tender to obtain the best prices for both patented and generic drugs and should not be undermined by the structural problems of the Agreement on TRIPS.

Dr MIRZA (Consumers International), speaking at the invitation of the CHAIRMAN on behalf of Health Action International, Médecins sans frontières, the World Council of Churches, OXFAM and his own organization, referred to the Director-General's address to the Health Assembly (document A54/3), in which she had said that WHO, except under particular circumstances, was not to take sides. However, his organization considered that the issue of access to essential drugs was one in which WHO could not, and should not, be neutral. It must take the side of the poor, who were denied access to essential health care. Improved access to medicines would require serious implementation of national health policies and drug policies based on the essential drugs concept. It was important to move from negotiating drug price discounts on a country-to-country, company-to-company or drug-to-drug basis to more reliable, sustainable, policy-based measures by national governments.

WHO's adoption of the revised drug strategy (resolution WHA52.19) had marked a major turning point in its activities in the field of access to drugs, particularly in respect of the request to the Director-General to cooperate in monitoring and analysing the pharmaceutical and public health implications of relevant international agreements, including trade agreements such as the Agreement on TRIPS. WHO must now take on a more proactive and visible role in that crucial area and provide poor countries with more technical assistance.

The discussion of differential pricing required a broader perspective. The recent meeting on differential pricing and financing of essential drugs hosted by WHO and WTO in Norway had failed to achieve any concrete results. Differential pricing by itself would not make drugs affordable: a combination of mutually supportive measures would be required. Drug prices were another area requiring WHO's clear leadership and support to Member States.

His organization commended WHO's efforts to strengthen the essential drugs list by reviewing and revising its procedures. Action was needed straight away: people in developing countries were
dying, not because they were ill, but because they were poor and could not buy life-saving medications.

Ms HEATON (Save the Children Fund (UK)), speaking at the invitation of the CHAIRMAN, commended WHO's recent work to improve access to drugs; however, it was vital that the standards and integrity of the Organization should not be compromised. There was a growing trend towards joint initiatives between WHO or other United Nations bodies and the private sector, most recently in the proposal for a global AIDS and health fund. WHO's collaboration with the private sector could be justified only as a means of pursuing the protection and promotion of the human right to health. Since the mission of the for-profit sector was ultimately different from that of WHO, there must be mechanisms to prevent any conflict of interests. It was the State that bore the primary obligation to protect the right to health of its citizens; any joint public-private initiatives must be accountable both to the Government and to civil society. Their impact on the people's right to health care must be clear. Many public-private initiatives were based on donations or preferential pricing arrangements. Questions had been raised about their sustainability and about the contribution of such programmes to public health systems, particularly if they involved a health delivery system parallel to the existing one. Her organization had voiced such concerns in a recent report.

Her organization welcomed WHO's work with the Interagency Pharmaceutical Coordination Group on its draft guidelines for accepting or endorsing preferential prices or donations of single-source pharmaceuticals, which was based on the WHO global framework for expanding access to drugs. However, she was concerned that there was no provision for monitoring compliance with the guidelines. Her organization recommended that every initiative between WHO and the private sector should be regulated by a contract specifying that the parties must comply with the guidelines or other relevant WHO standards. WHO should establish a mechanism whereby independent observers could assess the impact of any such public-private initiative, in line with its contractual objectives and standards. The managing body of the public-private initiative should respond to all such assessments, and a report should be submitted to the Health Assembly every year.

With the global AIDS and health fund likely to be established, and given the state of collapse of health systems in many countries in Africa, her organization believed that any drug-delivery programme undertaken by WHO should also aim to strengthen health systems as a whole. WHO's public-private initiatives must be both transparent and accountable to the public if the standards that the Organization represented were to be maintained and furthered. Achieving that goal would set a much-needed example among United Nations bodies.

Dr REINSTEIN (World Self-Medication Industry), speaking at the invitation of the CHAIRMAN, said that his organization, represented in 54 countries, dealt with products approved for self-medication and labelled with information that consumers could read in order to make safe and effective use of the product. The prices of such products were controlled by competition, since they were generally not under patent. The self-medication products in question constituted 20% of the items on the WHO Model List of Essential Drugs, which should, in theory, be available to everyone in the world. However, WHO statistics indicated that one-third of the world's population still did not have access to essential drugs. There was a need for better financing and infrastructure to ensure such access.

WHO had suggested that drugs used for nicotine replacement therapy should be given non-prescription status in all countries. That would allow more publicity about the availability of such therapy, encourage more people to try to quit smoking and thus save lives. Generic drugs were now available for nicotine replacement therapy, and the treatment was thus becoming more affordable. His organization called upon those Member States which had not yet done so to grant non-prescription status to such products.

Dr SUZUKI (Executive Director), welcoming the encouraging comments that had been made about the importance of access to safe, effective essential drugs and other aspects of the WHO
medicines strategy, said that the workshop on differential pricing and financing of essential drugs held in Norway had shown that governments, research-based and generic industries, nongovernmental organizations and consumer groups faced common issues. Although price did matter in terms of access to pharmaceuticals, financing and other supporting mechanisms such as logistics and sustainable health systems were required. It would be possible to implement the differential pricing regime while maintaining incentives for research and development. Mutually supportive strategies in that connection might include preventing the diversion of low-priced products into high-income markets and consideration of how consumers in high-income markets could accept the sustained price differences.

With regard to the Agreement on TRIPS, he said that the Director-General would continue to act in accordance with the terms of paragraph 2(7) of resolution WHA52.19 on the revised drug strategy. The suggestion of the delegate of Indonesia that WHO have a permanent observer position on the WTO Council on TRIPS was a matter to be decided by WTO members.

Turning to the role and ongoing work of WHO in traditional medicine raised by many delegations, he drew attention to the WHO Strategy for Traditional Medicine 2001-2005, which was being finalized with the input of Member States. The main focus in that strategy was the appropriate integration of traditional medicine into national health systems and increasing the accessibility and availability of traditional and other forms of alternative medicine, particularly for priority diseases such as HIV/AIDS and malaria. As the delegate of Indonesia had noted, the efficacy and safety of traditional and herbal medicine were particularly important issues.

With regard to research and development on neglected diseases and implications for technology transfer and domestic production, he said that WHO had recently established other programmes in addition to the Special Programme for Research and Training in Tropical Diseases and its programme on human reproduction. They included GAVI and the Medicines for Malaria Venture, and provided incentives for collaboration on research and development between the public and private sectors. Technology transfer and domestic production could not be underestimated, particularly as they formed part of the objectives of the Agreement on TRIPS, and could have a significant impact on affordability, availability and accessibility.

The CHAIRMAN invited the Secretary of the Committee to read out the proposed amendments to the draft resolution on the revised drug strategy that had been agreed upon by the drafting group following the sixth meeting of the Committee.

Dr HOLCK (Secretary) said that it was proposed to replace the title “Revised drug strategy” with a new title, “WHO medicines strategy”. The preambular paragraph beginning “Acknowledging the four main objectives ...” should be inserted as a new third preambular paragraph. In the fourth preambular paragraph, the word “allowing” should be replaced by “inhibiting”. The fifth preambular paragraph should be replaced by a new paragraph reading: “Recalling that the Constitution of the World Health Organization provides that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, and considering that progressive realization of that right should involve access, on a non-discriminatory basis, to health facilities, prevention, care, treatment and support in the context of access to medicines;”. In accordance with the proposed change of title, the words “revised drug strategy” should be replaced by “WHO medicines strategy” in the eighth and ninth preambular paragraphs. Lastly, in the thirteenth preambular paragraph, the words “and on the development of new drugs” should be inserted after “essential drugs”.

1 For the text of the draft resolution, see the summary record of the sixth meeting of the Committee.
Replying to a question by Dr AMATHILA (Namibia), the CHAIRMAN confirmed that the proposed change of title did not mean that the word ‘drugs’ would be replaced by ‘medicines’ in the body of the draft resolution.

Dr HOLCK (Secretary), referring to the operative part of the draft resolution, said that in paragraph 1(1), the words “to make every effort to promote” should be inserted before “equitable access”. In paragraph 1(3), the words “to join efforts” should be deleted, and the words “in the implementation of” should be replaced by “with respect to”. The words “taking into account the cost-effectiveness of rational drug use as well as affordability” should be added at the end of paragraph 1(4). Lastly, paragraph 1(5) should be amended to read: “in order to increase access to medicines, and in accordance with the health needs of people, especially those who can least afford the costs, and recognizing the efforts of Member States to expand access to drugs and promote domestic industry, cooperate constructively in strengthening pharmaceutical policies and practices including those applicable to generic drugs and intellectual property regimes in order further to promote innovation and the development of domestic industries, consistent with applicable international law.”.

The word “voluntary” should be inserted before “monitoring drug prices” in paragraph 2(2), and the phrase “in close cooperation with relevant intergovernmental organizations” should be added at the end of paragraph 2(4). In paragraph 2(5), the words “need and” should be inserted before “request support”, and “revised drug strategy” should be replaced by “WHO medicines strategy”. In paragraph 2(6), the word “national” should be inserted before “regulatory mechanisms”, and the phrase “and especially with national regulators for locally produced drugs” should be deleted. Finally, it was proposed to add an additional paragraph reading as follows: “to continue WHO’s work in the field of traditional medicines;” as a new paragraph 2(7).

The CHAIRMAN invited the Committee to approve the draft resolution with the incorporation of the amendments read out by the Secretary. He thanked the delegations of India and the Netherlands who had jointly chaired the drafting group, and all the others who had succeeded in formulating a text acceptable to the Committee.

The draft resolution, as amended, was approved. ¹

The CHAIRMAN took it that the Committee wished to note the report contained in document A54/17.

It was so agreed.

Health promotion: Item 13.2 of the Agenda (Document A54/8)

Dr BODZONGO (representative of the Executive Board) recalled that the Chairman of the Board had characterized health promotion as one of the main tasks facing WHO in the 21st century. It would require clearly defined strategies, and in that regard the Board at its 107th session had welcomed WHO’s willingness to cooperate with Member States on strengthening mechanisms for health promotion and incorporating them into national plans. In developing countries, WHO should base its research and pilot programmes more firmly on national conditions and cultural traditions. It should support not only evidence-based health promotion activities but also the development of national capacity for community empowerment, partnership development, promotion of research on health systems and provision of training for practitioners and professionals to increase their skills. Common terminology and a common approach should be adopted to help countries improve their health systems and to allow for comparison of results. Support for health promotion should be justified

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA54.11.
as cost-effective and considered as part of health system reform, and appropriate political, economic and regulatory approaches should be adopted. Well-targeted prevention and promotion activities were required to safeguard and improve public health and to teach people how to lead a healthy life. The Board had agreed that WHO should focus on streamlining health promotion in the areas of youth, health communications and health systems. Health services should develop strategies for the horizontal integration of health promotion issues into their activities. As many factors that determined health were beyond the control of the health sector itself, traditional boundaries should be extended to include partnerships with the private sector, the entertainment industry and legal and political bodies.

Professor MATHEWS (Australia) said that his delegation welcomed the report and endorsed the initiative. Australia had been a leader in health promotion in the Western Pacific Region and, through the Australian Agency for International Development, had supported regional health promotion projects. Within Australia, successful partnership forums, involving governmental and nongovernmental bodies and community groups, had coordinated planning and research as well as mobilizing resources for such activities. Such partnerships had already contributed to reducing the rate of smoking, improving nutrition and reducing mortality rates from heart disease and cancer, as well as helping to control HIV/AIDS in the country. Australia was particularly pleased to note the establishment of an international forum to coordinate health promotion planning and action at the international level.

Dr VIOLAKI-PARASKEVA (Greece) said that her delegation commended the report. Health promotion was a cornerstone of WHO policy, cutting across all the Organization’s programmes while maintaining its own identity and role. Health services should strive to develop health promotion as an integral part of the work carried out on a horizontal basis, and should target it at all population age groups, with particular emphasis on healthy ageing. Paragraph 8 of the report was especially relevant, stressing health promotion directed at young people and the need to make health promotion activities available both in and out of school. Likewise of importance was the need to pay attention to the influence of the mass media on young people.

Dr Fikri took the Chair.

Dr MAHJOUR (Morocco) said that his delegation supported the report contained in document A54/8. Health promotion was unquestionably a major factor in a country’s health. At the start of a new millennium, the need for further efforts, as noted by the Director-General, was greater than ever, as the evolution in factors such as market forces and communications had an ever-wider effect on patterns of behaviour and consumption. Those and other factors, such as emerging and re-emerging diseases, inevitably added to the pressures on already overburdened health systems. Since the adoption of healthy lifestyles everywhere could be achieved only with time, countries must redouble their social and political efforts. In Morocco, health promotion had always been central in health activities, as reflected in the ninth Economic and Health Development Plan 2000-2004, which, inter alia, would increasingly involve intersectoral activity and the contribution of civil society. Health promotion should include medium-term and long-term strategies, maintaining a realistic approach while respecting religious and other traditional values.

Dr SURENCHIMEG (Mongolia) thanked WHO, particularly the Regional Office for the Western Pacific, for the invaluable support received in initiating health promotion approaches in her country. The Mongolian Government recognized the potential of health promotion; she therefore welcomed WHO’s intended focus on five essential actions, including coordinating and planning mechanisms. Health promotion in her country was at a very early stage. It needed capacity-building, in view of the lack of human and technical resources, particularly for the development of primary and secondary prevention in the health service. It was important to encourage healthy behaviour among the young, a growing number of whom had suffered from impaired physical development during recent
years, possibly caused by the recent transitional economic crisis. Mongolia fully supported the health-promoting schools initiative; it currently had more than 40 such schools, thanks to WHO support, and needed further backing to encourage more.

One important task of health promotion was to synchronize the five spheres of action. In Mongolia, however, piecemeal funding and lack of holistic management skills remained a problem and emphasized the importance of capacity-building. Mongolia was currently developing a national public health policy, in which health promotion would be a major field of future action. Her delegation therefore requested WHO to continue its support.

Mr JUGNAUTH (Mauritius) said that his country fully supported the report and was pleased that WHO was concentrating on evidence-based health promotion as an effective means of population-based prevention of major health problems such as diabetes, hypertension and cancer. Those noncommunicable diseases were by far the greatest health problems in his country and were linked to nutrition and dietary habits as well as physical activity. Mauritius currently spent over 100 million rupees on renal dialysis caused by diabetes and carried out more than 450 open-heart operations yearly, at a cost of some 80 million rupees. Millions more were spent on drugs, overseas treatment, renal transplants and eye operations. His delegation welcomed WHO's further work relating to tobacco; it hoped that the Organization would also strengthen its efforts to formulate effective strategies on nutrition and physical activities and that a global strategy on nutrition and noncommunicable disease prevention could be developed.

Outlining the growing problems of breast and cervical cancer among women in Mauritius and the detection measures implemented or proposed, he urged WHO to develop appropriate health promotion strategies to address those preventive aspects.

Ms MIKKOLA (Finland), speaking on behalf of the Nordic countries, welcomed the progress reflected in the report. The intention to focus efforts on young people, health communication and health systems was justified; it was important, too, to focus on disadvantaged groups and inequalities. Moreover, efforts to improve the evidence base for health promotion would surely build Member States' capacity. The third priority area, health systems, had great potential, and much progress had been achieved by applying health promotion programmes to specific risk factors and diseases. But the transition from disease control to health promotion needed commitment from all sectors of society. Political, social and economic changes demanded an integrated approach and an awareness of health issues at all decision-making levels, nationally, regionally and locally. The pace of those changes would be slow and called for persistence, long-term objectives and new ways of thinking. In that connection, health impact assessment was a potential subject for multisectoral action.

The task would require a broad perspective and strong horizontal work to support vertical programmes. The recent development in WHO of health promotion activities had been reflected, for example, at the Fifth Global Conference on Health Promotion, held in Mexico City the previous year. It was hoped that WHO would continue its work along the lines set forth at that Conference. WHO's role in health policy development was one of its main responsibilities. A firm policy foundation was essential to establish the intersectoral mechanisms necessary to further the Director-General's initiatives to put strategic health items on the general political agenda — a matter that had been expressed more clearly in the Proposed programme budget 2002-2003 than in the present report. The Nordic countries proposed that a progress report on achievement of the expected results set out in the Proposed programme budget should be presented to the Fifty-sixth World Health Assembly in 2003. In that regard, health promotion should remain a top budget priority.

Dr VAN ETTEN (Netherlands) acknowledged the importance of health promotion, particularly the need to strengthen the evidence base, and he supported the choice of priority target populations. The role of civil society had not been mentioned in the report. He therefore sought confirmation that the principle of civil society participation in the development of health promotion policies and activities would be adhered to.
Ms GALLMANN (Switzerland) welcomed the inclusion of health promotion on the Health Assembly's agenda, as it was a priority in Switzerland's public health policy. Since the adoption of the Ottawa Charter for Health Promotion, that aspect had been an integral part of global public health. The Fifth Global Conference on Health Promotion had stressed the need for firm action at all levels, including the preparation of action plans at country level. Switzerland had established a national foundation for health promotion, which had just launched a nationwide information campaign. Her country's experience showed that health promotion was a response to the ever-growing needs and varying risks of life, as well as environmental hazards. She encouraged WHO to ensure that health promotion took its proper place in the sphere of public health.

Professor PATCHARAWAN SRISILPANAN (Thailand) said that her delegation welcomed the report, as Thailand had given top priority to health promotion at national and local levels, having adopted an action plan on that aspect in the national health plan. Thailand's experience in efforts to reduce mother-to-child transmission of HIV had highlighted the importance of social mobilization. Training, peer education, use of the mass media and improved educational and vocational opportunities were among the strategies used, and the experience had been shared with other countries of the region. Thailand had two robust legislative acts on tobacco as well as strong political support for related health policies; for example, 1% of tobacco excise revenue was earmarked annually for the health promotion fund, which aimed to support activities by governmental and nongovernmental organizations as well as research.

Her delegation considered that the report did not consistently reflect the concept of health promotion. Health should be viewed in a positive context, as enhancing social development and quality of life; in that context, the role of civil society was more important than disease reduction. Despite the welcome progress noted in paragraph 4, the report focused only on the outcome derived from conventional disease-based indicators and would present a better picture if it emphasized the process or strategies used in each programme.

With regard to paragraph 7, thorough consideration was required before rigid priorities were established; a guideline should be prepared to enable Member States to adopt appropriate priorities at local or national level and avoid top-down priority-setting by governments. While agreeing that strengthening the health system's capacity for health promotion should be a high priority, she considered that every unit in the system must clearly understand the health promotion concept in order to reorient the system as stated in the Ottawa Charter. Her Government was developing universal coverage for health care, 20% of the curative budget being devoted to health promotion and prevention activities.

Although the report stressed the importance of evidence, it should be noted that the technical report of the Fifth Global Conference on Health Promotion had warned that the traditional scientific and medical definition of evidence might not be relevant to health promotion and participatory action research might be more appropriate. Her delegation agreed that, as implied in paragraph 16, sharing information about what had been done worldwide would speed up implementation of health promotion programmes; it was proud of Thailand's record, mentioned in paragraph 4, in preventing HIV/AIDS and would be happy to share its experience with other Member States.

Dr TANGI (Tonga) said that his delegation fully supported the report contained in document A54/8 and that health promotion was a major part of his country's health activities, as the major cause of morbidity and mortality in Tonga was noncommunicable diseases. People should be made to want to be healthy and induced to take constant care of their health. To that end, all sectors in the community, including government ministries, church leaders and nongovernmental organizations, should be involved. In Tonga, the King himself had taken the lead by setting an example; although little short of his 83rd birthday, he still exercised in a gymnasium three times a week and had initiated a weight-reduction competition, which remained popular after many years. Monthly walks-for-health were organized in towns and districts, involving all age groups. At the meeting of the Regional
Committee for the Western Pacific in September 2000, during a session on noncommunicable
diseases, the delegates had participated in stretching exercises in their seats, and it had been decided to
do such exercises at subsequent annual meetings. Such activities were not only good for the
participants but set a good example.

Dr PARASRAM (Trinidad and Tobago) said that his delegation welcomed the report and was
pleased that health promotion was seen as a critical component of overall health. Specifically, his
delegation supported evidence-based health promotion activities and recognized the importance of
funding and legislation. His country’s health sector stressed health promotion and strategies based on
the Caribbean Health Promotion Charter. A national health promotion council was to be launched, and
a recently introduced Health Promotion Month had been a significant development.

Professor GRABAUSKAS (Lithuania), speaking also on behalf of the delegations of Estonia
and Latvia, said that health promotion was of special interest to the Baltic States since many
noncommunicable diseases, representing the major health problem for those countries, were related to
unhealthy lifestyles and the environment. Considerable research had been carried out on the causation
and prevention of noncommunicable diseases, but much more needed to be done, and implementation
would require further systematic support. The Baltic countries therefore welcomed WHO’s initiatives
and efforts on behalf of health promotion. The societal changes taking place in those countries in the
current transition period presented new problems, risks and challenges, including inappropriate
nutrition and such chronic conditions as cardiovascular diseases, diabetes and some cancers.

Particularly welcome was WHO’s intention, reflected in paragraph 15, to build up a vigorous
research and development component to improve the evidence base. For almost a decade, the Baltic
States had been actively involved in cooperative studies into population health behaviour, as part of
the FINBALT Health Monitor project, initiated by Finland, to provide a database allowing them not
only to monitor changes in health behaviour but to support health promotion interventions. Recently
the directors of the European Countrywide Integrated Noncommunicable Disease Intervention
Programme (CINDI) had decided to use the methods of the FINBALT Health Monitor to evaluate
their efforts. The Baltic countries fully supported the report contained in document A54/8.

Ms MOJI (Lesotho), referring to paragraphs 5, 6 and 7 of the document, emphasized the
importance of health promotion in health service delivery. She urged all Member States to recognize
health promotion as critical to ensuring healthy lifestyles and healthful practices and to accord it
appropriate status. She endorsed the plans outlined by WHO in the report.

Dr TOUYÁ (Uruguay) expressed disappointment that more delegates were not present in the
room, as the topic under discussion was a broad one: he believed firmly that health had cultural,
educational and social aspects as well as being concerned with individual capacity and the health
services. It was people themselves, rather than health professionals or the health services, who were
the chief players. A great effort should be made to ensure that people throughout the world enjoyed a
fulfilling life. Application of the concept of health development or promotion only to
noncommunicable diseases was restrictive, as all people had the right to decide on their quality of life
and to enjoy it. Health professionals were the true custodians of life.

Mrs EL REF AI (United Arab Emirates) stressed the importance of establishing a framework for
strategic dialogue on health promotion and of taking measures to implement health promotion
strategies, particularly for the benefit of young people. Efforts should also continue to develop health
systems in line with the goals of health promotion strategies, with special attention to health education
programmes.

Effective health promotion required the involvement of all relevant sectors, including those
concerned with environmental education, human resources and public welfare. Health professionals
should be given a greater role in formulating and designing health promotion policies and
programmes, so that States could make better use of their available human resources to deal with the challenges before them.

Dr SHIMODA (Japan) said that the rapidly ageing population was one of the most important health issues in Japan. It therefore emphasized health promotion policies in order to cope with ageing and changes in disease trends. It had launched the “Health Japan 21” national health promotion movement for the 21st century, setting out lifestyle improvements to be achieved by the year 2010 and covering areas such as nutrition, physical exercise, mental health, smoking and alcohol consumption. His country had advocated a health information system that was in accordance with ideas in the report, which it therefore welcomed and fully supported.

Mr LEVY (United Kingdom of Great Britain and Northern Ireland) commended the report and expressed satisfaction that priority was given to such action for young people, since a focus on youth was essential in order to ensure a strong foundation for a healthy, productive life. He welcomed WHO’s aim of enhancing the research and development component of the programme in order to improve the evidence base for health promotion, which would assist decision-making on priorities and would improve understanding of the value of health promotion. He strongly supported the inclusion of the topic as an integral component of national strategies and also of WHO’s largest programmes, including those on HIV/AIDS and tobacco control, as it must be recognized as central to health strategies. He expected that WHO would continue to strengthen its structures and capacity to support health promotion across its programmes.

Mr FETISOV (Russian Federation) welcomed the report and the summary given by the representative of the Executive Board of discussions at its 107th session. His delegation attached great importance to the WHO health promotion programme and reaffirmed its commitment to a single State policy in the effective implementation of health promotion countrywide which provided for concerted action. The participation in health programmes of regional and local authorities, relevant scientific institutions, social groups and business and other interests was welcomed. His delegation supported the agreed programmes and measures for health promotion, particularly for young people, and the plans for analysing the results of work done to strengthen national health systems, to promote health and to secure active participation in such efforts and implementation of the resulting recommendations. He called on WHO to be more active in disseminating the results of countries’ successful experiences in health promotion.

Mrs TAPAKOUDI (Cyprus) acknowledged with satisfaction the increasing importance attached by WHO to health promotion programmes, and specifically evidence-based ones such as the North Karelia project in Finland, which had proved its effectiveness in significantly reducing mortality due to heart disease. She also noted the emphasis placed on the application of health promotion principles to specific risk factors and diseases. She requested WHO to further intensify its activities, to take into account activities throughout the world and to develop approaches that would speed up implementation of activities in priority areas. Special emphasis should be placed on noncommunicable diseases and their underlying factors, including nutrition and physical exercise, and on the important role of nurses in public education for enhancing healthy lifestyles.

Dr MATHESON (New Zealand) acknowledged WHO’s leadership in health promotion and supported its intention to improve the evidence base in that field and to promote the dissemination and application of such evidence. His country was attempting to make health promotion the focus of a strategy aimed at improving people’s health and decreasing disparities between population groups. The approach that “prevention is better than cure” had proved valid, even before the existence of the Ottawa Charter for Health Promotion and supporting statements adopted subsequently. The dilemma for health promotion was that it did not have powerful backing from, for example, the pharmaceutical industry, and resources often had to be devoted to alleviating current suffering rather than influencing
the future some years hence. WHO played a critical role in ensuring that health promotion was afforded priority at all levels. He welcomed the report but suggested that, in future reports, WHO should indicate the extent to which the principles of health promotion, as articulated, for example, in the Ottawa Charter or the report of the Fifth Global Conference on Health Promotion in Mexico City, constituted the basis of health approaches globally and regionally. WHO should also support Member States in reporting on how those principles were applied by the health sectors. Health promotion was particularly important in the context of the proposed global AIDS and health fund, and he suggested that WHO should champion its inclusion.

Dr BOOTHMAN (Ireland) said that her country placed great emphasis on health promotion in its health strategy and also supported initiatives to enable individuals to take responsibility for their own health. Difficulties arose in incorporating the input from a wide variety of agencies outside the health sphere, and her delegation therefore encouraged WHO not only to underline the importance of intersectoral cooperation but also to support and encourage the development of structures to facilitate such cooperation.

Dr AL-OWAISH (Kuwait) said that health promotion should be the true role of health ministers, rather than focusing on the treatment of diseases. His country had several programmes for promoting health and preventing diseases such as cardiovascular diseases, cancer and diabetes, as well as a special programme for health promotion which received political support at every level. Emphasis should be placed on healthy lifestyles in keeping with the approaches and traditions of different countries, and communities should participate in the related efforts and assume their responsibilities rather than expecting governments to bear the entire burden. He urged WHO to continue its support for the concept of health promotion in developing countries, which had limited resources for combating diseases, as such efforts could do much to reduce health expenditure.

Mr HAN (Republic of Korea) emphasized the importance of the mass media as a communication strategy, particularly for health information; he therefore welcomed document A54/8. In the interest of developing that agenda, he drew attention to the issue of misleading health information, which was a serious problem in some countries and led to behaviour that was undesirable from the economic as well as the health perspective. In that regard, the vast flow of health-related information through the Internet should be appropriately managed and controlled. The so-called "digital divide" had widened the information gap between nations, regions and individuals, and he urged that WHO make efforts to bridge the gap in health information.

Ms COSTA COITINHO (Brazil) commended WHO for strengthening its work on evidence-based health promotion and for emphasizing health promotion as an effective means of preventing major health problems. Noncommunicable diseases were becoming prevalent in her country and in many others, and the poorest and most vulnerable groups were the most seriously affected. Nevertheless, communicable diseases and nutritional deficiencies still prevailed. Health promotion and associated efforts in communication, legislation and regulation were valid for prevention of the whole spectrum of diseases. She acknowledged the importance of focusing health promotion on young people, especially given the impact of events in the early stages of growth and development on health later in life. She commended WHO's increased focus on tobacco use, which had boosted global prospects for control, and considered that the Organization should step up its work on effective global strategies for nutrition and physical activity, which were key factors in the prevention of noncommunicable diseases. She asked that a global strategy on nutrition be developed, and an information document on the issue be submitted to the Executive Board in January 2002.

Dr HEREDEA (Romania) said that health promotion was an important means of empowering people to control and improve their own health. Her country had established a national programme for that purpose. In 1999, as the result of an official invitation, WHO had audited health promotion
services in Romania. The resulting report, which had been presented to both chambers of Parliament, contained four important recommendations: to formulate a strategy for health in Romania; to develop the necessary infrastructure for designing, implementing and monitoring that strategy; to establish long-term financing of health promotion services; and to improve a human resource strategy for health promotion. A three-year strategy had subsequently been formulated, and a Government decision had been adopted to participate in the European Community programme of public health. Joint activities had also been developed within the European Network of Health Promotion Agencies, and her country had signed the Ministerial Statement made at the Fifth Global Conference on Health Promotion held in Mexico City in 2000. Her delegation welcomed the document under consideration.

Professor Ongeri resumed the Chair.

Ms FORTIER (Canada) said that her country welcomed the horizontal integration of health promotion into ongoing activities at WHO. It was essential to maintain a strong focal point in order to ensure coordinated, consistent approaches throughout the Organization and to respond to Member States’ requests for technical support. Canada supported the continuing focus on evidence-based health promotion practices; it was pursuing research on the evaluation of health promotion outcomes and would participate in building evidence for effective health promotion interventions. Prevention, protection and promotion were increasingly being integrated within the health system in her country, an approach that was also part of the WHO strategy to strengthen health systems.

Mr ZHANG Li (China) welcomed the report. For some years, the Chinese Government had been mobilizing various sectors of society to participate in health promotion activities, in keeping with the policy of WHO since the adoption of the Ottawa Charter in 1986. The Jakarta Declaration on health promotion had been circulated widely in China and had received due attention. Furthermore, campaigns for health promotion had recently been conducted in rural communities, and several health activities had been held in towns, which had enjoyed a measure of success. He commended WHO for giving health promotion high priority and for its support to such activities.

Dr LEVENTHAL (Israel) commented that health promotion had been the last item to be discussed on the agenda of the Fifty-third World Health Assembly and had been carried forward to the present Health Assembly as the first item of the agenda. Yet, once again, the topic was being discussed at a late stage of the Health Assembly. A similar situation prevailed in all countries, where pressing matters of life and death were pushing health promotion to one side, even though it was recognized that it should be integrated into all activities. He commended the choice of staff at headquarters who would be responsible for health promotion and noted that the next World Health Day, which would be dedicated to physical activity, would provide a splendid opportunity to encourage a healthy lifestyle and good nutrition. He concurred with the views of the Brazilian delegate and supported the suggestion of the delegate of Finland that a report on health promotion be presented in 2003.

Dr EL-SHAFAI (Egypt) welcomed the report on health promotion. In response to WHO recommendations and the Ottawa Charter, her country had implemented a comprehensive strategy for health promotion in a national programme, concentrating on vulnerable groups in the community such as infants, young people and women, which would last until 2010, and paid special attention to poor areas. The activities planned were based on evidence, updated information and research results, and priorities were set according to community needs and the availability of resources. The key points were prevention of accidents, prevention and treatment of drug addiction, control of tobacco smoking, prevention and treatment of malnutrition, prevention of violence against women, specifically female circumcision, and prevention and treatment of blindness. The programme involved an intensive advocacy campaign through the mass media and political, community and religious leaders. Counselling services and follow-up were available for everyone. Her country acknowledged the need for a periodic review of priorities and for long-term planning.
Ms PHUMAPHI (Botswana) welcomed document A54/8, which highlighted the effectiveness of a very important tool in the attainment of good health in the community. Her country was particularly attracted to the concept of community-based health promotion which empowered individuals to assume responsibility for their own health. In that context, at the initiative of a nongovernmental organization, Botswana had introduced house-to-house counselling in combating the AIDS epidemic, in which trained counsellors visited households for the purpose of educating and advising on HIV prevention and care. That approach could be used effectively to promote health programmes that would improve the quality of life and provide an essential complement to primary health care. Botswana was also strengthening prevention and management programmes for several noncommunicable diseases and micronutrient deficiencies. The rapid ageing of populations in developing countries heralded an impending shift in disease patterns to add to the already heavy burden of poverty, communicable diseases and malnutrition. Many disabilities associated with ageing could be prevented or delayed, and it was imperative that appropriate strategies and programmes be factored into national plans, with WHO support.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) noted that the Committee had agreed at the Fifty-third World Health Assembly to devote more time to the subject of health promotion at its Fifty-fourth session. It was vital to maintain the momentum of the Ottawa Charter and to ensure follow-up to the outcome of the recent Fifth Global Conference on Health Promotion.

As indicated in paragraph 4 of the report, much of the progress in WHO's health promotion programme had been achieved by application of health promotion principles to specific risk factors and diseases in particular populations and settings. His delegation welcomed the successes scored in several countries. While his delegation endorsed WHO's decision to accord priority to young people, health communications and health systems, it hoped that those priorities would not imply the abandonment of other health promotion strategies which might prove useful to particular countries.

The forum for health promotion dialogue which WHO intended to establish could help to identify more effective ways of promoting health among the poorest populations. Health promotion strategies should not result in the State abandoning its responsibility for the health of the most vulnerable groups. Indeed, there was a risk that, by overemphasizing health promotion at the expense of other components of the health system, governments could find themselves giving more help to privileged groups and less to those in greater need. The report might have done better to stress the need for States to offer support to health promotion programmes through policies and decisions, since health promotion presupposed a systematic, sustained alliance between the health authorities and other sectors and nongovernmental organizations.

His delegation was concerned that health literacy, as explained in paragraph 9 of the report, might be construed as relating solely to problems of hygiene and environment. Furthermore, while it was true, as indicated in paragraph 11, that health promotion helped to reduce excess mortality, mention should also have been made of the fact that health promotion helped to reduce disability and improve the quality of life and the overall welfare of the population.

Professor AHYI (Benin) pointed out that there was a common tendency to confuse health promotion with disease prevention, as seen most clearly in the case of mental health. Health promotion measures could also include the kinds of initiative that had been taken in Benin, where actions to improve general security, to upgrade homes and basic infrastructure and to provide loans or easier access to credit for individual women or women's groups helped enhance the population's quality of life and thus promote health. Indeed, Benin had taken the view that health professionals were not always best placed to promote health.

His delegation would have liked to see some attention devoted in the report to the link between health promotion and socioeconomic development, as well as the important role played by older persons in the African region.
Dr LÓPEZ (Chile) said that the issue of health promotion was viewed in her country as one of the fundamental aspects of health system reform, together with equity, solidarity and quality of care, which should facilitate reorientation of services as recommended by the Ottawa Charter.

National health promotion plans should identify specific areas in which change was needed, consistent with national health objectives, and establish targets for each of them. Moreover, health promotion activities should be targeted at children in particular, in view of the fact that health habits were formed at an early stage of life. Consideration should also be given to health promotion activities in the area of mental health, including human rights, non-violent resolution of conflicts, interpersonal communication and stress control.

Dr Fikri resumed the Chair.

Dr NOVOTNY (United States of America) said that his country viewed health promotion and protection as an essential investment and component of health and economic development. Its own document entitled *Healthy people 2010* was a strategy for national health promotion and disease prevention that challenged stakeholders at national, state and community levels to take specific steps to eliminate disparities, increase life expectancy and improve the quality of life. His delegation commended WHO's efforts to ensure a sound evidence base for health promotion policy and practice, including the selection of indicators of relevant public policy and actions, using a full range of quantitative and qualitative methods.

Actions to promote health promotion, particularly the empowerment of people and communities, were cost-effective. Data were needed on the link between health promotion strategies and outcomes, as well as the cost-effectiveness of such strategies, in order to help policy-makers make difficult choices in allocating resources and framing health promotion as a public health practice. Increasing evidence supported the idea that health promotion and prevention strategies were economically sound and socially viable. Health promotion strategies that were culturally and linguistically appropriate could be especially effective among marginalized and at-risk populations. Clearly specified indicators and measurements among such populations could help establish future health policies and programmes.

Health promotion relied on a wide range of partners and alliances in order to achieve real progress. Such partners included the educational, judiciary, law enforcement, regulatory and political sectors of government, as well as community- and faith-based organizations, the entertainment industry and the media. Identifying common goals in an open and participatory manner was important to that process.

His delegation asked whether there was adequate support for the proposed world health report on risks, planned for 2002, given the decrease in regular budget funding for health promotion in the Proposed programme budget 2002-2003. It supported WHO's strategy of targeting young people, health communications and health systems as initial priorities for health promotion, including a lifespan approach. That approach was essential to ensuring that the quality of life over a lifespan was the best attainable, people and communities taking charge of their lives on a continuous basis.

Professor Ongeri resumed the Chair.

Dr TEE Ah Sian (Malaysia) said that health promotion principles and strategies were applied in Malaysia to a variety of health problems and behaviours. Annual “healthy lifestyle” campaigns had been launched by the Ministry of Health in 1991, with themes that for the first six years had largely been disease-based. Since 1997, the focus had switched to lifestyle practices that could influence health, including healthy eating, fitness and exercise, promotion of safety and injury prevention, promotion of mental health, healthy families and environmental health.

Malaysia's health promotion activities currently addressed factors that contributed to the high prevalence of such diseases as tuberculosis, HIV/AIDS, coronary heart disease, diabetes and
hypertension. Its activities included health education via the mass media, exhibitions, public dialogue and special health events such as World Tuberculosis Day and No Smoking Week.

Her delegation supported the view that a strong evidence base should be created for effective health promotion practice. To that end, Malaysia was supporting research in the field of health promotion.

Mrs GREUTER (Inter-African Committee on Traditional Practices affecting the Health of Women and Children), speaking at the invitation of the CHAIRMAN, recalled that her organization had been working since 1984 to eradicate female genital mutilation, or excision, taking into account the economic, social, health and human rights dimensions of the issue. The Inter-African Committee tailored its interventions to reach various target groups at different levels, including traditional birth attendants, persons who performed female excision, youth, religious leaders, policy-makers, village facilitators and women leaders.

Her organization had organized a youth forum in Addis Ababa in 2000 to encourage young people to work as agents of change to eradicate female genital mutilation. A declaration had been adopted to affirm their commitment to promoting the health of girls and boys. A symposium had been held in the United Republic of Tanzania in August 2000, bringing together 23 religious leaders, representatives of Inter-African national committees, nongovernmental organizations, United Nations bodies and government officials. The delegate from the Islamic Republic of Iran had proposed a comparative study of female genital mutilation in different religious traditions, and a declaration on harmful traditional practices had been issued. The organization’s national committees in Burkina Faso, Guinea and Mali had achieved some success in convincing a large number of persons performing excision to desist from that practice. A draft convention on the elimination of all forms of harmful traditional practices affecting the fundamental rights of women and girls had been adopted in 1999 and submitted for study by legal experts of OAU. A proposal had been made to incorporate the draft convention into an OAU draft protocol to the African Charter on Human and People’s Rights. When adopted, the document would be a binding regional instrument and an important tool in the campaign against harmful traditional practices.

The Inter-African Committee belonged to an ad hoc advisory group of nongovernmental organizations that had worked together since WHO’s Fourth Conference on Health Promotion in Jakarta. That group worked in partnership with the Health promotion unit at WHO. Cooperation with WHO and with nongovernmental organizations would enhance health promotion, since the latter organizations had wide constituencies. The Inter-African Committee was willing to use its experience and broad network to promote the Jakarta Declaration.

Mrs HERZOG (International Council of Women), speaking at the invitation of the CHAIRMAN, proposed that WHO should consider the possibility of inviting a group of young persons and adolescents to participate actively in the round-table discussions to be held in May 2002, or of holding a full day of technical discussions with them on the issue of health promotion. Such an initiative might help launch an international young leadership movement for health promotion.

Young people should participate actively in all health promotion programmes for youth, from the early stages of thinking and planning through to implementation, since they knew what influenced them and were an innovative group. Moreover, peer education was known to be the most effective form of education.

When WHO had first launched health promotion, the idea that health should be on the agenda of all sectors and government ministries, since their policies affected the health of citizens, had been revolutionary. WHO had advocated intersectoral cooperation at the national level, both between ministries and with civil society. It could be asked in how many countries that goal had been achieved, where national or local authorities applied criteria conducive to health promotion and risk prevention before issuing a building permit, for example. Similar questions could be asked of ministries of transport, environment, agriculture, education and so forth.
Questions had been raised as to whether health promotion was an overarching concept covering nutrition, smoking cessation and alcohol and drug abuse, or whether it was in competition with other programmes. WHO was to be commended for examining those questions and seeking to clarify them. The strength of any effective organization lay in its flexibility and ability to re-evaluate the outcomes of its work and adapt its activities to changing needs.

The International Council of Women reiterated its pledge to continuing its cooperation with WHO in raising the awareness of women and their families of their needs, rights and responsibilities with a view to improving the welfare of people everywhere.

Dr YACH (Executive Director) said that the enthusiastic participation in the debate by the delegates of Member States and representatives of nongovernmental organizations indicated a determination to go beyond merely noting the report on health promotion. Most Member States had re-emphasized the importance of the Ottawa Charter and called for it to be operationalized to a greater extent at national level. They had highlighted the importance of building and enhancing capacity and translating that effort into national plans, an area in which WHO was actively engaged. In response to the question of the delegate of Cuba concerning the follow-up to the Fifth Global Conference on Health Promotion held in Mexico, he said that WHO activity at the country level was increasing.

Innovative mechanisms for financing health promotion already existed, as seen in Australia and Thailand, which drew on the duty raised on tobacco to sustain their health promotion activities. He welcomed the comments of the delegation of Canada regarding strengthening of the evidence base and its offer to participate in gathering evidence and rapidly disseminating best practices to countries.

At national level, monitoring and surveillance of health behaviour were an important part of health promotion; WHO had, with the support of the Finnish and United States Governments, begun to establish a global surveillance system to that end. It was hoped that the initiative would soon cover all countries, in much the same way as for communicable diseases.

In focusing on youth, WHO was stressing the life course, while its plans for participating in the Second World Assembly on Ageing (Madrid, April 2002) were progressing well.

With regard to the importance of the media, the role of entertainment and the problem of misleading health information, highlighted by the delegation of the Republic of Korea, he said that some of those issues were to be addressed in The world health report 2002.

The fact that the epidemiological transition was not occurring smoothly and that most developing countries were trapped with a double burden of disease, as pointed out by the delegate of Brazil, had forced WHO to focus more intensively on the role of specific risk factors.

The Organization's success in moving the tobacco agenda forwards was due to simultaneous economic, legislative and educational approaches and recognition that no action would succeed in an individual country if it were not supported by global action. It was time to take equivalent action with respect to diet, nutrition and physical activity, and he fully endorsed the comments of the delegates of Brazil, Finland and Israel to the effect that it was time to prepare a global strategy. He strongly echoed the view that the Organization could not achieve those results alone. As the delegate of the Netherlands had said, it was important to ensure the full participation of civil society. At the meeting of the International Union for Health Promotion and Education in July, a new approach to a global forum on health promotion dialogue would be unveiled, which would show that WHO was already working with civil society and others, including the private sector.

As the delegation of New Zealand had recalled, it would be important to ensure that the Ottawa Charter principles underpinned the proposed global AIDS and health fund.

The critical role of political leadership (including the inspiring example set by the King of Tonga), the importance of funding institutions for health promotion and the fact that health promotion was underfunded in most countries had been among the lessons learnt from the current discussion. WHO recognized the importance of sustained advocacy at all levels of society and looked forward to the opportunities afforded in that domain by preparations for World Health Day 2002 and the physical activities that would take place during that year, including the Salt Lake City Olympics and the World Cup, hosted by Japan and the Republic of Korea, which would have a strong health component. The
World Cup opening day would coincide with World No Tobacco Day 2002, an event that WHO hoped to exploit with the strong support of Member States.

The outcomes of WHO's work on physical activity went well beyond the focus on common risk factors or cardiovascular health and underlined the importance of a broad approach to health promotion.

The Committee noted the report.

**Strengthening health services delivery: Item 13.4 of the Agenda**

**Strengthening nursing and midwifery (Resolution EB107.R2; Document A54/11)**

Dr TIERS (representative of the Executive Board) said that the Board had considered the subject of nursing and midwifery in the light of the status report on implementation of resolution WHA49.1. Members had stressed that nursing and obstetrical care were essential to any health system and played a primordial role in health services, and that nurses and midwives must be at the centre of health policies. The increasing shortage of nurses and midwives aroused concern throughout the world, especially in developing countries, where decreasing financial resources and poor working conditions were causing many to abandon such work or to emigrate to countries where prospects were better. The widespread impact of disease, war and civil strife likewise added to the shortage of health staff. The Board's concerns were reflected in resolution EB107.R2.

Professor AKIN (Turkey) said that nurses and midwives were key professionals in health promotion and care, at local and national levels. Her delegation welcomed the progress made in implementing resolution WHA49.1 and appreciated the report contained in document A54/11. She stressed that, in spite of that resolution's recommendations, there were few developing countries in which nurses and midwives were involved in the elaboration of national health policies and health care reform. In addition, the education and training available to them was usually far from commensurate with population demands because of the lack of standardization and the paucity of opportunities for continued education. She welcomed the reference to such problems in the draft resolution recommended by the Executive Board, which called for developments in education, legislation, regulation and practice as well as the monitoring and reporting of achievements at national and global levels. Her delegation supported approval of the draft resolution.

Professor RUCHA PHUPHAIBUL (Thailand) said that her delegation welcomed document A54/11, which drew the attention of public health policy-makers to the lack of skilled health workers and the need to ensure the latter's full participation in health care development. Success in applying WHO's suggested strategies would be a practical demonstration of good governance and equal partnership. Experience in Thailand confirmed that lack of suitably trained staff had a profound effect on the quality of care. Her country's authorities had responded with a massive expansion of education and training during the past decade. That had resulted in a surplus of newly-trained nurses, as the public health sector, which was the main employer, had a limited capacity to absorb them and the employment opportunities available in the private sector were restricted as a result of the economic downturn. The issue of the shortage of nurses and midwives was thus not merely a question of the lack of available personnel but also one of the scarcity of opportunities for employment owing to economic factors. Her delegation was concerned at the problem of migration and its effect on poorer countries in particular. It agreed on the areas warranting more attention, outlined in paragraph 14. Efforts to remedy those shortcomings should aim at practical solutions while not overlooking possible consequences.

Mrs EL REFAI (United Arab Emirates) said that her delegation appreciated the report and supported the draft resolution, since its implementation would help to improve the channelling of
efforts and the efficiency of systems in an area of immediate priority for WHO and its Member States. The mechanisms established in various countries should be studied with a view to showing the progress made, and a further report should be prepared for submission to a subsequent Health Assembly. International solidarity and coordination, especially for follow-up on communicable diseases, had had positive results, and in many countries, including her own, it had been possible to eradicate certain diseases. Such efforts should lead to even better results in the future, thus helping to strengthen the quality of overall health service provision.

Staff shortages continued to have an adverse effect, however, on health service provision everywhere, and her delegation appreciated the Director-General’s efforts to establish measures for assessing staff numbers. Her country and other members of the Gulf Cooperation Council were collaborating to strengthen nursing and midwifery services, providing mutual assistance for that purpose. The number of places in training schools available for nurses and midwives was being increased, and pupils were being encouraged to consider such activities as a profession.

Her delegation supported the draft resolution.

Dr Fikri resumed the Chair.

Professor MASLIN (United Kingdom of Great Britain and Northern Ireland) said that her country was grateful for the report and strongly supported resolution WHA49.1. It had consistently taken action to promote nursing and midwifery, for example, by recognizing and encouraging their contribution to the nation’s health. Each country within the United Kingdom had an up-to-date strategy, including plans to improve recruitment, retention and conditions of work, to strengthen education and training and to develop a more flexible career structure. It also sought to enhance the quality of care, strengthen leadership, modernize professional self-regulation and support new methods of work. Nurses and midwives in the United Kingdom were to be found in policy-making positions in government as well as in important leadership roles at national, regional and local levels. For example, the Chief Nursing Officer in the Department of Health in England advised ministers on all aspects of health care, including nursing, midwifery and health visiting, and was also a member of the National Health Service Policy Board.

Leadership and policy development programmes for nurses and midwives existed throughout the United Kingdom. Nurses, midwives and health visitors were already taking the lead in a wide variety of roles – for example, in the National Health Service’s direct telephone advice service, walk-in centres, rehabilitation services and the redesign of hospital services. Important new leadership roles were likewise being established through the introduction of nurse consultant posts.

Although many Member States had recorded good progress in nursing and midwifery services, some still needed help and looked to WHO for relevant guidance. Her delegation agreed that the ongoing work should include action to combat staff shortages, which might relate to certain specialties, be country-specific or reflect an urban-rural divide. Experience had shown the capacity of nurses and midwives to make an optimum contribution to health care. Her delegation strongly supported the draft resolution.

Miss CAMPBELL (Jamaica) said that in all countries nurses and midwives continued to be an essential resource for the provision of quality health care, for example, by reducing maternal and infant mortality rates. Similarly, nurses and midwives were the backbone of programmes aimed at increasing immunization coverage, sustainability and safety, and their contribution to the elimination of poliomyelitis and measles from Jamaica had been recognized. Nurses were also crucial in efforts to reduce the growing burden of noncommunicable diseases through early detection, promotion of healthy lifestyles and the delivery of community-based care. Nurses were at the forefront of the provision of mental health care in the community, supporting the integration of mental health services into primary health care as opposed to institutionalization. The quality of services and the health care of the population would suffer unless effective action were taken to address the growing migration of skilled nursing and midwifery personnel, attracted by the terms and conditions of employment
available elsewhere. That staffing crisis called for partnerships and measures to strengthen the education and training of candidates, improve the recruitment and retention of skilled nursing and midwifery personnel and devise policies for ethical international recruitment. Nurses in the Caribbean community had developed an action plan to manage the migration of skilled nursing personnel. Her delegation welcomed the draft resolution and hoped that it would be widely supported. She asked for information on how it was proposed to strengthen the input of nursing and midwifery in the work of WHO at all levels.

Dr SHIMODA (Japan) expressed his delegation’s support for the draft resolution and said that his Government would continue to seek opportunities to support the work of the WHO Collaborating Centre for nursing research, established in Japan.

Dr MBATIA (United Republic of Tanzania), expressing appreciation for the work on implementation of resolution WHA49.1, strongly urged WHO to continue to support efforts in that area and to strengthen nursing resources both at headquarters and in the regional offices. His country faced shortages of manpower and of the skills needed to respond effectively to new challenges, including the growing demand for quality nursing care. He called on WHO to support capacity-building and research and urged the Regional Office for Africa to develop an information network to support African countries in strengthening nursing and midwifery capabilities to deal with diseases such as HIV/AIDS and Ebola haemorrhagic fever. While supporting the draft resolution, his delegation proposed amendment of paragraph 2(8) to allow for biennial progress reports for the purposes of monitoring.

Dr AL-AWADI (Kuwait) observed that, although the heaviest burden of health care delivery was borne by nurses, they did not enjoy equal opportunities and the profession had not received sufficient attention in recent years. He considered that nurses should play a major role in national health care systems. He echoed the delegate of the United Republic of Tanzania in requesting WHO to strengthen nursing resources at headquarters, and urged their involvement in decision-making on human resources in health care delivery. Referring to the draft resolution, he requested that gender-neutral language be used to refer to nurses in the Arabic version. Also, with regard to paragraph 2(3) he considered that nurses should be involved in health planning in general and not just in the planning of human resources, and requested that the draft resolution be amended accordingly.

Dr ADAM (Kenya) said that nursing and midwifery personnel played an important role in health care delivery, particularly in developing countries. In view of the low ratio of doctors to the population in many developing countries, he recommended that the skills of nursing personnel be upgraded so that they would have the capacity to provide the care traditionally provided by doctors. That was of particular importance in reducing maternal and infant mortality and morbidity.

The meeting rose at 18:20.
EIGHTH MEETING

Saturday, 19 May 2001, at 9:20

Chairman: Dr M. FIKRI (United Arab Emirates)
Later: Professor S.K. ONGERI (Kenya)
Later: Dr C.T. OTTO (Palau)
Later: Professor S.K. ONGERI (Kenya)

1. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Strengthening health services delivery: Item 13.4 of the Agenda (continued)

Strengthening nursing and midwifery (Resolution EB107.R2; Document A54/11) (continued)

Ms BALOCH (Pakistan), speaking on a point of order, recalled that her delegation had requested that all documents relating to The world health report and those submitted to the Executive Board at its 107th session be submitted to the Committee. However, one of the documents referred to in resolution EB107.R8 contained in document EB107/2001/REC/1, namely resolution 2000/27 of the United Nations Economic and Social Council entitled “Basic indicators for the integrated and coordinated implementation of and follow-up to major United Nations conferences and summits at all levels”, said to be dated 28 August 2000, had not been made available. In that connection, she pointed out that the Economic and Social Council had not been in session on the supposed date of adoption of the resolution, and she requested the Chairman to ask the Secretariat to check the reference and provide copies of the resolution of the Economic and Social Council to the Committee.¹

The CHAIRMAN said that the comments by the delegate of Pakistan had been noted.

Dr RIAZANTSEV (Russian Federation) said that his delegation fully supported the draft resolution contained in resolution EB107.R2. The penultimate preambular paragraph, however, referred only to nursing services and midwifery services, whereas some countries had other categories of health workers who fulfilled similar functions but under different names. In his country, for example, medical attendants known as feldschers did important work in emergency maternity facilities. He therefore requested the inclusion of the words “officially recognized equivalent staff” after “midwifery services” in the penultimate preambular paragraph.

Mrs RAVN (Denmark) welcomed the initiatives proposed in the draft resolution. She also supported the statement that would subsequently be made by the delegate of Finland, highlighting the need to use the full potential of nurses and midwives, and stressing the importance of planning to enable nurses and midwives to contribute directly to health services and programmes. Denmark had chosen a national health policy approach and had organized nursing and midwifery vertically in the various national policy and activity areas. To ensure the optimal use of nursing knowledge and expertise in interprofessional work at the central administrative and advisory level, her country had

¹ Resolution 2000/27, adopted by the United Nations Economic and Social Council on 28 July 2000, was later made available to the Committee.
also formed a horizontal coordinating group to promote the provision of nursing care to people throughout their lives.

Her delegation considered that the document provided strategic guidance on implementation of the Munich Declaration on Nurses and Midwives of June 2000, and therefore also of the draft resolution under discussion. She asked for information on the plans for reporting on that implementation, both in the short term and the long term.

Dr WIUM (Norway) welcomed the priority given by WHO to human resources in the health sector. Nurses and midwives were important health personnel groups, and his country supported the draft resolution. Important health sector goals would not be achieved without well-trained, motivated health staff. Human resources were often planned and managed by people outside the health sector, and ministries of health should discuss human resources with other relevant ministries, such as those of finance and education, and with professional organizations. He urged the Organization to collaborate with ILO on human resources issues, in order to interact with relevant actors at global, regional and local levels.

Dr EL SAYED (Egypt) said that his delegation supported the draft resolution. Egypt was training additional nurses and midwives, as it was experiencing a shortage of such staff. Nursing experts were involved in health-care planning, particularly in regions with heavy disease burdens. Nurses had a crucial role to play in health services, advocacy and training and, in his country, were expected to give advice to hospitals.

Ms HEAD (United States of America) said that, as a registered nurse who had worked throughout her career in maternal and child-health care, her presence on the United States delegation reflected the importance that her country attached to the need to strengthen nursing and midwifery. The problems that many countries experienced in delivering primary health care to all of their people were due in no small measure to the widespread and increasing shortage of nurses and midwives. Many countries did not have the capacity to use to the best advantage the substantial funds that were becoming available globally. Comprehensive planning to build human resource capacities should include efforts to increase the number and improve the training of nurses and midwives.

Although nurses were front-line providers of health care and an integral part of health systems, they were not generally involved in decision-making and tended not to be consulted on the development of programmes that they would be responsible for implementing. The image of nursing as an underpaid, over-worked and mainly female occupation, demanding hard work and sacrifices and with poor working conditions, made it difficult to recruit and retain nurses. Nurses and midwives were health promoters, advocates for those who might otherwise be neglected, planners and advocates for more effective personal-care services and partners with patients in enhancing compliance with complex drug regimens.

She urged WHO and other partners to address such issues as the inclusion of nurses and midwives in formulating public policy on workforce challenges, the enhancement of educational and career opportunities for nurses, the development of clearer, more concise professional classifications, the development of consistent credentials for the nursing workforce, the identification of data gaps that impeded effective workforce development, the development of models to facilitate monitoring of competence and to forecast workforce needs and, finally, a more radical approach to the potential role of nurses in making good the deficits in health systems.

The United States supported the draft resolution.

Ms O’HALLORAN (Ireland) welcomed the role of WHO in revitalizing the Global Advisory Group on Nursing and Midwifery. Given the proportion of health care delivered by nurses and midwives and their numerical strength among health care personnel, the importance of those professions in the formulation of national and international policy should be fully recognized. Recognizing that the success of any health system depended on careful stewardship, WHO should
improve mechanisms for bringing nursing and midwifery expertise to bear on the formulation of policies and programmes. Sustainable programmes were needed to increase the leadership capacity of nurses and midwives so as to enhance their contribution to the policy-making process. Ireland had achieved significant progress in that area, in particular through the appointment of a Chief Nursing Officer and a team of nursing and midwifery advisers to posts in the Department of Health. The personnel in question worked together, in a spirit of partnership and cooperation, to advance the health agenda.

The global shortage of nurses and midwives and the problems of recruitment and retention were well documented. The crisis had the potential seriously to threaten the continued improvement of health systems performance. WHO would be an appropriate agency to develop a global response to the nursing crisis, taking account of the ethical dimension of recruitment in order to build a sustainable workforce. Her delegation urged caution against short-term solutions that could lower standards, such as replacing nurses and midwives with poorly trained health care providers. Where the introduction of a support worker was deemed appropriate, it should be effected in the context of providing assistance to the nursing function, not as an alternative, and should be accompanied by an appropriate system of education and training.

Ireland welcomed and endorsed the draft resolution but, with reference to paragraph 2(8), considered that a report on progress achieved in its implementation should be made earlier than 2005.

Dr AGARWAL (India) also endorsed the draft resolution. There were currently some 700 000 registered nurses in India. His Government had, since 1994, strengthened existing training institutions for nurses and set up additional ones. Various continuing education courses had been organized and midwifery syllabuses were being revised. A new category of "speciality midwifery practitioners" had been established to provide services in rural areas where there were few gynaecologists. Such practitioners would be given intensive training in delivering care effectively in order to reduce maternal mortality. A group of experts was currently preparing new strategies to strengthen nursing and midwifery services in India as part of a five-year plan, implementation of which was due to begin in 2002.

Mrs YANI (Indonesia) said that her delegation supported the recommendation of the Global Advisory Group on Nursing and Midwifery that nurses and midwives should participate in formulating health policies. In Indonesia, 52% of health personnel were nurses and midwives. They helped needy people in remote areas and in areas of conflict, regardless of their own safety. While Indonesia had made substantial progress in preparing a national policy for nursing and midwifery practice, the problems of inadequately qualified nurses and midwives, inadequate working facilities, low salaries, poor incentive systems and inadequate laws to protect such staff in the workplace remained to be overcome. Such conditions had led to a poor self-image among nurses and midwives, which was reflected in the poor quality of health services.

To improve the quality of health service delivery, it was important to ensure that nursing and midwifery formed an integral part of the health services in all Member States, and her delegation therefore strongly supported the draft resolution.

Mr ZHANG Li (China) noted that the draft resolution, resolution WHA49.1 and other resolutions on strengthening nursing and midwifery services all made recommendations for future work, which China supported. The draft resolution addressed the shortage of nurses and midwives, which was particularly serious in developing countries, especially in remote areas. It was important to note that health authorities, with a view to reducing expenses, were recruiting a minimum number of nurses, a practice that not only overburdened existing nurses but compromised the quality of nursing services. It was essential to reinforce the role of nurses and midwives in all fields of national health and to strengthen their training.
Mrs AL-ANSARI (Bahrain) said that the serious problem of the shortage of nurses and midwives was aggravated by the fact that they tended to seek work abroad. Bahrain considered that national and international laws should be brought to bear on the problem, although the application of such legislation should not discriminate between national and foreign nurses and midwives. The Gulf Cooperation Council was currently examining the problem of the migration of nurses and midwives from the region. She requested WHO to study ways of attracting and retaining nurses and midwives and limiting migration and to provide technical support to Bahrain and other Gulf countries to establish a database on such migration.

Dr MOSOTHO (Lesotho) said that the population of his country had for many years enjoyed the services of the nursing profession, even in harsh conditions that were beyond the control of the national authorities. The scope of nurses’ work had been broadened to meet the ever-increasing demand for their services, but a lack of policy direction had marginalized their role and demoralized the profession. Unacceptably high maternal mortality rates and the HIV/AIDS pandemic had renewed the urgency of strengthening nursing services.

His country supported resolution WHA49.1 and paragraph 2(8) of the draft resolution contained in resolution EB107.R2, and urged WHO to note the position statement of the International Council of Nurses regarding the retention of nurses, particularly with reference to their remuneration.

Mrs VIOOT (Seychelles) welcomed the report, particularly its emphasis on the pivotal role of nurses and midwives in providing cost-effective health care and promoting healthy lifestyles. However, further action was required to redress the low level of participation of nurses and midwives in health care reform, the limited use of nursing and midwifery skills and interventions and the global shortage of nurses and midwives. The interventions outlined in the draft resolution would assist in strengthening nursing and midwifery and thus health services delivery. She asked for information on the Organization’s plans to ensure the involvement of nurses and midwives in its programmes at all levels.

Her delegation welcomed the proposal for an enquiry into the global shortage of nurses, as it was concerned that a lack of adequately trained nurses and midwives might lead to interventions that compromised nursing standards. She asked what systems were in place for periodic reporting by countries with a view to assisting in the preparation of the report to the Fifty-eighth World Health Assembly in 2005 as requested in paragraph 2(8) of the draft resolution.

Her delegation commended WHO for its initiative in addressing human resources development and in strengthening the partnership between national nurse leaders, in particular by cosponsoring the forthcoming conference to be held on Global Nursing Partnerships: Strategies for a Sustainable Nursing Workforce to be held in Atlanta (United States of America), and asked whether WHO would support national nursing leaders and human resources units to attend that conference.

Her delegation supported the draft resolution and urged its adoption.

Mrs NADAKUITAVUKI (Fiji) said that her country acknowledged the leadership role of WHO and agencies such as the International Council of Nurses, the Commonwealth Nurses Federation and the Commonwealth Steering Committee for Nursing and Midwifery in developing nursing and midwifery at national, regional and global levels. Fiji would have liked to have been singled out in the report, as it had scored notable successes in capacity-building in the area of nursing and midwifery. The success of her country’s initiative had been due to several factors. The initiative had come from the country itself and was based on needs identified by the national health authorities. It had been innovative, in so far as it had not copied models from other countries, although valuable support had been received from the authorities of Samoa, the United Kingdom of Great Britain and Northern Ireland, and the United States of America. Furthermore, the strategy had been based on the actual needs of clients. The general environment in the health sector had been conducive to change and little resistance had been encountered. Fiji’s national health institute had already acquired the basic capacity
needed for the change, and additional requirements for capacity-building had been carefully identified. The initiative had been characterized by a strong sense of national ownership.

In 1998, with the support of WHO, her Government had approved a proposal to create and train a new cadre of nurses and midwives, operating at the middle level of the health care system, with advanced skills and knowledge and with training that enabled them to assume greater responsibilities in diagnosis and the management of primary health care problems. Those nurse practitioners were well accepted and were able to mobilize communities to address various health concerns. The programme also allowed nurses and midwives to become more innovative, dedicated and flexible in their practice, capitalizing on their experience to help improve both curative and preventive health service delivery in Fiji. The programme had significantly improved career prospects for nurses and midwives, in keeping with the Government's human resources development policy of stemming the outflow of nurses.

Fiji supported the draft resolution and particularly the proposed establishment of mechanisms for enquiry into the global shortage of nurses and midwives and the ethical dimension of international recruitment and the provision that a report should be submitted to the Fifty-eighth World Health Assembly on progress achieved in its implementation.

Ms VALLIMIES-PATOMAKI (Finland) commended WHO’s work on nursing and midwifery. Nurses and midwives constituted the largest group in the health care workforce and were closely involved with people’s health and social needs. They played a crucial role in the implementation of health care reforms and national health policy at the local level. With the support of WHO, significant progress had been achieved in developing national activities and establishing regulatory, support and steering mechanisms for nursing and midwifery practice. However, shortcomings such as the underutilization of the expertise of nurses and midwives remained challenges for all Member States, and her delegation welcomed the actions proposed by WHO in that regard. It was particularly important that nursing and midwifery expertise should be used in health system reform and health policy formulation, as underlined by the Munich Declaration adopted by the Ministerial Conference on Nursing and Midwifery in Europe in June 2000.

As shortages of nurses and midwives were likely to continue and become more serious, the recruitment, retention and maintenance of the working capacity of existing personnel were challenges for the future. Member States should be aware of the disadvantages of the migration of nurses and midwives, and should address the issue from a broad perspective, taking account of such factors as opportunities for continuous professional learning, individual career development and the need to reconcile work and family life.

Her delegation endorsed the draft resolution and underlined the importance of implementing it. Member States should submit their plans for implementation and provide information on progress achieved, and a report should be made to the Executive Board in two years’ time to provide input for the progress report that was to be made to the Health Assembly in 2005.

Dr KORTE (Germany) recalled that the Munich Conference had been a turning point in establishing a new direction for nursing and midwifery in the countries of the WHO European Region. Not enough progress had been achieved since the European Conference on Nursing held in Vienna in 1988 in strengthening the position of nurses and midwives and making better use of their potential. Recent research and developments in that area had been presented at the Munich Conference, and health ministers and senior decision-makers had made a commitment to encourage the participation of all relevant stakeholders in policy measures aimed at making better use of nurses’ and midwives’ skills, knowledge and experience in facing key health care challenges.

The draft resolution was based on the results of that Conference, as summarized in the Munich Declaration on Nurses and Midwives, and contained a large number of proposals and desired outcomes addressed to Member States. Germany had already implemented some of those proposals by strengthening the position of nurses in its health care system, amending training regulations for nurses and working to provide a healthy workplace environment.
Germany strongly endorsed the draft resolution, although it recognized that its own federal system might require a certain degree of flexibility as regards the application of its provisions. His delegation would assume that the draft resolution offered sufficient leeway for Member States to act in accordance with their specific circumstances.

Dr VAN ETTEN (Netherlands) said that, while his delegation fully endorsed the draft resolution, it was important, within the WHO context, to distinguish more clearly between the professions of nursing and midwifery, a principle highlighted at the Munich Conference. By making such a distinction, rather than treating nursing and midwifery as a single profession, the respective competences and characteristics of each could be better identified with a view to promoting the professional development of both specialities.

Dr SHAMIAN (Canada) said that her country was grateful for the work carried out by WHO since the adoption of resolution WHA49.1. Significant progress had been made in strengthening the role of nurses and midwives in Canada, by placing them in senior positions at Federal and provincial government levels. National and provincial nursing plans of action had been developed, addressing the role and function of nursing expertise in the formulation and management of health policy and in health reform and health services.

Her delegation welcomed the call in the draft resolution for Member States to develop and implement policies and programmes that ensured healthy workplaces. Canada was engaged in research and programme development in that area in the belief that healthy workplaces for nurses, midwives and other health providers would result in higher retention rates and greater job satisfaction and would help resolve some personnel shortages.

It was unfortunate that States tended to wait for a nursing crisis before placing the subject on the international agenda. There were two main challenges for the future: the growing international shortage of nurses and midwives coupled with the problem of migration, and the need to make maximum use of nursing and midwifery expertise in the areas of health care policy, health services, development of care, policy implementation and evaluation.

Canada welcomed the emphasis in the draft resolution on setting up mechanisms to enquire into the global shortage of nurses and midwives and wished to know what specific plans the Secretariat had in that regard. She suggested that WHO might collaborate with the Commonwealth Secretariat, which was already working on that issue. Canada would welcome the opportunity of hosting a meeting of experts to examine the current global shortage and propose solutions to it.

Her delegation noted with pleasure that the draft resolution requested the Director-General to prepare rapidly a plan of action to strengthen nursing and midwifery and she asked when countries could expect to see such a plan and what it might contain. Canada wanted the plan of action to incorporate the work of WHO in strengthening nursing and midwifery expertise in the 11 priority programmes described in the Proposed programme budget 2002-2003. Her delegation wanted, in particular, to know what nursing and midwifery expertise was currently available in the HIV/AIDS, tuberculosis, health promotion and mental health programmes.

Canada supported the amendment to the draft resolution proposed by the United Republic of Tanzania at the seventh meeting of the Committee.

Mrs TAPAKOUDI (Cyprus) expressed her country's appreciation of the report and of the increasing support provided by WHO to nursing in Member States. For its part, Cyprus had taken action to involve nurses and midwives more closely in the overall management, planning and development of nursing services and education with a view to achieving efficiency, effectiveness and continuous quality improvement in nursing services in the context of health reform. However, nurses and midwives were still not sufficiently involved in overall health policy in her country.

Cyprus had developed its own national plan of action, focusing on policy development, needs analysis, resource utilization, legislation, working conditions, basic and continuing education, quality assurance and research. Changes had been introduced in nursing care delivery, through the promotion
of specialized nursing care and the development of care standards and protocols. Nurses in Cyprus participated in the delivery of primary, school and mental health care, and their role in the promotion of community-based care was under consideration.

There was only one level of basic nursing training in Cyprus, lasting a total of three years, although a recent decision had been taken to offer nursing education at the university level. Nurses continued to specialize in various fields, and opportunities for continuing education had increased. There had been some general improvement in working conditions, thanks to a review of the nurse:patient ratio aimed at ensuring more efficient and effective staffing. Continuous professional development was encouraged, promotion opportunities had increased, and salaries had been adjusted to reflect the general socioeconomic conditions of the country. Sufficient nursing students had been enrolled to meet the country's major health needs. However, there was still a long way to go in according nurses the status they deserved in the health care system.

The Ministry of Health of Cyprus, recognizing the importance of nursing and midwifery services, strongly supported the draft resolution and requested a progress report on implementation in 2003.

Dr Kim Won Ho (Democratic People's Republic of Korea) affirmed that the problem of the shortage of nurses and midwives was serious. Furthermore, having been trained at government expense, nurses in many developing countries tended either to seek work in private hospitals where the salaries and working conditions were better than in the public sector or to migrate to other countries. WHO should give still greater attention to the problem of the migration of nurses and midwives. His delegation supported the draft resolution.

Mrs Feliu Escalona (Cuba) said that the report provided a sound analysis of the work achieved since the Forty-ninth World Health Assembly. However, it was not sufficient merely to recognize that nurses and midwives constituted the largest group of health service personnel. Emphasis should be placed on the need for nurses and midwives in providing high quality care. In Cuba, as part of the reform of the health sector, nurses and midwives participated in formulating policies through their representation within the Ministry of Health and in formulating the national health plan. They thus contributed to all programmes and strategies, and the quality of their work was evaluated by various means. She noted with concern, however, that, although some countries in the Region of the Americas had, like Cuba, managed to strengthen nursing and midwifery, many had weakened their health systems by taking on less qualified personnel in an attempt to save money.

In Cuba, as a result of new administrative and training policies, the number of nurses and midwives and the quality of care that they provided were increasing, for her Government believed that neither health indicators nor the general health of the population would improve if attention were not paid to nursing and midwifery.

She supported the emphasis that the report placed on the need to enhance technical support to countries in order to strengthen nursing and midwifery services, education and practice, to seek solutions to the problem of staff shortages and migration, to increase support for the Global Advisory Group on Nursing and Midwifery and to elaborate and use uniform indicators to monitor and measure progress at country, regional and global levels in achieving the stated goals. She emphasized that, if the guidelines used by Member States did not include input from nurses and midwives, they would lack the necessary clarity to enhance the quality of nursing care.

Dr Leventhal (Israel) said that the shortage of nurses and midwives highlighted in the report and in the draft resolution had become a real problem for his country. The shortage was most acutely felt in the public health services, where nurses accounted for most of the staff. He supported the draft resolution, but urged that the report on progress made in its implementation should be submitted in 2003 rather than in 2005.
Dr FALL (Senegal) said that in his country nurses participated in every stage of the health planning process. He considered that the report should have laid greater emphasis on the fact that the availability of nurses and midwives depended to a large extent on ministries of finance: structural adjustment programmes meant that ministries of health had only limited resources to pay for such staff. In Senegal, the situation was compounded by the fact that highly qualified nurses often preferred to work in the private sector, where salaries were higher. In order to solve that problem, his Government had decentralized recruitment to local level to ensure that there were nurses and midwives serving their own communities. The Government also provided incentives to encourage staff to work in the public health sector and in rural areas. He expressed support for the draft resolution.

Dr AL KHARABSEH (Jordan) said that one of the main problems facing nurses and midwives in many countries was that they were not involved in planning and decision-making in the health sector, although their contributions would be just as valuable as those of doctors. He therefore called upon Member States to review the role of midwives and nurses and to place them in senior positions in public health authorities. He also requested the Organization to provide a list of indicators for measuring progress made in developing nursing and midwifery services in Member States and the overall performance of such services.

Mrs MAGWAZA (Swaziland) said that strengthening the delivery of nursing and midwifery services was important for disease prevention, health promotion, treatment and rehabilitation. In her country, there was a need to improve in-service training programmes for nurses and midwives, including leadership courses, and to better working conditions, salaries, accommodation and benefits in order to encourage them to remain. She urged WHO to continue providing assistance to Swaziland for the improvement of in-service training. She too would welcome the greater involvement of nurses and midwives in policy-making. Her delegation supported the draft resolution.

Mr GODDARD (Barbados) joined in supporting the draft resolution. In 2001, his country had increased the intake of nursing training programmes fourfold to cope not only with natural wastage but also with the effects of aggressive recruitment programmes by developed English-speaking countries. He recognized the need for appropriate compensation as well as for the creation of an environment conducive to continued learning and the cross-fertilization of skills. Further training in a variety of disciplines, including management, information technology, medical ethics and strategic planning, should be provided to encourage upward mobility. The profession should also be made gender-neutral, perhaps by changing the nomenclature of nursing disciplines and by launching a recruitment drive at secondary-school level.

Mrs AL-GHAZALI (Oman) endorsed the remarks of the delegate of Bahrain about the "brain drain" of highly qualified staff, especially from vital services such as intensive care and midwifery. Given that nurses accounted for almost 50% of all health workers, such migration had a negative effect on the whole health sector. She expressed support for the draft resolution and for the proposal for a progress report on its implementation in 2003. She called upon WHO to provide the necessary support to regional offices for the development of nursing training programmes in Member States.

Mr HAN (Republic of Korea) said that nurses in his country had to complete three to four years of college education, pass a national examination and undergo a training programme. There were currently 112 schools of nursing in the country, and many nurses held master's degrees and doctorates. Nurses were in sole charge of primary health care in rural and remote areas where there were no doctors. Since nursing and midwifery services played a pivotal role in public health, he urged Member States to support WHO initiatives in the areas of capacity-building, working conditions and health and safety in the workplace.
Dr PARASRAM (Trinidad and Tobago), after expressing support for the draft resolution, said that his country too had been forced to introduce measures to cope with the shortage of nurses, including an increase in the intake of training programmes. Nurses were involved in a variety of health initiatives, and the Chief Nursing Officer was a member of the health management team, which allowed her to continue to advocate the cause of nursing and midwifery and to take part in the development of programmes to encourage nurses to stay in the country. He welcomed the recommendation in the draft resolution for the establishment of a mechanism to enquire into the global shortages of nurses and midwives, including the impact of their migration.

Dr VIOLAKI-PARASKEVA (Greece) said that the availability of qualified nurses and midwives was a vital prerequisite for progress in any health care system. She welcomed the revitalization of the work of the Global Advisory Group on Nursing and Midwifery. In order to emphasize the importance of the role of nurses, she proposed the insertion of the words “being the core of any” before “health system” in the penultimate preambular paragraph of the draft resolution.

Dr TEMU (Papua New Guinea), referring to paragraph 1(3) of the draft resolution, proposed insertion of the word “training,” before the words “recruitment and retention”. He further proposed that some reference be included to the expansion of the role of midwives to include the training and supervision of village birth attendants. His country was looking into the possibility of asking midwives to take on that role, for which appropriate guidelines and training modules would be required. The Organization might consider the possibility of including areas other than nursing and midwifery, such as paediatric nursing, in the progress report on implementation of the draft resolution.

Dr STAMPS (Zimbabwe) observed that, in the past, western nations had come to Africa for slaves: now they came for nurses, using similar methods.

Dr ROMUALDEZ (Philippines) said that in his country nurses and midwives were important members of the health team, especially at community level. Nurses were in charge of many rural health units, covering local populations, numbering some 40,000, and of village health stations, providing services for some 5000 people. Unfortunately, many nurses were among the large number of Filipinos recruited to work overseas. While the Government had no intention of restricting their movements, given the importance of foreign currency for the national economy, it was concerned about the appropriateness of some of the duties assigned to them, especially the most highly qualified. It would therefore welcome close cooperation between international organizations such as WHO and ILO and the governments of sending and receiving countries on all aspects of the migration of nurses, midwives and other health professionals. He expressed support for the draft resolution.

Dr TEE Ah Sian (Malaysia) said that Malaysia had made considerable progress in the areas of concern identified in the draft resolution. Many nurses were involved in health reform and policy-making, having acquired degree-level training and the necessary managerial skills, and they played a vital role in initiatives such as the Baby-friendly Hospital Initiative, compliance with the ISO9000 quality standard and patient satisfaction surveys. The number of courses enabling nurses to acquire specialist skills had been increased, and research was open to them. In the area of primary health care, the role of nurses had been upgraded to cover care of the elderly, mental health and health-risk assessment. The Malaysian Nursing Board continued to play a major role in standard-setting, certification and human resource planning, which was particularly significant given the current rise of private-sector hospitals, which had resulted in a greater demand for nurses and the need to maintain standards. She joined in supporting the draft resolution.

Dr AMEGNIGAN (Benin) said that the analysis presented in the report accurately reflected the situation in his country. A nursing and midwifery department had recently been established by the
Government to redefine the role of nurses and midwives and to set standards for quality of care, with the support of a WHO consultant. He endorsed the draft resolution.

Mrs SUÁREZ VÁZQUEZ (Mexico) welcomed the discussion on the draft resolution, which she strongly supported. In Mexico, a shortage of nurses, especially trained nurses, and their unequal distribution between rural areas, hospitals and cities was a major problem. In addition, they were insufficiently involved in policy-making, in the management of the health system and in the formulation of strategies to improve the quality of health services.

Ms PHUMAPHI (Botswana) said that WHO had played a critical role in strengthening nursing and midwifery in her country over the past two decades. The high standards achieved were widely recognized, with the unfortunate result that major developed countries were now depleting Botswana’s scarce human resources. She welcomed the draft resolution, which was crucial to the development, adaptation and promotion of nursing and midwifery to cope with the many challenges facing developing countries. She commended the emphasis on the urgent problem of the migration of trained nurses and midwives. A mechanism should be developed to define and monitor a code of conduct for international recruitment, which would specify the responsibilities of recruiting countries. The current situation, whereby Botswana and other developing countries were obliged to recruit from poorer countries in order to make up for the loss of their own skilled staff, was untenable.

Dr OSMAN (Sudan) said that it was important to combat the loss of nursing and midwifery personnel by improving training and working conditions. The question of training in particular called for cooperation, and Sudan had set up a partnership for that purpose involving the Ministry of Health, the Ministry of Education and the universities. His Government’s policy was to support the health sector and to enable nurses and midwives to participate in decision-making. It was hoped that WHO and the international community would assist the efforts it was making in that area.

Dr DRAVE (Mali) emphasized the importance of strengthening nursing and midwifery to improve the performance of health systems. The scarcity of nurses and midwives was due to many factors that were not limited to the health sector. His delegation supported the draft resolution but asked that the report on progress in its implementation to be examined by the Fifty-sixth rather than by the Fifty-eighth World Health Assembly.

Ms HARALDSDÓTTIR (Iceland) commended WHO for highlighting the contribution of nursing and midwifery to the reduction of mortality, morbidity and disability and to the promotion of healthy lifestyles. The strengthening of those professions had been on the agenda of the Health Assembly since 1948, and the fact that so many delegates were participating in the current debate showed how important the issue still was. Member States should follow WHO’s lead and recognize the crucial role of nurses and midwives in providing cost-effective health services.

Iceland fully supported the draft resolution and was confident that an appropriate mechanism would be developed for its implementation.

Dr SANOU (Burkina Faso) welcomed WHO’s interest in the work of nurses and midwives, who formed the largest category of health personnel in her country but were still too few to meet its needs. They played an important role in all aspects of the health system, serving as the interface between the health services and the population. Their workload was enormous, especially in outlying areas, and the strengthening of their capacities was therefore essential.

A start had already been made in some countries of the African Region to involve such personnel in the planning and implementation of health policies through decentralization of the health system. Nurses were involved in planning and programming at district level. The inadequate numbers were due to widespread poverty, policies of structural adjustment and poor management of resources.
Her country hoped that WHO would continue to support nursing training and the development of appropriate management tools, and would help it to achieve the goals defined in the draft resolution.

Mrs STALLKNECHT (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that, as noted at the recent meeting of the Global Advisory Group on Nursing and Midwifery, the performance of many health systems would suffer if current trends were not corrected. In many countries, patients were sharing beds or lying on stretchers in hallways, with little regard for their care or privacy. Entire health systems were heading for disaster owing to the shortage of nurses and midwives.

Her organization was heartened by the renewed commitment of WHO to improving health system performance. However, governments should realize that if that improvement was to be achieved they would have to engage in long-term, integrated human resources planning and development, especially in regard to nursing and midwifery. She asked whether WHO had plans to augment nursing resources and to offer fellowships for nursing and midwifery at regional and national level, and what action it was taking to improve working conditions at country level. She urged the Health Assembly to endorse the draft resolution.

Ms BRAUEN (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said that the problem of the recruitment, education, deployment and retention of midwives and nurses required constant attention, including supportive legislation and efforts to attract more young people to the profession and provide them with interesting careers. The Confederation welcomed WHO's leadership on the issue. It was also important that the Organization and its partners, as well as national governments, appoint midwives and nurses to policy-making positions and provide them with proper support; as such personnel formed the majority of the health care workforce, attention should be paid to their specific needs. The progress made in the strengthening of nursing and midwifery should be constantly monitored to allow any necessary adjustments, and the Executive Board and the Health Assembly should set aside time for that purpose.

Dr MURRAY (Evidence and information for policy) expressed his satisfaction at the great interest that had been shown in nursing and midwifery. Many speakers had drawn attention to the critical role of those professions in providing cost-effective health care, especially for the poor. He assured them that WHO had been careful in defining strategies to ensure that nurses and midwives played a vital role. Many delegates had mentioned the lack of evidence on the extent of the flow of nurses and midwives from low-income to high-income countries and on the human resource implications of such migration. WHO was committed to cooperating with Member States to supply information on the numbers of nurses and midwives in various categories and on the extent of their mobility between countries of both the developing and the developed world. He thanked Canada for its offer to support a meeting on those issues. WHO was planning to hold discussions with the Commonwealth Secretariat and other partners, as recommended by several delegations.

In regard to the action plan for nursing and midwifery, WHO would be holding a series of consultations, as well as a meeting of the Global Advisory Group on Nursing and Midwifery, in the coming months. The action plan should be available in September 2001.

In response to questions concerning the recruitment of nurses to WHO, he observed that, in all cases, the Organization's policy was to recruit applicants with appropriate skills, which included nursing and midwifery. He had taken note of comments by several delegations regarding the importance of careful use of language so as not to give the impression of restricting nursing and midwifery, and certain categories within those professions, to women. He had also taken note of the remarks by the delegate of the Netherlands, who had stressed the importance of re-examining the differences between the two professions. That task was part of the broader issue of defining appropriate subcategories in nursing and midwifery, which would be important for policy and for the development of an evidence base incorporating national performance indicators.
Professor Ongeri took the Chair.

Dr THIERS (representative of the Executive Board) noted the concordance of the views expressed in the Executive Board and the Committee. The matter was of grave concern to all countries, and he urged the Committee to approve the draft resolution with a view to its rapid implementation.

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Board in resolution EB107.R2, together with the amendments proposed.

Mrs EL REFAI (United Arab Emirates) pointed out that the amendment proposed by the delegate of the Russian Federation might mean having to accept less qualified people into the two professions.

Dr RIAZANTSEV (Russian Federation) said that in his country feldschers underwent longer training than did nurses or midwives and were therefore more highly qualified.

The CHAIRMAN suggested that the amendment proposed by the delegate of the Russian Federation be added in the form of a footnote.

It was so agreed.

Dr HOLCK (Secretary) said that the second amendment proposed by Papua New Guinea to be added at the end of paragraph 2(3), would read: “including to support Member States undertaking programmes of village skilled birth attendants by developing guidelines and training modules as an expanded role of nurses and in particular midwives”. In addition, several delegates had proposed changing the date in paragraph 2(8), the end of which would then read: “Report to the Fifty-sixth World Health Assembly in 2003”.

In response to a query from Professor MASLIN (United Kingdom of Great Britain and Northern Ireland) the CHAIRMAN said that the amendment proposed by Papua New Guinea to paragraph 2(3) referred to an expanded role for professional nurses and midwives in helping to develop programmes within countries.

The draft resolution, as amended, was approved.¹

2. THIRD REPORT OF COMMITTEE A (Document A54/48)

Mrs POPESCU (Romania), Rapporteur, read out the draft third report of Committee A.

The report was adopted.²

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA54.12.
² See page 305.
3. **TECHNICAL AND HEALTH MATTERS**: Item 13 of the Agenda (resumed)

**Strengthening health services delivery**: Item 13.4 of the Agenda (resumed)

**Strengthening health systems in developing countries** (Document A54/12)

Dr THIERS (representative of the Executive Board) noted that at its January 2001 session the Board had discussed at length a draft resolution submitted by Chad entitled “Partnership with nongovernmental health care providers”. No consensus had been reached, and the Board had agreed to consider a revised text in January 2002.

Dr HOLCK (Secretary), replying to the point of order raised earlier in the meeting by the delegate of Pakistan, said that copies of the United Nations Economic and Social Council resolution 2000/27, to which reference had been made in resolution EB107.R8, were then available in the conference room. As the delegate of Pakistan had pointed out, there was an error in the eighth preambular paragraph of resolution EB107.R8, in which the date should read 28 July 2000.

Ms BALOCH (Pakistan) wished to place on record her disquiet with the way in which the Board had adopted resolution EB107.R8 in January 2001. That resolution affected all Member States, yet the Board had taken it upon itself to adopt the resolution without submitting it to the Health Assembly for approval. The Board had had before it a resolution of the Economic and Social Council on basic indicators for the implementation of and follow-up to major United Nations conferences and summits, yet had not even read the date of that resolution correctly. The Health Assembly reported to the Council every year. Since its decisions affected all Member States, all should take part in decision-making. Operative paragraph 6 of Council resolution 2000/27 read as follows:

*Calls upon* the United Nations funds and programmes, functional and regional commissions and specialized agencies to keep under review the full range of indicators used in their reports and information networks with full participation and ownership of Member States, with a view to avoiding duplication, as well as ensuring the transparency, consistency and reliability of those indicators.

Operative paragraph 5 read:

*Emphasizes* that the indicators used by the Secretariat in the context of the coordinated and integrated implementation of and follow-up to major United Nations conferences and summits should be developed with the full participation of all countries and approved by the relevant intergovernmental bodies.

Thus, the Council resolution made it clear that all countries should participate fully. At the same time, decisions should be approved by the relevant intergovernmental body, which meant the Health Assembly, not the Executive Board.

Operative paragraph 8 read:

*Invites* the Statistical Commission to serve as the intergovernmental focal point for the review of the indicators used by the United Nations system for the integrated and coordinated implementation of and follow-up to major United Nations conferences and summits at all levels, and the methodologies employed in formulating them, including in the context of the elaboration of the common country assessment, and to make recommendations with a view to facilitating future consideration by the Council.
Operative paragraph 9 read in part:

_Reiterates its invitation_ to the Statistical Commission, with the assistance of the Statistics Division and in close cooperation with other relevant bodies of the United Nations system, including the Administrative Committee on Coordination, and, as appropriate, other relevant international organizations, to review, with a view to facilitating future ... work ... .

In operative paragraph 8, the Statistical Commission was clearly designated as the focal point for the review of indicators. It was a major flaw in the Board’s resolution that there was no recognition of that. Moreover, there was no provision for the indicators or methods to be submitted to the Health Assembly for approval. As an organ of a specialized agency of the United Nations, the Health Assembly had a duty to respect the resolutions adopted by the Economic and Social Council. Moreover, any decision taken by the Health Assembly or its subsidiary organs, including the Board, must not contradict what happened elsewhere in the United Nations system. The Board must not act as a parallel decision-making body within the Organization. She therefore wanted to propose some amendments to resolution EB107.R8.

The CHAIRMAN said that Committee B had a substantive agenda item on the effective functioning of the governing bodies in WHO. He believed that to be the place for discussion of the issue raised by the delegation of Pakistan. He had noted the point raised regarding relations between United Nations agencies; however, since resolution EB107.R8 had not been submitted by the Board to the Health Assembly, he did not see how it could be considered at the present stage. As a self-contained Executive Board resolution, it remained within the ambit of the Board.

Mr Topping (Legal Counsel) said that the Executive Board acted as the executive organ of the Health Assembly and, as a policy-making organ, often dealt with issues that did not need to be brought before the Health Assembly. The Board had considered the subject of its resolution to be a methodological issue related to drawing up _The world health report_, and as such had considered that it was within its mandate to make decisions on how future world health reports were to be produced. With regard to the references in the preamble mentioned by the delegate of Pakistan, it was common practice for the preamble to a resolution to refer to a variety of decisions or articles of the Constitution covering a range of issues; the decision was contained in the operative section. It was therefore normal for the Executive Board to have considered a range of items before coming to a decision. In his view, there was no reason the Executive Board should not adopt a resolution along those lines.

Dr Temu (Papua New Guinea) said that his delegation was not prepared to discuss an Executive Board resolution that had not been referred for the Health Assembly’s consideration and was not on the Committee’s agenda.

Ms Baloch (Pakistan), speaking on a point of order, took strong objection to the fact that the Chairman had called on other delegates when she had indicated her wish to speak again. She asked to be given the floor before the next speaker.

The CHAIRMAN explained that he would like to hear the views of other delegations before inviting the delegation of Pakistan to intervene again.

Dr Larivière (Canada), endorsing the Legal Counsel’s position, said that there were several issues on which the Executive Board was called to provide administrative guidance in the light of existing policies. Recently, following extensive debate at the Health Assembly, the Board had adopted a useful resolution containing guidelines on the use of languages at WHO. The extensive discussion on _The world health report_ had focused primarily on issues of process being dealt with by the Secretariat.
The position taken by the Board was consistent with its mandate and the role it had played for the past 50 years. He saw no need to reopen debate on a resolution that was fully within the Board’s mandate.

Ms BALOCH (Pakistan) said that, although she did not want to reopen debate on a Board resolution, the Health Assembly, as the Board’s parent body, was duty bound to ensure that Board decisions did not contradict WHO principles and purposes or run counter to WHO agreements with the United Nations. She cited the Agreement between the United Nations and the World Health Organization, in particular Article XIII (Statistical Services). Paragraphs 1, 2, 3, 4 and 5 were all relevant, and paragraph 3 in particular stipulated: “The United Nations recognizes the World Health Organization as the appropriate agency for the collection, analysis, publication, standardization, dissemination and improvement of statistics within its special sphere, without prejudice to the right of the United Nations to concern itself with such statistics so far as they may be essential for its own purposes or for the improvement of statistics throughout the world.”

Her delegation understood that resolution EBI07.R8 concerned a procedural matter, but it nevertheless believed that the resolution contained certain flaws which the Health Assembly had a duty to correct. She wanted to propose amendments to that end. She did not question the Board’s authority to take decisions. The issue she had raised was not related to the functioning of the Board, which would be discussed in Committee B, but to The world health report. For that reason, her delegation could legitimately ask that the issue be discussed by Committee A. As Pakistan was not a member of the Board, its only means of amending the resolution was to raise it before the Health Assembly.

The CHAIRMAN said that when the agenda had been adopted he had not been informed that there would be a substantive change. The issue was a new one that had arisen without notice. His only recourse therefore was to ask the Committee whether it wanted at that point to include the matter as a substantive agenda item.

Ms BALOCH (Pakistan) said that when Committee A had started its deliberations she had asked whether all the documents regarding the matter under consideration could be brought to the Committee’s attention. The Chairman had consented, and the Committee had raised no objections. She therefore considered that it had been decided that the resolution and the subject would be discussed.

Her delegation understood that resolution EBI07.R8 concerned a procedural matter, but it nevertheless believed that the resolution contained certain flaws which the Health Assembly had a duty to correct. She wanted to propose amendments to that end. She did not question the Board’s authority to take decisions. The issue she had raised was not related to the functioning of the Board, which would be discussed in Committee B, but to The world health report. For that reason, her delegation could legitimately ask that the issue be discussed by Committee A. As Pakistan was not a member of the Board, its only means of amending the resolution was to raise it before the Health Assembly.

Dr LEVENTHAL (Israel) said that, with all due respect to the delegation of Pakistan, the item was not on the agenda and his delegation was therefore not prepared. In 10 years on the Committee, he had seen it discuss only technical matters, never political ones. He suggested that the delegation of Pakistan raise the issue at the next plenary meeting.

Mr TOPPING (Legal Counsel), referring to the comment by previous speakers that resolution EBI07.R8 was not on the agenda, recalled that the last sentence of Rule 55 of the Rules of Procedures stated: “The President may call a speaker to order if his remarks are not relevant to the subject under discussion.” As to whether the matter should be discussed in plenary rather than in the Committee, the question was whether the topic was covered by the agenda; the plenary was subject to the same agenda as the Committee.

Professor ABOUO N’DORI (Côte d’Ivoire) emphasized that the issue raised by the delegation of Pakistan was not on the agenda. He suggested that the delegation submit its amendments in writing to the officers of the Committee, who could then forward them to the General Committee.
The CHAIRMAN said that resolution EB107.R8 was not before the Committee. He therefore ruled that the delegation of Pakistan was out of order.

Ms BALOCH (Pakistan), speaking on a point of order, reiterated her belief that the relevance of the matter she had raised had been approved by the Committee at its first meeting. She asked the Chairman to rule on two points: first, that resolution EB107.R8 was in conformity with Economic and Social Council resolution 2000/27, and secondly, that resolutions adopted by the Board that were not brought before the Health Assembly could not be considered by the Assembly.

The CHAIRMAN replied on the first point that he could not rule on a resolution he had technically not seen. With regard to the second point, some issues were procedural, others required a decision by Committee A. If the Executive Board, in its wisdom, considered that an issue implied a substantive change of policy, that issue was placed before the Committee. The Committee did not, however, expect the Board to inundate it with countless procedural matters. All he could do was to ask the Executive Board at its next session to discuss the matter and to place it before the Committee if it considered it necessary to do so.

Ms BALOCH (Pakistan) said that she fully respected both rulings made by the Chairman. She had two requests: first, that all her comments be duly and completely reflected in the Committee's summary records; and secondly, that the Chairman should formally request the Board to reconsider resolution EB107.R8.

The CHAIRMAN said that the delegate of Pakistan's comments would indeed be reflected in the summary records. However, he could not formally request that the Executive Board reconsider a resolution he had never seen.

He drew attention to the report before the Committee on "Strengthening health systems in developing countries" (document A54/12), and invited the delegate of South Africa to introduce a draft resolution on the subject.

Dr JOHNS (South Africa) said that, since it had first been circulated, the draft resolution had been the subject of great discussion and had undergone several changes. In order to facilitate the collation of those changes, he requested a brief suspension of the meeting.

The meeting was suspended at 12:20 and resumed at 12:50.

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegation of South Africa on behalf of Member States of the Non-Aligned Movement, which read as follows:

The Fifty-fourth World Health Assembly,

Mindful of the principles of, and obvious need for, technical cooperation among developing countries and of the interest shown by the World Health Assembly by virtue of its resolutions WHA31.41, WHA31.54, WHA32.27, WHA35.24, WHA36.34, WHA37.15, WHA37.16, WHA38.23, WHA39.23, WHA40.17, WHA40.30, WHA50.27, WHA51.16 and WHA52.23 in strengthening this type of cooperation with a view to improving the health situation in developing countries;

Underlining the principles and purposes of the United Nations as set out in the United Nations Charter, including the sovereign equality of States and the development of friendly relations among nations based on the respect for equal rights and the self-determination of peoples, which have been consistently reaffirmed by Members of the Non-Aligned Movement;

Recognizing that in order to realize aspirations and achieve the social development and well-being of people, it is a central responsibility of governments and all sectors of society to
establish measures which would facilitate the attainment of goals relating to the eradication of poverty, and to food security, health, education, employment, housing and social integration;

Reaffirming the commitments made in this regard during the twenty-fourth special session of the United Nations General Assembly entitled “World Summit for Social Development and beyond: achieving social development for all in a globalizing world”;

Recognizing that the primary determinants of ill health such as poverty and lack of education are also among the critical causes of underdevelopment, and that health is both a necessary precondition to, and an outcome of, the overall development process;

Further recognizing that the health needs of women, girls, children and older persons shall be given particular attention;

Mindful of the fact that developing countries, especially the poorest, are vulnerable to the harmful effects of globalization which have led to greater inequities in health and health care both within such countries and between developed and developing countries;

Recalling that the lack of access to safe and affordable essential medicines and other health technologies is a significant factor in perpetuating and extending such inequities;

Noting with concern the progressive decrease in funds available for development assistance in the face of growing needs within developing countries, and recognizing that debt-relief efforts could potentially free up considerable resources for use in the development of health infrastructure and services;

Recognizing the progress that has been achieved in the areas of human genetics and biotechnology, and the potential rewards that could accrue from research in this area;

Noting with concern the increase in HIV/AIDS in developing countries, especially in sub-Saharan Africa;

Welcoming the prominence accorded to HIV/AIDS on the international agenda, including adoption of resolution 2001/33 on the access to medication by the 57th Session of the Commission on Human Rights, the special session of the WTO Council for Trade-Related Aspects of Intellectual Property Rights on access to essential medicines to be held at the request of the Africa Group (Qatar, June 2001), and the special session of the United Nations General Assembly on HIV/AIDS (June 2001);

Endorsing the recognition of mental health as a significant challenge requiring special attention within the health systems of developing countries;

Appreciating WHO’s initiatives with regard to the promotion of horizontal cooperation among developing countries,

1. **REAFFIRMS** its commitment to the objectives of the health-for-all strategy, in particular the achievement of equitable, affordable, accessible and sustainable health care systems based on primary care in all Member States;

2. **RECOGNIZES** the sovereign right of each country to adopt national policies appropriate to the specific needs of their people;

3. **URGES** Member States:
   1. to reaffirm the importance of health as an indispensable resource for sustainable development and to advance such development through actions which promote and maintain equity and equality, including between men and women;
   2. to continue to develop health systems in accordance with the principles listed above, and to ensure that where markets exist within the health sector, they function efficiently within a suitable framework of ethical principles and in accordance with the technical regulations and standards established by the governmental authority;
   3. to ensure that ministers of trade adopt a decision on public health and the Agreement on Trade-Related Aspects of Intellectual Property Rights at their forthcoming
meeting, so as to address the issues of concern to developing countries in the area of access to essential medicines;

(4) to adopt, as a matter of priority, measures that will serve the needs of the most vulnerable of their populations;

(5) to ensure that countries are not hindered in their efforts to use the options available to them under international agreements, including parallel importation and compulsory licensing, in order to protect and advance the access to life-saving and essential medicines;

(6) to ensure that the accumulation and application of knowledge in respect of the common human genetic endowment is at all times subject to accepted scientific, moral and ethical standards and to the potential benefit of all, especially the poor in developing countries;

(7) to refrain from all measures, including unilateral coercive measures, that are contrary to international law, including international conventions, and which hinder health service delivery and deny care to those in greatest need;

4. CALLS upon developed countries:

(1) to continue to facilitate the transfer of materials, equipment, technology and resources appropriate to the health needs of developing countries;

(2) to support the application of technical cooperation with and among developing countries;

(3) to review, with a view to increasing, their allocation of resources intended for development assistance and the fight against HIV/AIDS and other priority diseases;

5. REQUESTS the international community and multilateral institutions:

(1) to maintain a people-centred focus in their deliberations, particularly where measures proposed in such deliberations could directly or indirectly impact negatively on the health status of the most vulnerable;

(2) where appropriate, to integrate the health dimension into their programmes and strategies, particularly in respect of HIV/AIDS and other priority diseases;

(3) according to their mandate and particular expertise, to provide support for efforts aimed at strengthening the health systems of developing countries;

(4) to identify and implement development-oriented and durable solutions to alleviate external debt and to solve the debt-servicing problems of developing countries;

(5) to implement the conclusions of the United Nation summits and conferences that address health problems and to make further recommendations in this regard;

(6) to support the establishment of a global fund for HIV/AIDS and related infectious diseases as set out in the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infections (April 2001);

6. REQUESTS the Director-General:

(1) to continue to support Member States in their efforts to meet the health needs of their people, especially those who are most vulnerable;

(2) to cooperate with Member States in achieving access to safe and affordable essential medicines and other appropriate health technologies;

(3) to strengthen the capacity of the health sector to participate effectively in multisectoral efforts which seek to address the root causes of ill health;

(4) to continue to provide support for the work being undertaken by institutions in developing countries in the area of health sector reform, and to validate and collate the work of these and other institutions, in order to ensure that future policies and advice are founded on the best available evidence;
(5) to expand on the opportunities for interaction with Members of the Non-Aligned Movement and other developing countries, aimed at facilitating and enhancing the work of WHO;

(6) to report to the Fifty-sixth World Health Assembly on the steps taken and progress made in implementing this resolution.

Dr JOHNS (South Africa) informed the Committee that the draft resolution was based to a large extent on resolution WHA52.23 but had been updated to include some of the principles established at the Social Summit +5, a special session of the United Nations General Assembly, held in Geneva the previous year. It sought to highlight some of the concerns of the developing countries regarding the demands and capacities of health systems and how to meet future challenges, and attempted to indicate a policy framework to address those concerns. Various amendments would be read out later to the Committee. He expressed the hope that the draft resolution, as amended, would be approved by consensus.

Mr STEIGER (United States of America) said that, although there was some wording in the preambular part of the draft resolution with which his delegation did not agree, such as the fundamental premise that globalization inherently led to greater inequities in health and health care, the draft resolution was, on balance, a strong one, which offered Member States and multilateral institutions an opportunity to cooperate constructively to strengthen health systems worldwide and combat many important health problems. He thanked the delegation of South Africa for its efforts.

Mr RAHMAN (Bangladesh) said that the draft resolution struck a delicate balance. It touched upon the obstacles and challenges that developing countries faced in bringing better health care to their peoples while seeking to address the concerns of all States. Although it might not be fully satisfactory to some States, it reflected the maximum that could be delivered under the given circumstances, and he commended the delegation of South Africa for its leadership in such a difficult endeavour. He hoped that the draft resolution, as amended, would be approved by consensus.

At the suggestion of Ms BALOCH (Pakistan), the CHAIRMAN asked the Secretary of the Committee to read out the proposed amendments, which, he said, were the product of extensive discussions on the draft resolution over the previous week.

Dr HOLCK (Secretary) said that in the fifth preambular paragraph the word “primary” should be replaced by “main”. The seventh preambular paragraph should be amended to begin: “Mindful of the fact that globalization presents opportunities and challenges for all countries and that developing countries, especially the poorest, are vulnerable to those adverse effects of globalization that lead to greater inequities ...”, in order to bring the text into line with resolution WHA52.23. In the ninth preambular paragraph, the words “progressive decrease in funds available for development assistance” should be replaced by “need for funds for development cooperation”, the word “needs” should be replaced by “demands” and the words “including HIPC and other” should be inserted after “debt-relief”. In the eleventh preambular paragraph, the words “and other diseases” should be inserted after “HIV/AIDS”. Lastly, the twelfth preambular paragraph should be amended to read: “Welcoming the prominence accorded to HIV/AIDS on the international agenda, and noting the adoption of a resolution on the access to care by the 57th Session of the Commission on Human Rights, the decision by the Abuja Summit on HIV/AIDS, tuberculosis and related diseases, the special discussion of the TRIPS Council of the WTO on the TRIPS Agreement and access to essential medicines to be held at the request of the Africa Group in June 2001, and the forthcoming United Nations General Assembly special session on HIV/AIDS”.

Dr TEMU (Papua New Guinea) suggested that the eleventh preambular paragraph might be further amended to read “... increase in HIV/AIDS, tuberculosis and other diseases ...”.
Dr HOLCK (Secretary) said that in paragraph 1, the word “care” should be deleted between “health” and “systems”. In paragraph 2, “their” should be replaced by “its”. Paragraph 3(3) should be amended to read: “to participate in the special discussion of the WTO TRIPS Council on intellectual property issues relevant to the access to essential medicines with a view to addressing the concerns expressed by developing countries”. Paragraph 3(5) should be reworded to read: “to make every effort to ensure that countries are not hindered in their efforts to utilize the options available to them under international agreements acceded to in order to protect and advance the access to life-saving and essential medicines”. Paragraph 3(6) should be amended to read: “to continue to support research in the area of human genetics and biotechnology subject to accepted scientific and ethical standards and to the potential benefit of all, especially the poor”. In operative paragraph 3(7), the words “including unilateral coercive measures” should be deleted to bring the text into line with resolution WHA52.23.

Paragraph 4 should be amended to read “CALLS upon Member States, especially developed countries.”. In paragraph 4(2), the words “the application of” should be deleted, and in subparagraph 4(3), the word “assistance” should be replaced by “cooperation”.

Paragraph 5(4) should be reworded to read: “to identify and implement development-oriented and durable solutions to debt-servicing problems of developing countries so as to alleviate external debt”.

Finally, as reference to the Abuja Summit had been made in the preambular part of the draft resolution, paragraph 5(6) should be amended to read: “to support the establishment of a global HIV/AIDS and health fund.”

Dr AL-SAIF (Kuwait) said that he would prefer the words “including unilateral coercive measures” to be retained in paragraph 3(7).

Dr JOHNS (South Africa) recalled that deletion of those words would bring the text into line with the text of resolution WHA52.23, and was supported by most countries.

Dr ROMUALDEZ (Philippines) suggested that, in order to convey the view that health concerns should take precedence over profit-making actions, the phrase “on the health implications of the Agreement” should be added at the end of the proposed amended paragraph 3(3).

Dr LEVENTHAL (Israel) said that the draft resolution should be brought into alignment with resolution WHA54.10 “Scaling up the response to HIV/AIDS”, in view of the many similarities between the two texts.

Dr STAMPS (Zimbabwe) maintained that the first “and” in paragraph 3(7) was redundant.

Mr STEIGER (United States of America) disagreed, as the proposed amendment gave the impression that all international conventions hindered health service delivery. Additional punctuation would help. It should read “... conventions, and which hinder ...”. 

Dr STAMPS (Zimbabwe) said that reference was being made to measures that were contrary to international conventions. Repetition of “contrary” might clarify the text.

Mr STEIGER (United States of America) explained his understanding of the text: both “and which hinder” and “contrary to international law” modified “all measures”; without the comma and the addition of “and”, the clause “which hinder ...” would modify “international conventions”.

Dr JOHNS (South Africa), explaining that he had had a hand in the drafting, underlined the need to retain the “and”.
Dr STAMPS (Zimbabwe) doubted that any State could be required to refrain from a measure that was legal, as the text would imply with the “and”. Some measures that accorded with international law and conventions did actually hinder health service delivery.

Ms BALOCH (Pakistan) agreed with the need for further drafting to allay apprehensions on that point. She suggested the following text: “to refrain from all measures that are contrary to international law, which hinder ...”.

Professor ABOUO N’DORI (Côte d’Ivoire) observed that the French text appeared to be correct with its inclusion of the word “et” (and).

Dr LARIVIÈRE (CANADA) stated his delegation’s preference for a text that urged Member States to refrain from “all measures that were contrary to international law” as a matter of course, but especially those measures that hindered service delivery. He proposed retention of the “and” or use of the phrase “inter alia” to follow “which”. The choice depended on the exact meaning that was to be conveyed.

Dr HOLCK (Secretary) read the proposed text: “to refrain from all measures that are contrary to international law, including international conventions, and, inter alia, which hinder ...”.

Dr MBAIONG (Chad) proposed wording in the French language version of the text which took out reference to international conventions and did not require the conjunction “and”.

Dr JOHNS (South Africa) remarked on the similarity of the present discussion with that which had led to formulation of the text two years previously, which, no matter how bad the grammar might have been, had been adopted in resolution WHA52.23.

Dr STAMPS (Zimbabwe) accepted the proposal to follow that phraseology.

Mr STEIGER (United States of America) asked whether the amendment proposed by the delegate of the Philippines had been accepted, preferring to retain paragraph 3(3) as it had been read out by the Secretary.

Responding to Dr ROMUALDEZ (Philippines), who had explained that his amendment had been intended to ensure that health concerns, especially those of developing countries, were taken into account in application of the terms of the Agreement on TRIPS and in related activities, the CHAIRMAN pointed out that the special discussion of the WTO Council on Trade-Related Aspects of Intellectual Property Rights had not yet taken place. The concerns expressed by developing countries on health issues could be dealt with effectively at that session.

Ms BALOCH (Pakistan) commented that the Member States of WTO, and in particular those involved in that Council, were not the same as those of WHO.

Dr TEMU (Papua New Guinea) proposed two amendments. He asked for paragraph 4(1) to be changed so as to read “to continue to facilitate the provision of materials, equipment and resources, including the transfer of technology, appropriate to the health needs of developing countries”. In paragraph 5(6), he suggested inclusion of the words “and maintenance” after “to support the establishment”.

Professor MASLIN (United Kingdom of Great Britain and Northern Ireland) said that her delegation preferred to retain the original wording of paragraph 4(1). “Provision” did not have the same meaning as “transfer”.
The CHAIRMAN noted that United Nations texts conventionally referred to “access to” and “transfer of” technology, services and the like.

Mr STEIGER (United States of America), referring to the amendment proposed to paragraph 5(6) by the delegate of Papua New Guinea, suggested that it was premature to specify maintenance as the fund had not yet been formally established and only one country had contributed funds.

Dr KITEZE (Central African Republic) suggested that the text of paragraph 5(2) be amended to refer to the programmes and strategies “of cooperation” or “of development” of developed countries or the international community.

Dr JOHNS (South Africa) remarked that the actions described in paragraph 5 were phrased as requests to the international community and multilateral institutions in the broadest context. He expressed concern that the proposed amendment might, in fact, be limiting.

Noting no further objection or comment, the CHAIRMAN invited the Committee to approve the draft resolution as amended.

The draft resolution, as amended, was approved.1

The CHAIRMAN took it that, in the absence of any comments, the Committee wished to note the report contained in document A54/12.

It was so agreed.

Communicable diseases: Item 13.3 of the Agenda

Global health security: epidemic alert and response (Resolution EB107.R13; Document A54/9)

Dr THIERS (representative of the Executive Board), introducing the draft resolution contained in resolution EB107.R13, recalled that a global epidemic alert and response network existed to collect information on suspected outbreaks, to verify the information confidentially with Member States and to ensure that appropriate measures were taken. In view of the growing threat posed by infectious diseases, several members of the Board had stressed the need to increase partnerships and technical cooperation between industrialized and developing countries, especially since surveillance in many countries was weakened by lack of laboratory support and trained personnel. Thus, the opening of a WHO office in Lyon, France, dedicated to training in field epidemiology, was warmly welcomed. The threat posed to global health security by the spread of antimicrobial resistance was recognized as needing leadership from WHO. The reported progress on the revision of the International Health Regulations, with its flexible step-by-step approach, was also welcomed. The revised Regulations would be useful for responding to the potential rapid global spread of infectious diseases. Resolution EB107.R13 had been adopted by the Board by consensus.

Dr Otto took the Chair.

1 Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA54.13.
Dr YUNES (Brazil) expressed his country's support for the draft resolution recommended by the Executive Board. Recalling that the purpose of the International Health Regulations was to maximize protection against the global spread of disease with minimal interference with trade and travel, he called for strengthening of critical areas to ensure global capability of detecting and responding to outbreaks. The revision of the Regulations should be accorded high priority on the international health agenda, and consensus needed to be reached. Under the leadership of WHO, the new outbreak management system should be tested in the field.

Brazil was promoting training in field epidemiology for the early detection of and response to outbreaks, providing technical and financial support to states and municipalities, improving surveillance systems and amplifying laboratory networks. More research was needed into the potential impact of climatic changes on morbidity and mortality trends in infectious diseases and especially vector-borne diseases.

Dr LARIVIÈRE (Canada) said that his country attached the highest priority to effective surveillance and control globally for infectious diseases. For instance, it had worked with WHO in response to the recent outbreak of Ebola haemorrhagic fever in Uganda. It would continue to try to find resources for WHO to use as part of the multinational alert and response network, whose establishment was an effective mechanism for drawing on national expertise. Further, efforts would be made to increase the capacity of developing countries to respond to outbreaks. His delegation commended WHO's work in strengthening disease surveillance and outbreak verification with the Global Public Health Intelligence Network and WHO's progress towards a global strategy for the containment of antimicrobial resistance. He urged the Organization to ensure that, in the revision of the International Health Regulations, steps were taken to ensure their compatibility with other relevant regulatory instruments. His delegation had noted with interest WHO's contribution to the battle against bioterrorism. He considered that WHO should investigate the role of migration in the transmission of disease in order to improve the capacity to respond to emerging infectious diseases and outbreaks. His delegation supported the draft resolution.

Mrs RA VN (Denmark) welcomed the emphasis on the increasing globalization of infectious diseases and the consequent need for a stable, relevant platform for epidemic alert and response. Her delegation appreciated the initiatives proposed in the draft resolution, in particular the revision of the International Health Regulations, although it had some concern about the pace of that process. That revision would, of course, require appropriate resources.

Dr MOETI (Botswana) endorsed the need for a management system for global epidemic events. Publication by WHO of vital information in electronic format had greatly improved access. He concurred with the position that, in order to maximize use of existing capacities, all partners in the area of disease surveillance must be engaged. HIV/AIDS and tuberculosis were the major communicable diseases in his country, which, nevertheless, remained acutely aware of the continuing threat of other such diseases with significant epidemic potential, such as plague, cholera, dysentery and viral haemorrhagic fevers, whose increased frequency emphasized the need to strengthen epidemiological and laboratory investigation capacity and emergency management at country and regional levels. The integrated disease surveillance strategy that his country was implementing provided a sound framework for preparation and response to such threats. However, considerable technical support would be required, and he underscored the request in the draft resolution for such support to Member States.

With respect to the revision of the International Health Regulations, he agreed that a syndromic reporting system would pose problems within a regulatory framework. He said that he looked forward to the proposed consultations with Member States and supported the suggestion that meetings of regional working groups be held to review the applicability and relevance of the text. His delegation supported the draft resolution.
Professor OMASWA (Uganda) thanked WHO for its efficient and effective response to the outbreak of Ebola haemorrhagic fever that had occurred in Uganda at the end of 2000, and the multilateral and bilateral agencies that had also provided efficient support under the leadership and coordination of the Government of Uganda. The combined efforts had resulted in a low mortality rate in one of the largest outbreaks of that disease. He also commended the Ugandan health care workers, some of whom had died during the outbreak. He called for a strengthening of the programme in order that it might respond to similar epidemics elsewhere and help Member States to build up their own capacities at national and regional levels.

Dr ADAM (Kenya) said that integrated disease surveillance and response could evolve only through priority setting, detection and prediction, planning, resource mobilization, adequate intervention, monitoring and evaluation. With the support of WHO, Kenya had established disease outbreak monitoring and response units in all health authorities, which had responded to outbreaks of cholera, typhoid and Ebola haemorrhagic fever in the previous year. The main weaknesses in the response had been lack of generic case definitions, particularly for emerging diseases, within the local context and insufficient laboratory services. The design of any response should include those core elements. The improvement of reference diagnostic capacity in developing countries would go far towards improving responses to disease outbreaks.

He thanked WHO for its immense material and technical support, and said that his delegation supported the draft resolution.

Dr NOVOTNY (United States of America) welcomed the report, in particular for setting a realistic calendar for revision of the International Health Regulations and for stressing the improvement of national capacity for epidemic alert and response. His delegation endorsed the formulation of a strategy for surveillance and response in which public health risks of urgent international importance were identified and which provided a basis for choosing appropriate responses. The current Regulations were clearly insufficient in view of the speed and extent of migration, emerging infections and the possible threat of bioterrorism. His country was contributing to the revision and would contribute to the field testing of the revised Regulations through PAHO. As the Regulations were an integral part of WHO's normative function, he urged the Organization to ensure sufficient funding for timely completion of the revision. The revised Regulations must be flexible but clearly specify the authorities and the appropriate conditions for restricting the movements of people, animals and cargo in order to contain the spread of disease. Such restrictions should be carefully balanced against infringement of individual liberties and a nation's right to engage in international trade, commerce and migration. His delegation endorsed the draft resolution.

Mr MAJORI (Italy) commented that recent epidemics and concern about emerging diseases and the spread of drug resistance justified the importance the Organization attached to the subject in terms of management, national capacity building and revision of the International Health Regulations. He pledged continuing collaboration of his country's institutions in partnership with WHO in order to provide appropriate technical support. His delegation endorsed the draft resolution.

Dr PINTÉR (Hungary) said that his country shared the concern that new and re-emerging infectious diseases remained a threat to the health of populations. The risk of epidemics was increased by environmental changes, poverty and increased population movement, and that was particularly true in central Europe. Hungary aimed to improve its already well-functioning surveillance system and advocated intersectoral cooperation both within the country and between international agencies. His delegation welcomed the revision of the International Health Regulations and the work towards a global strategy for containment and prevention of antimicrobial resistance. It also emphasized the importance of collaboration between WHO and national and international partners in the area of epidemic alert and response. His delegation strongly supported adoption of the draft resolution.
Dr TAHA ARIF (Malaysia) asked when the report of the pilot study on syndromic reporting, referred to in paragraph 14 of document A54/9, would be made available to Member States. In his country, syndromic reporting was found to be useful in the national system of surveillance. Recent outbreaks of enteroviral vesicular stomatitis with exanthem and Nipah virus infection had shown the importance of early warning surveillance systems, epidemic preparedness and effective dissemination of information in facilitating responses. His country had created an infectious disease research centre with a focus on the strengthening of surveillance activities, laboratory capabilities, research and training. His Government considered that such work would contribute to global health security. Malaysia supported adoption of the draft resolution.

Dr MAHJOUR (Morocco), endorsing the draft resolution, called on WHO to continue its support to countries in formulating and strengthening their plans for preparedness and response to epidemics, particularly with regard to early warning, rapid intervention measures, training of personnel and strengthening of laboratory structures. The revision of the International Health Regulations to adapt them to the current global epidemiological context would effectively contribute to a global early warning system. The Regulations should also specify concrete measures to protect the interests of countries that reported epidemics. The reporting of information about actual or potential epidemics was vital for the health of the international community, but it should be recalled that such information was often used against the reporting countries, resulting in enormous economic damage, particularly with regard to trade and tourism.

Dr VAN ETten (Netherlands), acknowledging the importance of WHO's global outbreak alert and response network, asked about the extent of the confidentiality referred to in paragraph 16 of the report. Official representatives of national authorities, the focal points in each country, must have access to that information, and that principle should be formalized. His delegation supported the importance of national capacity building and endorsed the draft resolution.

Dr SHIVUTE (Namibia) thanked WHO for its rapid response and support during the recent outbreak of malaria in his country. With the emergence of many communicable diseases and the spread of antimicrobial resistance throughout the world, it was imperative that countries were prepared to cooperate fully to contain epidemics. The need to strengthen countries' capacity for surveillance could not be overemphasized. Namibia supported the revision of the International Health Regulations and adoption of the draft resolution.

Dr RIAZANTSEv (Russian Federation) said that the potential of globalization to facilitate the rapid, wide spread of infectious diseases made the subject important and urgent for WHO. His country welcomed the measures taken and planned, including epidemiological surveillance and response and the training of national staff, without whom even the best surveillance systems would not be effective. His delegation supported the draft resolution.

Dr DLAMINI (Swaziland) thanked WHO for its response and support during the recent cholera epidemic in her country; however, WHO should not wait to be invited to a country when an epidemic broke out. Limitations on resources to improve basic infrastructure contributed to some epidemics, and further training was needed to strengthen surveillance of communicable diseases. She also expressed concern about the spread of drug resistance, as countries in southern Africa had limited access to the latest antibiotics. She appealed for support to improve laboratory facilities. A regional approach to epidemic alert was essential, and she urged WHO to continue its activity. Her delegation supported the draft resolution.

Dr SANOU (Burkina Faso) reported that various epidemics hindered development in her country in general and the health services in particular. The management of epidemics depended on
accurate information, and, in order to strengthen its laboratory system and to improve the integrated surveillance of diseases, her Government was organizing a network of health laboratories with a focus on epidemic control.

She thanked WHO for its support during the recent meningitis epidemic, especially in the acquisition of vaccine at an affordable price. She also thanked all the partners and neighbouring countries that had helped to control the epidemic, and especially the Government of Mali for providing vaccine. At that time, there had been an international shortage of vaccine, and she encouraged consideration of ways in which that situation could be avoided in the future.

Dr TOUYÁ (Uruguay) stressed the importance of the revision of the International Health Regulations. While supporting the draft resolution, he asked for a paragraph to be inserted in which the Director-General was asked to support Member States in implementing the global strategy to contain and prevent resistance to antimicrobial agents.

Mr ZHANG Li (China) said that the report's analysis of the global threat of infectious diseases indicated the need to improve the exchange of accurate information. Member States should receive timely information on progress towards the establishment of a global management system to deal with epidemic events and on the results of international epidemiological and laboratory studies. Caution should be exercised in replacing disease-specific reporting by syndromic reporting in the revised International Health Regulations. The conventional system should be maintained for reporting major infectious diseases, and those with a global impact should be identified as the basis for global reporting. There should be full consultation about which diseases should be subject to surveillance and reporting. Infectious diseases should be reported only if they had not been seen previously in a country, but should be reported as soon as they were detected. With regard to infectious diseases and diseases of unknown causes, countries should report the incidence of symptoms that appeared to form part of a syndrome, and to apply for assistance, if necessary, from WHO and from other countries.

Dr LEFAIT-ROBIN (France) hoped that WHO would enhance its collaboration with existing networks, as infectious disease surveillance was an essential decision-making tool. France, like other European countries, had established a national health-monitoring agency. The current International Health Regulations, in existence for some 50 years, were obsolete and ineffective in the context of the current globalization and growing population movements. Revision of the Regulations would not be easy, and her country hoped to be actively involved. Her delegation supported the draft resolution.

Dr TROOP (United Kingdom of Great Britain and Northern Ireland) said that her delegation acknowledged the importance of early recognition, investigation and control of outbreaks of communicable diseases of international dimensions. While welcoming the report, she endorsed the Danish delegation's comments about the slow progress of the revision of the International Health Regulations. Moreover, her delegation hoped that the next report on the subject would include clearer goals and milestones. It nevertheless strongly supported WHO's continued efforts as well as adoption of the draft resolution.

Dr SAKOI (Japan) said that his delegation recognized the increasing needs for international cooperation and national capacity-building, as events such as the recent outbreak of Ebola haemorrhagic fever and the spread of bovine spongiform encephalopathy posed threats to people everywhere. Developed and developing countries alike must strengthen their response capacity, by harmonizing national with international measures. In that regard, Japan intended to participate actively in WHO's initiative and strongly supported the draft resolution.

Dr BELLO DE KEMPER (Dominican Republic) said that her delegation strongly supported the draft resolution, particularly the request, in operative paragraph 3(2), to the Director-General to provide technical support to Member States for formulating intervention programmes. The need had
been illustrated in her country the previous autumn, when certain patients had displayed symptoms which at first had suggested paralysis caused by pesticides; laboratories in the United States of America had been instrumental in identifying the disease as poliomyelitis. Her delegation was grateful for the assistance of PAHO in detection of the disease and for initiating a prompt vaccination campaign.

Dr CHATREE CHAROENSIRI (Thailand) commended the WHO initiative and the draft resolution. His country recognized the threat of communicable diseases and the need for timely action, at national, regional and international levels, and had long been a participant in capacity building at all levels, in epidemiology, surveillance, data sharing and response. Public health care currently transcended national boundaries, and new or newly recognized pathogens as well as recurrent outbreaks of known diseases were a challenge to the outdated International Health Regulations, whose revision his delegation supported.

Dr STAMPS (Zimbabwe) also thanked WHO for its assistance in the control of epidemics and strongly supported revision of the International Health Regulations. He agreed with the United Kingdom delegation’s call for an early conclusion to a first draft, but the revision should involve as much participation as possible so as to avoid it being dominated by infectious diseases seen as threatening only to the west. In that regard, the number of collaborating centres in developing countries should be increased, with a view to better assessing the genuine risks in those countries.

On behalf of all southern African countries, he thanked WHO and other international agencies for their response to the effects of cyclone Eline. The damage in his country had been aggravated by the land policies of the former colonial regime, which had led to high population densities on poor land and thus to erosion, deforestation and desertification.

The influence of the international food trade in spreading epidemic outbreaks should not be overlooked. For instance, a consignment of tinned food sent in response to the cyclone had been found to be contaminated with clostridia; the donor had sought to retrieve the consignment and re-export it to Malta, where there was an offshore repackaging plant. Such misdeeds highlighted the need for constant alertness.

With regard to paragraph 2 of the draft resolution, his delegation proposed addition of 2(1)(bis), worded: “To develop and update national preparedness and response plans”.

Professor Ongeri resumed the Chair.

Dr KHAZ’AL (United Arab Emirates) said that, despite all efforts towards global health security, pressing needs remained, including a requirement for speedy information. Her country would welcome an emphasis on use of information technology in the management of infectious diseases, taking account of regional and national requirements. Countries required national entities that could intervene more swiftly than WHO. The Organization should provide means for analysing data, especially for help in avoiding the use of misleading information, since data were at times difficult to interpret. Her delegation supported the proposed resolution.

Mr KINGDON (Australia) said that his delegation supported the proposed measures to strengthen international capacity for surveillance and prevention as outlined in the draft resolution. A major departure in the proposed revision of the International Health Regulations was that it would not contain a list of diseases; the current proposal was that “all urgent international public health events” should be notified. His delegation hoped that the revision team, in consultation with public health experts, would provide an acceptable, practical definition of what those events were. The revised Regulations would benefit Member States by providing a system of speedy detection and response, and a set of generic rules to resolve various emergencies. It was also envisaged that each country should have the capacity to report and analyse events rapidly.
His country supported the development of global and regional public health alert and control networks; at the regional level, rich countries should share infrastructure, skills and information with poorer countries. Australia already had some domestic networks; New Zealand had been an active collaborator in that regard, East Timor and Papua New Guinea had recently been invited to take part as observers, and the Pacific Public Health Surveillance Network, through the Secretariat of the Pacific Community, would be invited to participate.

Mr CHETLEY (Save the Children Fund (UK)), speaking at the invitation of the CHAIRMAN, said that effective epidemic alert and response was an element in the strengthening of health systems. His organization welcomed the extra resource commitments to global health but said they would be effective only if used to strengthen and rebuild basic health infrastructures, with particular attention to human resource development, including the pay and conditions of health staff. To that end, WHO should play a critical role.

It was disquieting that the proposed global fund for AIDS and health had been linked with calls for speedy action. That approach, if not controlled, could lead to vertical programming and parallel structures, with the risk of diverting trained health staff in developing countries from the public health sector services that remained. Governance of the plan was critical, and those responsible must focus on grass-root needs rather than macroeconomic or commercial considerations. There, too, WHO should play a leading role. That fund would be a radical step and must be accompanied by an equally radical commitment to basic health services in all countries. His organization pledged its support for an approach in which intersectoral management by developing countries was encouraged and supported and in which health was viewed as an intrinsic right and not simply a stepping-stone to economic growth.

Dr HEYMANN (Executive Director) thanked delegates for their comments on the report and the draft resolution. The alert and response network and the International Health Regulations had been a strong unifying factor in WHO and the six regional offices. The Organization was investigating the relationship between climate changes and infectious disease in order to include it in the assessment process. Revision of the International Health Regulations had indeed been slow. A report on the field-testing in five countries of syndromes as a basis for reporting, which was available on request, indicated that the revision should in fact be based not on syndromes but on public health risk. The WTO Committee on Sanitary and Phytosanitary Measures had been consulted, and consultations were to be held in all regions, in order to be sure of addressing all concerns.

In response to the question from the delegation of the Netherlands, he said that, by confidentiality, WHO meant that it would not share reports of infectious diseases with the public, even though much of the information did come from public sources, usually the press. Instead, it was shared confidentially with countries, the members of the 72 networks with which WHO collaborated, and with focal points for the International Health Regulations in each country. About 90 focal points had been identified; WHO wanted to receive nominations for focal points in the remaining Member States. Once the confidential negotiations and validation were completed to the satisfaction of the affected countries, the public was informed through various channels, including the Weekly Epidemiological Record and the worldwide web.

He regretted that during the current year there had been a shortage of vaccines against meningitis and yellow fever, and steps had been taken to ensure that vaccines for those infectious diseases would be included in the programmes of the Global Alliance on Vaccination and Immunization. It was hoped that the WHO office in Lyon, in collaboration with international training institutions, could begin to meet the demand for training in laboratory work and epidemiology.

Several delegations had asked about the reporting of diseases in accordance with the International Health Regulations. Diseases could be reported by name if the etiology of an outbreak had been confirmed. Efforts were being made to develop a system that would facilitate the reporting of diseases that had not been identified early in their course, in order that containment could begin even before the disease had been identified.
Dr TEMU (Papua New Guinea), referring to the draft resolution recommended by the Executive Board, proposed that, in paragraph 3(2), the word “clinical” should be preceded by “community and”. In paragraph 2(1), he suggested that the term “qualified partners” should be replaced by “technical partners”, in order to be consistent with paragraph 1(3).

Dr LARIVIÈRE (Canada) said that his delegation had no objection to the amendments proposed by Papua New Guinea and Zimbabwe, but the Uruguayan delegation’s proposal referred to implementation of the global strategy for containment of antimicrobial drug resistance, when that strategy was still in draft form. He appreciated the intention of the proposed amendment and would have no difficulty with a request for support for national programmes and strategies.

Dr TOUYÁ (Uruguay) said that his delegation wanted to stress the importance of technical cooperation in the containment and prevention of resistance to antimicrobial agents, quite apart from the proposed global strategy. Following a suggestion by the CHAIRMAN, he said that his delegation could agree, instead of his earlier proposal, to an amendment worded “to provide technical support to Member States in the implementation of national efforts to contain and prevent resistance to antimicrobials”.

The draft resolution, as amended, was approved.¹

The meeting rose at 15:00.

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA54.14.
1. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Communicable diseases: Item 13.3 of the Agenda (continued)

Control of schistosomiasis (Resolution EB107.R12; Document A54/10)

Dr BODZONGO (representative of the Executive Board), introducing the item, recalled that Executive Board members had reviewed a report on control of schistosomiasis and soil-transmitted helminth infections, including the strategy and targets set in that regard by WHO. Those targets included the regular administration of chemotherapy to at least 75% of all school-age children at risk of morbidity by 2010 and access to essential anthelmintic drugs in health services in endemic areas, even at peripheral level, for the treatment of symptomatic cases and of children, women and other groups at risk of morbidity. The Board had commended the report and had approved by consensus the resolution contained in EB107.R12, which it recommended for adoption by the current Health Assembly.

Dr LARUELLE (Belgium), noting that the health effects of parasitic diseases had been eclipsed somewhat by other diseases, such as HIV, tuberculosis and malaria, said that he was pleased to note that the scope of the report had been broadened to cover other helminthiases. Belgium had a long tradition of providing treatment as part of its primary health care services for forgotten tropical diseases such as human African trypanosomiasis, schistosomiasis and other helminthiases. It welcomed the draft resolution, which not only drew attention to the scale of the problem of such infections but also called upon Member States and WHO to take steps to reduce their impact. Many countries had already achieved remarkable results in that regard, and simple measures relating to health education, prevention and treatment in populations at risk were required. It was important for such activities to be sustainable: they should be provided by countries’ health care services and be accessible to all. In that regard, his country would be organizing a colloquium on access to health care for all in the course of its presidency of the European Union, in collaboration with the Institute of Tropical Medicine and the city of Antwerp. He emphasized the importance of ensuring the quality of the drugs used, and of monitoring the possible build-up of resistance due to the widespread use of antiparasitic drugs.

He proposed that in the draft resolution under consideration the words “while monitoring drug quality and efficacy” should be added at the end of paragraph 2(1). Paragraph 2(2) should be amended to read “… for the treatment of clinical cases and groups at high risk of morbidity such as women and children, with the goal of …”. The words “and health education” should be added after “sanitation” in paragraph 2(3), and in paragraph 2(4) the words “national and international” should be inserted after “to mobilize”. In paragraph 3, the word “sustainable” should be inserted before “prevention”. Lastly, he suggested the inclusion of a new subparagraph after paragraph 4(2) to read “to continue to promote the strengthening of health systems and services as the basis of successful and sustainable disease control”.

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Dr ROMUALDEZ (Philippines) said that his country was pleased to have been mentioned in the report as one of the countries having achieved impressive results with regard to schistosomiasis. Indeed, in some communities in areas of high endemicity in his country, mass treatment programmes, and in particular the use of low-cost praziquantel, had led to a reduction of over 90% in incidence and prevalence. However, the disease was spreading into new areas as a result of climate change and development projects, resulting in new snail infestation, and there was a need for continued epidemiological vigilance. Further research and development were needed in order to design new measures for detection and prevention, including new diagnostic reagents and, possibly, vaccines. The health of individuals should be rated higher than the financial well-being of commercial institutions. He expressed support for the draft resolution as amended by Belgium.

Dr SILWAMBA (Zambia), noting that schistosomiasis was a significant public health problem in Zambia, said that, while he supported the use of chemotherapy as a significant tool in the fight against schistosomiasis, it was important not to lose sight of other equally important complementary tools such as vector control. Such measures would help to strengthen community participation and would be sustainable if carried out properly, together with other strategies such as the promotion of hygiene, water management and education.

His delegation urged WHO to advocate the use of traditional herbal preparations alongside western preparations for molluscicides and to encourage further research in that regard.

Dr MAHJOUR (Morocco) welcomed the attention that WHO was devoting to schistosomiasis, a disease that was continuing to pose serious health problems all over the world, especially in countries where a structured prevention programme had not been put into place early enough. However, other countries had brought about a significant reduction in the transmission of the disease with a view to its elimination.

The draft resolution, as amended by Belgium, was of particular importance as it would facilitate international action against the spread of the disease. The measures taken should depend on the epidemiological situation in each country; high-transmission countries should, with WHO's assistance, develop control measures targeted to their specific needs, whereas in countries where the prevalence was low strategies aimed at eliminating the disease should be implemented and more sensitive diagnostic tools should be used.

Morocco was in a position to overcome the problem after 20 years of efforts under a structured control programme and following adoption in 1994 of a strategy to eliminate infestation over 10 years. However, support, assistance and encouragement from WHO and national and international partners were needed more than ever. The remarkable progress made in eliminating schistosomiasis in some countries should serve to encourage the elimination of other parasitic diseases, including echinococcosis and soil-transmitted helminth infections which had a high prevalence in developing countries.

Dr YUNES (Brazil), having expressed support for the draft resolution, said that, despite important reductions in schistosomiasis-related morbidity and mortality, the disease was still widespread in the poorest regions of Brazil, where severe cases, such as hepatosplenic forms, had been recorded. Specific treatment of affected individuals had been applied as a control measure in Brazil since 1976, and there was evidence of the benefits of chemotherapy in mass treatment. However, control measures associated with improved access to safe water, sanitation and health education were more effective.

Mr ZHANG Li (China) welcomed the emphasis laid by WHO on the importance of factors other than medication in the prevention and treatment of schistosomiasis and other helminth diseases, such as social and economic development, health education and environmental improvement.

In China, there were many highly qualified experts and specialists in schistosomiasis and other helminth infections, and an international conference on schistosomiasis would be held in July 2001.
His country invited international experts and academics from regions where the prevalence of schistosomiasis was high to participate in that event, in order to promote exchanges of experience and enhance cooperation.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that schistosomiasis and soil-transmitted helminth infections constituted a major health problem in developing countries, and in particular for the most vulnerable populations in those countries. Although the basic strategy called for in the report was drug therapy, he emphasized the importance of other measures such as health education and environmental and personal hygiene in order to prevent recurrences of infection.

He expressed the hope that funds could be made available within the next decade to provide chemotherapy to 100%, rather than 75% of all school-age children and suggested that the draft resolution should be amended accordingly.

Dr ENDZANZA (Congo) welcomed the report and emphasized the need for concerted intersectoral action with regard to diagnosis, chemotherapy, environmental improvement and the provision of safe drinking-water and health education.

In his country, children were systematically screened for helminth diseases every two to three months and adults every six. Schistosomiasis had been highly prevalent in the south of the country; however, a specific prevention programme carried out in cooperation with the Government of Germany had made it possible to reduce the prevalence from 75% to 5% in seven years. Unfortunately, as a result of the armed conflicts in his country in the 1990s, the prevalence in most foci had risen to 60% and new centres of infection had been identified in other parts of the country. He appealed for assistance from WHO and other partners in implementing his Government’s post-conflict programme.

He suggested that the draft resolution should be amended by insertion in the third preambular paragraph of the word “intersectoral” before “control measures”. The words “supplemented by the simultaneous implementation of plans for improving the quality and supply of sufficient clean water and health education” should be added at the end of paragraph 1. Lastly, a new paragraph should be added along the following lines: “It is desirable to call upon the international community and multilateral institutions to give support to sanitation and safe water programmes, as well as taking into account the health aspects of agricultural development programmes and programmes to develop water resources in respect to the possible re-emergence of diseases”.

Dr RIAZANTSEV (Russian Federation) expressed support for the draft resolution. As a result of targeted efforts against helminthiases in his country, it had been possible to eliminate the foci of ankylostomiasis and strongyloidiasis and to reduce the prevalence of trichuriasis to isolated cases. There were many highly trained specialists in Russia with experience in control measures against helminthiases in various climatic zones. His country also had several effective, inexpensive and original antihelmintic remedies and would be willing to share its knowledge with interested countries and organizations.

Dr MAZONDE (Botswana) also endorsed the draft resolution as amended by Belgium. He pointed out that schistosomiasis and soil-transmitted helminthic diseases were often treatable with a single dose of inexpensive drugs, resulting in significant public health benefits. In the 1980s, over 80% of children attending primary school in the north-west of Botswana had been infested with intestinal schistosomes. As a result of a control programme supported by WHO and improvements in access to safe water and sanitation from the mid-1980s, the prevalence of infestation in that region had been reduced to less than 10% in the 1990s. However, when such successful results were achieved, resources were inevitably shifted to more pressing health problems, opening the possibility that low levels of infestation might remain and that the disease might recur should conditions change.

Botswana welcomed the renewed attention being paid to diseases that caused severe suffering in the developing countries, and urged the Health Assembly to ensure that sufficient resources were
provided to address them. Concerted public education efforts, improved surveillance and effective intersectoral collaboration with water and sanitation services were essential in order to achieve further public health gains. Although the major efforts were required in countries with high levels of transmission, it was important that countries where low levels of transmission had been attained should also receive adequate support in order to ensure that the gains achieved were not eroded over time, and to bring elimination one step closer.

Dr NOVOTNY (United States of America) agreed that schistosomiasis and soil-transmitted helminth infections were the most prevalent parasitic diseases in the world. The report pointed to the need to reduce the disease burden through regular treatment with single-dose anthelmintic drugs and drug intervention programmes. Population-based programmes to target schistosomiasis and hookworm disease should be inclusive enough to benefit long-term population health and improve birth outcomes. His delegation endorsed the Belgian delegate's comments in that regard.

To integrate schistosomiasis and intestinal helminth control efforts into programmes such as those on the integrated management of childhood illness, school health, onchocerciasis and lymphatic filariasis would require continuing operational research, and any studies required should be initiated promptly, with systems already developed so as to ensure programme integration. WHO and countries should also consider linkages to national drug policies and strategies, including improved distribution mechanisms. Sustainable access to antiparasitic drugs within a health care system was essential for school or community-based programmes, and the role of the private sector might be critical in ensuring that access. Although water and sanitation issues needed to be addressed, intervention in that area would be much costlier, and slower in effect, than mass chemotherapy, although it held promise for addressing infectious diseases as well as more complex development issues. His delegation supported the draft resolution.

Dr ADAM (Kenya) also welcomed the draft resolution. He proposed that the fifth preambular paragraph should be amended to read "Further recognizing that sanitation and safe water are essential and that ...", and that in paragraph 4(2) the word "programmes" should be added after the word "coordination".

Mr MAJORI (Italy) said that WHO's leadership had helped to ensure success in the control of schistosomiasis and soil-transmitted helminth infections in many parts of the world. He noted with interest that the report had been expanded to include the treatment of disease caused by food-borne helminths, which were prevalent in many countries. He joined in endorsing the draft resolution.

Mr DEBRUS (Germany) said that, although schistosomiasis could not compare with such global scourges as malaria, HIV/AIDS and tuberculosis, it did cause chronic disability in hundreds of thousands of people. Germany had been privileged to pioneer some of the modern population-based approaches, together with WHO and partner countries, and was ready to continue dialogue on the issue. His delegation supported the draft resolution.

Dr ENDO (Japan) said that, although schistosomiasis could not compare with such global scourges as malaria, HIV/AIDS and tuberculosis, it did cause chronic disability in hundreds of thousands of people. Germany had been privileged to pioneer some of the modern population-based approaches, together with WHO and partner countries, and was ready to continue dialogue on the issue. His delegation supported the draft resolution.

Dr EL SAYED (Egypt) also supported the draft resolution. Egypt had been one of the first countries to attempt to reduce the incidence rate of schistosomiasis in rural areas. Under a programme launched in 1997 aimed at protecting all population groups, including schoolchildren, in endemic
areas through mass treatment, efforts had been focused on sanitation as well as on vector control. A programme of biological control had been initiated in cooperation with the Ministry of Agriculture, as well as measures for the provision of clean water. The incidence of schistosomiasis had been reduced to 4.2%, and that of urinary-tract schistosomiasis in particular had fallen from 35% to 3% in the year 2000.

Mr NEZHIR (Mauritania) endorsed the draft resolution and proposed the addition of a new subparagraph to paragraph 2, requesting Member States to ensure that any development action that might lead to the outbreak or propagation of parasitic diseases should be accompanied by preventive action designed to limit its impact.

Miss ORNELAS LOERA (Mexico) said that her delegation was pleased that, for the first time in nearly 25 years, the Executive Board had recommended adoption of a resolution dealing specifically with the world’s most prevalent parasitic diseases. One aspect deserving special attention was the application of regular single-dose treatment, especially for school-age children, and the need to sustain effective control activities in low-transmission zones. The draft resolution was in line with internationally agreed control methods based on scientific evidence.

Professor BADIANE (Senegal) suggested that the method for rapid assessment of the prevalence of urinary-tract schistosomiasis, which had proved its worth on several occasions, should be adopted in operational plans to identify priority areas for intervention. He also suggested that the Bill & Melinda Gates Foundation should be approached with a view to securing additional funding to support activities to combat schistosomiasis.

Dr SADRIZADEH (Islamic Republic of Iran) said that schistosomiasis and soil-transmitted helminth diseases were a burden on hundreds of thousands of people throughout the world. Nevertheless, appropriate strategies were available in almost all affected countries which made control and even elimination feasible, and greater awareness and strengthened political commitment, intersectoral collaboration and financial support were required to enable them to be used. His country had already eliminated the transmission of schistosomiasis and looked forward to full implementation by other affected countries of the measures proposed in the draft resolution.

Dr TOUYÁ (Uruguay) said that schistosomiasis did not occur in his country. With regard to helminth infections, a national commission to combat hydatid disease had made significant progress in controlling infestation in humans and animals and, in coordination with the PAHO veterinary service, had contributed to an initiative for its elimination in the Southern Cone. With support from WHO, Uruguay was also working in its health and education sectors to prevent and control soil-transmitted helminth infections and disease in urban areas. His delegation supported the draft resolution.

Dr HEYMANN (Executive Director) said that WHO appreciated the renewed interest in hitherto-neglected diseases that caused high levels of chronic disability, such as schistosomiasis and intestinal parasites. The draft resolution, if adopted, would request countries to strive to reach at least 75% of school-age children with interventions: in some countries an even higher target had been set and he said that he looked forward to hearing of the results achieved. The draft resolution would also enable the Organization to move ahead with preparations for a large meeting on parasite control planned tentatively for 20 June 2001, representing a broad range of cross-sectoral partners including WFP, the World Bank, UNICEF, UNHCR and the Hashimoto Initiative. That partnership would facilitate coordination at global level and, more importantly, create a global environment in which partners at the national level could work together with governments. At the same time, it would permit WHO to work closely with UNDP and the World Bank in the context of the Special Programme for Research and Training in Tropical Diseases, which had been investing more funds in research on diagnostics for schistosomiasis.
Dr Fikri took the Chair.

Dr HOLCK (Secretary) read out the amendments proposed by Belgium, Cuba, Congo, Kenya and Mauritania to the draft resolution in the languages in which they had been proposed.

Dr NOVOTNY (United States of America) considered that the wording of the new subparagraph 4(3), proposed by Belgium, implied that the strengthening of health systems and services was a prerequisite for disease control, whereas in fact the treatment regimens already in place were much more cost-effective in helping to reduce morbidity. He would submit an alternative wording for that subparagraph.

Professor Ongeri took the Chair.

Dr MAHJOUR (Morocco) considered that insertion of the word “intersectoral” in the third preambular paragraph, as proposed by Congo, might restrict innovative activities in many countries where good results had been obtained despite lack of access to safe water and sanitation. In any case, the original wording, “control measures”, covered intersectoral measures.

Dr ENDZANZA (Congo) explained that the addition of the word “intersectoral” was intended to make clear that control measures would have to be taken in sectors other than the health sector.

Dr MAHJOUR (Morocco) again emphasized that the term “intersectoral” was too restrictive. Many countries had succeeded in eradicating the disease through action taken within the health sector alone, whereas “intersectoral” implied that access to safe water and sanitation was also needed before the disease could be eradicated.

Dr ENDZANZA (Congo) said that in the light of that comment he would withdraw his proposal.

Dr LARIVIÈRE (Canada) suggested that paragraph 3, as amended by Belgium, should be merged with the new paragraph proposed by Congo.

Dr LARUELLE (Belgium) suggested that, in order to overcome the objection raised by the United States of America, the wording of his proposed new subparagraph under paragraph 4 should be amended to read “to continue to promote the strengthening of health systems and services to ensure successful and sustainable disease control activities”.

Dr NOVOTNY (United States of America) proposed the formulation “to continue to promote the strengthening of health systems and services as an important component of successful and sustainable disease control”.

Dr HOLCK (Secretary) said that the English text of the new paragraph proposed by Congo would read “... to sanitation and safe water programmes as well as taking into account the health aspects of agricultural development programmes and programmes to develop water resources in respect to the possible re-emergence of diseases”.
Dr ENDZANZA (Congo) explained that the purpose of that addition was to emphasize the importance of including a health component in all development programmes. He supported Canada's proposal to merge the proposed new paragraph with paragraph 3.

The draft resolution, as amended, was approved.¹

2. FOURTH REPORT OF COMMITTEE A (Document A54/50)

Mrs POPESCU (Romania), Rapporteur, read out the draft fourth report of Committee A.

The report was adopted.²

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (resumed)

Smallpox eradication: temporary retention of variola virus stocks: Item 13.7 of the Agenda (Document A54/16)

Dr STAMPS (Zimbabwe) said that there was no logical reason for retaining variola virus stocks so long after smallpox had been eradicated in humans, unless the intention was to use them for biological warfare. As a country that had experienced that type of warfare at first hand, Zimbabwe was particularly concerned about the true objectives of current research with variola virus stocks, particularly since information about the smallpox virus was already well documented. He expressed the hope that the Executive Board would submit a resolution to the next Health Assembly calling for the elimination of variola virus stocks, so that they did not fall into the wrong hands.

Dr RIAZANTSEV (Russian Federation), noting that document A54/16 provided information on progress in variola virus research in his country and in the United States of America, outlined the main directions of research in the Russian Federation over the previous year and said that the preparation of the research programme and main projects and their approval by WHO were almost complete. Methods of culturing the virus, isolating and analysing DNA and determining antiviral activity had been standardized in the WHO collaborating centres in both countries. Human monoclonal antibodies had been developed that neutralized vaccinia virus. The entire primary structure of monkey pox virus (Zaire 1996 strain) had been described and compared with that of several strains of variola virus. All the safety-at-work recommendations of the WHO inspection team had been implemented.

The research had yielded interesting and promising results which deserved to be taken further. Unfortunately, however, for financial and other reasons, research into the variola virus had fallen considerably behind the schedule recommended by WHO and fixed by the national research programme. For instance, the project to develop sets of monoclonal antibodies for various types and strains of orthopoxviruses had not been completed; neither had the project to prepare an antigen standard for variola virus or the project to develop safe, new-generation vaccines against smallpox. Those projects were potentially of great practical value. His country was prepared to allow scientists from other countries to participate in the research, based at the WHO Collaborating Centre at Koltsovo, in order to speed up the work.

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA54.19.
² See page 305.
Mr KINGDON (Australia) said that the WHO Advisory Committee on Variola Virus Research had done an excellent job in systematically and comprehensively assessing the need for further research, if any, with a view to achieving consensus on the destruction of existing variola virus stocks. Australia supported that Committee’s recommendation that, although further limited research with such stocks could be justified, it should under no circumstances continue after 2002.

He noted with interest the finding of the antiviral activity of cidofovir, referred to in paragraph 16 of the report, which meant that other orthopoxviruses could be developed as surrogate models for antiviral drug testing after variola virus stocks had been destroyed. He also noted that, whereas the Advisory Committee was satisfied with progress achieved thus far, such progress had been slow. He said that he hoped that the agreed timetable for the destruction of stocks as soon as possible, and no later than 2002, would not be compromised as a result.

Resolution WHA52.10 had marked a significant achievement in obtaining consensus on the timing of the destruction of the remaining stocks. It would be most regrettable if that timetable, marking the final chapter in one of WHO’s greatest achievements—the eradication of smallpox—were not to be respected. Implementation of resolution WHA52.10 should continue to receive the priority it deserved.

Mr MAJORI (Italy) expressed appreciation of the report and the work done by the WHO Advisory Committee on Variola Virus Research. He was confident that that Committee would be in a position by the end of 2001 to submit appropriate recommendations so as to enable the Executive Board to take a final decision on the question of variola virus research.

Dr VAN ETTEN (Netherlands) asked for additional information on the procedures referred to in the last part of the second sentence of paragraph II of document A54/16.

Dr SADRIZADEH (Islamic Republic of Iran) fully supported the recommendation made by the WHO Advisory Committee on Variola Virus Research that retention of the existing variola virus stocks at the current locations should under no circumstances continue beyond the end of 2002. However, he was concerned about the possible threat of biological warfare. The fact that the smallpox virus could easily be spread required special attention for public health preparedness at the global level. To that end, in addition to the development of antiviral agents against variola virus, adequate facilities should be made available for the timely production of smallpox vaccines in all six WHO Regions.

Dr HEYMANN (Executive Director) said that he would provide clarification directly to the delegation of the Netherlands on the query it had raised. The Director-General had been engaged in consultations on the issue of global preparedness, and WHO would be issuing appropriate recommendations in due course.

The CHAIRMAN took it that the Committee wished to note the report contained in document A54/16, its comments having been noted by the Secretariat.

It was so agreed.

Health effects of depleted uranium: Item 13.10 of the Agenda (Documents A54/19 and A54/19 Add.1)

Dr MUBARAK (Iraq) recalled that weapons containing radioactive depleted uranium had been used against Iraq since 1990, with serious health consequences for the population. A clear link had been established between the use of such weapons and their toxic effects on the environment and human health. Iraq had set up a special committee to investigate the impact of the acts of hostility being perpetrated against it. It had asked for international cooperation on what was essentially a
humanitarian issue, particularly as it was one of the countries whose population had been worst affected by the use of depleted uranium. The incidences of genetic deformities, lung and breast cancers and leukaemia continued to rise in Iraq as a result of inhalation of chemical and radioactive products. Diseases never previously seen in Iraq had also begun to appear for the first time.

For years, Iraq had been trying to bring such matters to the attention of the specialized agencies, including WHO, so that appropriate action could be taken. Some progress had been achieved, and the holding of a meeting under United Nations auspices to address the underlying problem was a step forward. Since many countries were affected by the use of depleted uranium weapons, urgent measures should be taken to ban their use and manufacture.

In its cooperation with WHO, Iraq was trying neither to underestimate the threats and dangers posed by the use of depleted uranium weapons nor to act too hastily. It was important to identify the problems in as precise a manner as possible, through a system of health surveillance, the planning of health prevention measures and in-depth research into the link between depleted uranium use and disease. Iraqi scientists had discovered traces of depleted uranium in the patients they saw, and were willing to share their findings with the rest of the world, so that everybody could benefit from what they had learnt.

Countries using weapons containing depleted uranium should bear responsibility for their actions. In spite of the scientific evidence that Iraq had gathered proving a causal link between the use of such weapons and the incidence of diseases, the issue had not received the attention it deserved. More research should be carried out in a scientific and objective manner that avoided exploiting the issue for political ends. The problem did not affect Iraq alone; it was a concern for many other countries.

At the request of the CHAIRMAN, Dr MUBARAK concluded his intervention in order to respect the three-minute time limit, although he said that he had further information to provide on the health effects of exposure to depleted uranium.

Mrs RADIĆ (Yugoslavia) said that environmental degradation in some parts of her country had worsened over the previous 10 years, particularly after the bombing of large chemical complexes and power supply facilities in March-June 1999. The bombing had caused large-scale regional pollution, with swift and uncontrolled spread, spillover, evaporation and sublimation of enormous quantities of highly toxic substances, as well as full or incomplete combustion of inflammable substances. Enormous quantities of substances with carcinogenic, allergenic, teratogenic, mutagenic and other toxic effects on plants and animals had been released into the environment.

Depleted uranium ammunition had also been used. At the beginning of 2001, the Government had established a council to monitor the environmental and health consequences of the bombing, which would also deal with the issue of depleted uranium. The council would study the report by a UNEP mission in November 2000 on the use of depleted uranium against Yugoslavia (see document A54/19, paragraph 8).

Her country considered that WHO, in cooperation with Yugoslav institutions and experts, should take part in activities to monitor the possible consequences of the bombing on human health. The affected areas should be decontaminated as soon as possible. Her delegation had paid particular attention to the remarks by the Director-General about depleted uranium in her address to the Health Assembly (document A54/3). Financial and technical support from the international community would be required in view of the scope and complexity of the necessary decontamination activities. Her country would also need to evaluate the continuing pollution of the environment and develop environmentally sound methods of rehabilitating the main sources of pollution. Priority would be given to facilities in ecological "black spots" posing high-level risks.

Dr VIOLAKI-PARASKEVA (Greece), welcoming the reports before the Committee, said that more epidemiological and scientific research was needed to investigate the possible risk to human health of depleted uranium. A complete health risk assessment must be prepared covering the general
population, especially children. WHO must play a major part in that process in order to provide more scientific information about the preventive measures that should be taken.

Dr RIAZANTSEV (Russian Federation) said that no objective conclusions could be drawn from the contradictory information available from international organizations and the press on the risks associated with depleted uranium. He therefore supported the preparation of a review of the scientific literature by the Secretariat, as well as continued research on the potential health risks of depleted uranium; those activities, which should be financed principally from extrabudgetary resources, would allow an objective assessment of the potential risks. Recommendations could then be drawn up on health monitoring and preventive measures for people affected by exposure to depleted uranium.

An interdepartmental group of experts set up in his country to analyse the available information had concluded that the main health risk from depleted uranium was not radiation but the chemical toxicity of the element. Mortality rates from leukaemia and other cancers in people coming into contact with depleted uranium, or living close to factories which used it, were no higher than normal. Nevertheless, the Russian experts had agreed on the need for further national and international research on the effects on human health and the environment of a range of factors arising from the use of depleted uranium. He supported WHO's efforts and its cooperation with UNEP, IAEA and other international organizations. Russian experts were willing to participate in future missions to affected areas.

Dr TEE Ah Sian (Malaysia) welcomed WHO's cooperation with other international organizations in reviewing scientific studies on workers and military personnel exposed to uranium and depleted uranium (document A54/19, paragraph 6). She expressed the hope that the review would soon be completed. The monograph entitled "Depleted uranium: sources, exposure and health effects", summarized in document A54/19 Add.1, should be distributed to Member States.

Dr NOVOTNY (United States of America) commended WHO for its exhaustive work to identify health effects associated with the use of depleted uranium. The Organization's conclusions so far were consistent with the findings of research in his country: extensive scientific studies of the use of depleted uranium on the battlefield in the Gulf and the Balkans had shown no evidence of links with cancer, leukaemia or other ill-effects. People with the highest exposure to depleted uranium had been kept under medical surveillance but had shown no signs of adverse health effects related to that exposure. Similar conclusions had been reported by United Nations agencies and many scientific organizations.

He supported WHO's ongoing work on depleted uranium and the agreed agenda for further joint study with UNEP and IAEA to identify future needs. The planned radiological assessment should be the first step in deciding whether any study of health effects was warranted.

Mr KINGDON (Australia) welcomed WHO's contribution to general understanding of the degree of risk associated with depleted uranium. The Australian Defence Health Service and the Department of Veterans' Affairs were closely monitoring international research into the effects of depleted uranium. The Repatriation Medical Authority was conducting an independent assessment of the possible health implications.

In view of some of the claims made, it was important to ensure that global responses to the issue of depleted uranium were based not on allegations but on the best available evidence and scientific data. He commended WHO for taking the lead in sorting fact from fiction.

Mr YUSHKEVICH (Belarus) said that the issue of depleted uranium was a particularly sensitive one for his country, which had suffered most from the effects of the Chernobyl disaster. High radiation levels were already present in the environment as a result of nuclear testing and technological disasters, and the deliberate dispersal of yet more radioactive substances, whether depleted or not, into the soil and the air was a cause for concern and regret.
Activities to combat radiation pollution included studying the effects of radiation on human health, and he considered that such research should continue. His country had gained considerable experience of pollution with transuranic elements since the Chernobyl disaster. He suggested that Belarussian experts take part in the research on depleted uranium. Eliminating the after-effects of radiation pollution was an extremely expensive process. For instance, the official cost to Belarus alone of removing radioactive deposits after the Chernobyl disaster had been estimated at US$235 000 million. He therefore wondered where the necessary resources could be found for research into depleted uranium. It was not only the health sector that was interested in such research; he hoped that a financing mechanism could be found that would involve a large number of interested parties.

Ms SUNDREHAGEN (Norway) said that her country had taken seriously the reports on a possible association between the use of depleted uranium in ammunition and the development of disease. The health and safety of local populations in areas where depleted uranium ammunition had been used was a primary concern. Recent studies by WHO and other institutions had concluded that, on the basis of the evidence currently available, there was no causal link between exposure to depleted uranium and the illnesses suffered by the population or military personnel who had served in areas of conflict. Nevertheless, Norway supported scientifically justified studies in order to clarify the situation further. Her country would donate about US$100 000 to WHO's flash appeal of February 2001 for funds to support its investigations. Norway had begun medical examinations of its personnel who had served in the Balkans and would share the results of those studies with all interested parties when they became available.

Dr STAMPS (Zimbabwe) expressed concern that the issue of depleted uranium had not warranted a resolution by the Health Assembly. Instead, it was merely to be tacked on to other technical activities. He hoped that a draft resolution on the subject would be submitted to the next Health Assembly.

He was concerned about the cost of the research needed to determine whether the potential harm caused by depleted uranium was significant enough to justify clean-up operations of the kind referred to in the monograph summary (document A54/19 Add.1). There was evidence of a link between the use of depleted uranium and human cancers, especially those of the blood system; it was important to know whether it was a genuine link or merely a coincidence. The fact that no firm evidence had been found did not mean that there was no evidence to find. More research was urgently needed.

He regretted that the delegate of Iraq had not been given more time to speak, since his remarks had been of concern to all countries that might suffer violent invasion at some point in the future.

Dr LEFAIT-ROBIN (France) welcomed the summary of the WHO monograph on depleted uranium contained in document A54/19 Add.1. The document showed the gaps in the current state of knowledge and the need for more research to improve understanding of the issue. Her country supported WHO's recommendations and would provide funding for their implementation.

Mr DÜRLER (Switzerland) called upon WHO to continue its research on the health effects of depleted uranium and expressed his full support for the Organization's activities in that field. A Swiss expert had been seconded to WHO to work on the problem.

Mr RI Si Hong (Democratic People's Republic of Korea) welcomed WHO's activities on the problem of depleted uranium, but shared Zimbabwe's concern that no resolution was to be submitted to the Health Assembly. His country was concerned by the severe health risks faced by people exposed to depleted uranium in areas of conflict.

The use of depleted uranium for military purposes was unjustifiable. He called upon WHO to continue its research on the health effects of depleted uranium in areas of conflict, in collaboration with national authorities.
Mrs KERN (Executive Director) said that the full version of the monograph “Depleted uranium: sources, exposure and health effects” was available to delegates at the Health Assembly or from the Department for Protection of the human environment at WHO headquarters.

WHO would continue its cooperation with agencies such as UNEP and IAEA. A relatively small amount of regular budget resources had been allocated to environmental issues, including radiation, and research of the kind advocated by several delegates would require considerable extrabudgetary resources, which were not available at present. WHO was grateful for the assistance received from France, Norway and Switzerland. Member States could assist WHO in its activities in the field of depleted uranium by pledging resources and providing the names of professionals skilled in that field who could give advice.

Dr MUBARAK (Iraq) regretted that, because of the time limitation, he had been unable to complete his earlier intervention by providing data on the health effects of depleted uranium on the people of his country. More research was needed on ways of minimizing the effects of exposure to depleted uranium. He would provide any interested delegations with more information on the studies in Iraq.

The CHAIRMAN took it that the Committee wished to take note of the report on the health effects of depleted uranium contained in documents A54/19 and A54/19 Add.1.

It was so agreed.

The meeting rose at 12:45.

\* Document WHO/SDE/PHE/01.1.
TENTH MEETING (resumed¹)

Monday, 21 May 2001, at 16:40

Chairman: Professor S.K. ONGERI (Kenya)

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

International Classification of Functioning, Disability and Health (ICIDH-2): Item 13.9 of the Agenda (Resolution EB107.R15; Document A54/18)

Dr THIERS (representative of the Executive Board) said that the Executive Board had expressed support for the endorsement of ICIDH-2 as an international standard for reporting on health and disability to extend WHO's statistics to include aspects in addition to mortality. Given the major challenges facing all Member States in protecting and improving health, common standards for the classification of functioning, disability and health were indeed required. Through ICIDH-2, WHO would be fulfilling one of its basic constitutional functions: the development of international standards and classification. The Board had welcomed the extensive preparatory work and involvement of Member States in the revision of the classification. The five-year consultations, field trials and the series of ICIDH-2 revision meetings, including the final one held in Madrid in which official delegates of 49 countries had participated, had constituted a solid base and consensus. A draft resolution was being recommended to the Health Assembly by the Executive Board in resolution EB107.R15.

Mr KINGDON (Australia) expressed support for the draft resolution, with respect to both endorsement of the ICIDH-2 and the commitment to implementation and greater international collaboration on further improvement. WHO should continue to foster consultation and cooperation with countries on the use and further development of the Classification, including the elaboration of survey and other measurement methods. He also supported immediate publication of the Classification.

There had been considerable discussion about the most appropriate acronym for the Classification, for instance at a recent meeting of WHO collaborating centres on health classification held in Copenhagen. While the full title, International Classification of Functioning, Disability and Health, was accepted, its acronym – ICFDH – was somewhat clumsy. He therefore proposed that a new, shorter acronym be used – ICF. As a new acronym it would signal a clear departure from ICIDH, which, although a valuable development in its time, had been superseded by the new classification. ICIDH-2 was meaningless except to those closely involved in its development. The letter “F”, standing for “Function”, was a neutral umbrella term covering all aspects of human function and activity and was broader than, but encompassed, disability, which was the limitation of functioning owing to the consequences of a health condition. As a result, the letter “D”, standing for “Disability”, was not required in the acronym. Nor was “H”, “Health”, as the functioning of an individual was relevant only if related to a health condition. “ICF” followed the same format as the well-known acronym ICD for the International Classification of Diseases. The first ICIDH had been published solely for trial purposes; there was therefore no need for continuity. The second edition of the Classification was new and, like the ICD, would probably undergo many changes. It should therefore start out with a relevant and manageable acronym.

¹ For sections 1 and 2, see summary record of the seventh meeting of Committee B.
Mrs SINIRLIOGLU (Turkey) said that the report highlighted the specific need for a common language to collect information and undertake comparative analyses. ICIDH-2 would be an efficient tool for describing human functioning and disability, and she therefore supported adoption of the draft resolution.

Dr THORNE (United Kingdom of Great Britain and Northern Ireland) said that her country had been pleased to contribute to the revision of the Classification since 1997 through its WHO collaborating centre. Those in the United Kingdom familiar with the Classification strongly supported its endorsement as a means of providing a common approach to functional problems and outcomes and a broader picture of the longer-term needs of individuals with functional limitations, thereby enabling them to live optimally in the community. The document crossed the boundaries of health and social care. She recommended that the Classification should not remain static and stressed the need for it to keep pace with the changing needs and patterns of care worldwide. She supported the delegate of Australia's proposal for a new acronym to reflect the fundamental change in focus.

Professor RUCHA PHUPHAIBUL (Thailand) expressed appreciation of the report under discussion and support for the draft resolution. ICIDH-2 had been introduced to complement or supplement the International Classification of Diseases (ICD) system and reflected the convergence of medical and social models in classifying the consequences of health and illness. One of the objectives of the classification system was purportedly to provide basic scientific understanding and a universal language for health and health-related states to allow comparisons of data worldwide and a coding scheme for health information. Nevertheless, it was not clear whether the Classification would be one of the basic indicators for assessing health system performance. What steps would WHO take to ensure use of the Classification? The draft resolution recommended that use of ICIDH-2 should take into account the specific situations in Member States. However, as the Classification could be applied in a variety of sectors other than health, its users would be non-specific; that might compromise its successful use. She recommended that target users should be identified. Like many other countries, Thailand had found in using ICD-9 and ICD-10 that it was the users rather than the hardware that caused problems. Preparation of target users for ICIDH-2 was therefore essential, and lessons should be drawn from application of the ICD to ensure a successful outcome.

Dr RIAZANTSEV (Russian Federation) said that the ICIDH-2 would provide information on the 20% of the population in need of medical or social assistance, care and rehabilitation. A Russian language version of the Classification had been prepared; however, it would have to be adapted before it could be widely used in the health sector, which would take at least five years. In future, the Russian Federation would make available its data for international comparative studies on specific sectors of the population, as WHO introduced its corresponding systems of indicators. He endorsed international use of the Classification and the draft resolution.

Dr YUNES (Brazil) supported endorsement of the Classification, as recommended in the draft resolution. Following the extensive consultations and trials promoted by WHO, the present version of the Classification had reached a level of technical consensus that assured its quality and allowed its application by Member States in their research, surveillance and reporting. In Brazil, the Classification would be very useful as a framework for activities in areas including disabilities and health status, where there was a general lack of information. Since the Classification was comprehensive and allowed users to select a set of codes according to their needs, it could have many other applications beyond the health sector, including research, clinical medicine, surgery, information and statistics and policy-making. It therefore had the potential to result in the improvement of the health status of the world as a whole. Once endorsed, the Classification would be translated into Portuguese by the Brazilian Centre for Health Classification, to facilitate its use by Brazilian institutions and to allow for greater collaboration on possible future revisions. He endorsed the proposal by the delegate of Australia to change the acronym to “ICF”.
Mr MAJORI (Italy) expressed full support for the draft resolution, for publication of the Classification and for its wide use in research, surveillance and reporting. He also endorsed the proposal to change the acronym.

Ms VALDEZ (United States of America) expressed support for efforts to achieve greater comparability in international health statistics and her country’s commitment to participating with WHO and other Member States in developing and improving methods and data sources to that end. She commended WHO on the successful revision of ICIDH-2, which should be published as a valuable tool for classifying functioning, disability and health with multiple applications. Nonetheless, the ICIDH-2 approach covered only a portion of the information necessary for a broad and meaningful picture of health. Functioning at a given time was not the only issue at stake, and thus a subset of domains derived from the ICIDH-2 would not suffice to describe health status. Additional information on risk factors, disease prevalence and the causes of injuries and diminished functioning was crucial for framing policy and taking action at international, national and local levels. Consultation had been an integral part of the process, and WHO had worked hard through its collaborating centres and with other experts in the development of ICIDH-2. The United States was ready to cooperate in future updates and revisions. She endorsed the draft resolution and the proposal to change the acronym.

Mr ZHANG Li (China) said that, in order to adjust to changes in disease models and the general acceptance of the three-dimensional concept of health, publication and implementation of the Classification were required, so that Member States and regions could establish relevant data collection systems. ICIDH-2 would provide practical guidance for measuring and reporting on global health trends. China was ready to share its experience of applying the ICD but looked to WHO for technical guidance on the broader application of ICIDH-2. In that connection, WHO’s assistance in drafting guidelines, organizing workshops and training would be found particularly useful by Member States.

Dr VAN ETTEN (Netherlands) strongly endorsed ICIDH-2, to which various institutions in the Netherlands had contributed. He also endorsed the draft resolution and the proposal of the delegate of Australia for a new acronym.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the Classification was a good attempt to provide a coherent version of the various dimensions of health from the biological, psychological and social standpoints. The approach, in particular its gender-based aspects, must be validated in practice. He endorsed the Classification and proposed that a programme be set up for its application to and validation by a larger sector of the population worldwide.

Mrs NIELSEN (Denmark) commended the results of the work done by WHO and all the experts involved in developing the Classification, and endorsed the draft resolution. It was important to implement the Classification without delay. She supported the proposal to use the short acronym ICF, on the understanding that it did not affect the substance or full title of the Classification.

Dr LARIVIERE (Canada) expressed support for the draft resolution, the use of the Classification and the proposed change of acronym.

Mr EINARSSON (Iceland) said that his country had been following the work on revision of the Classification closely, including the extensive field testing, which had had broad participation by WHO Member States. He considered the new Classification to be a very useful instrument and therefore endorsed the draft resolution as well as the proposal to use “ICF” as the acronym.
Dr LEFAIT-ROBIN (France) reiterated the reservation expressed by the member from France during the 107th session of the Executive Board in January 2001 to the effect that the Classification was not a descriptive tool for health status intended to provide a clear operational definition of health. While she would not oppose the draft resolution, she requested that a proper evaluation of the use of the new Classification be started as soon after its initiation as possible.

Dr DONAYRE VALLE (Peru) said that his country had cooperated in the revision of the first edition of the Classification together with most of the Latin American countries and Spain. That had resulted in a great demand for the tool, which had been found useful for monitoring functioning and disability and had provided a common language for reporting and policy promotion. Peru had been using the first edition of the Classification since 1992, on the basis of which the National Rehabilitation Institute had developed a disability statistic information module, in use since 1998, as well as an official disability certificate, issued the previous year. For those reasons, Peru considered it important for the Health Assembly to adopt and recommend use of the second edition of the Classification, which would provide other indicators of the quality of life and life expectancy of the disabled and of other sectors of the population. He therefore endorsed the draft resolution.

Ms MERCER MOORE (World Confederation for Physical Therapy), speaking at the invitation of the CHAIRMAN, said that the organization for which she spoke grouped together 83 national professional associations representing over 250,000 physical therapists and physiotherapists from all WHO regions. The revised ICIDH could make an invaluable contribution to the development of rehabilitation policy and services and the education of rehabilitation professionals. Through the implicit inclusion of the environment as a critical determinant in disability and a focus on individual problems, the Classification had moved from a disease model of care to allow identification of the resources needed for long-term health and social care. The involvement of disabled people, and of physical therapists and other health care professionals, at the testing and at the strategic level in WHO collaborating centres had ensured their commitment to implementation; attention had also been paid to cultural issues. As a conceptual model, the Classification was already being introduced into professional curricula and used as a model for structuring information needs and research initiatives. The next challenge was to ensure that the revised Classification was used systematically and could be reliably coded. Further national and international development of training tools to suit different user communities was also needed. Successful implementation of the ICIDH and its continuing relevance would require an agreed plan, and her organization looked forward to working with WHO at all levels in making the Classification a dynamic and useful tool for policy, planning and practice.

Dr THIERS (representative of the Executive Board) welcomed the suggestion of the delegate of Australia to adopt a simpler acronym for the Classification than that set out in the text.

Dr MURRAY (Executive Director) thanked the many Member States who had contributed to the revision of the Classification and welcomed the offer of the delegation of Brazil to translate the text into Portuguese. He had noted the many requests for plans to support implementation of the revised Classification. Training manuals had been developed on how to use ICIDH-2, work was under way on clinical assessment guides and a website had been set up to support implementation. The comments made by the delegates of Thailand and other Member States in regard to the multiple audiences for ICIDH-2 would be taken into consideration in the plans for support and implementation. Referring again to the comments made by the delegate of Thailand, he noted the implications of the revised Classification for the broader work on health statistics and health data assessment. He looked to Member States for guidance concerning the acronym proposed by the delegate of Australia.

Dr LARIVIÈRE (Canada) suggested that, in the draft resolution being recommended to the Health Assembly, the phrase “henceforth referred to as ICF” be added in paragraph 1, after the full name of the Classification, with consequential modification of the acronym in the subsequent paragraphs 2 and 3.

Mr KINGDON (Australia) welcomed that suggestion and asked that the amended wording in paragraph 1 also include “in short”, to ensure that the full title was not lost, in accordance with the expressed wishes of some delegations.

Miss ORNELAS LOERA (Mexico) asked that the acronym in Spanish should be “CIF”.

It was agreed that the acronym in the Spanish and French languages should be “CIF”.

The CHAIRMAN asked the Committee if it accepted the draft resolution, as amended.

There being no objections, the draft resolution, as amended, was approved.¹

(For continuation of discussion of Technical and health matters, see summary record of seventh meeting of Committee B, section 4).

The meeting rose at 17:20.

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA54.21.
1. **FIFTH REPORT OF COMMITTEE A (Document A54/51)**

Mrs POPEȘCU (Romania), Rapporteur, read out the draft fifth report of Committee A. She drew attention to the need for minor editorial corrections in relation to the resolution on the International Classification of Functioning, Disability and Health to align the different language versions. In addition, in paragraph 1 of the English version of the draft resolution on schistosomiasis and soil-transmitted helminth infections, the word “completed” should be replaced by “complemented” and in paragraph 2(4) “parasite” should be replaced by “parasitic”.

The report was adopted as amended.1

2. **CLOSURE**

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 9:45.

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1 See page 306.
COMMITTEE B

FIRST MEETING

Wednesday, 16 May 2001, at 16:30

Chairman: Mr D.A. GUNNARSSON (Iceland)

1. OPENING OF THE COMMITTEE: Item 14 of the Agenda (Document A/54/41)

The CHAIRMAN expressed gratitude for his election and welcomed all those present. In order to deal satisfactorily with the many important issues on the agenda, goodwill and cooperation would be required on the part of all Committee members. He was confident that all interventions would be made with the sole aim of improving the work of the Organization. He drew the Committee's attention to the third report of the Committee on Nominations (document A54/41) in which Dr M. Dahl-Regis (Bahamas) and Dr Pakdee Pothisiri (Thailand) were nominated for the offices of Vice-Chairmen of Committee B, and Dr J.M. Kunene (Swaziland) was nominated as Rapporteur.

Decision: Committee B elected Dr M. Dahl-Regis (Bahamas) and Dr Pakdee Pothisiri (Thailand) as Vice-Chairmen and Dr J.M. Kunene (Swaziland) as Rapporteur. 2

2. ORGANIZATION OF WORK

The CHAIRMAN recalled that the role of representatives of the Executive Board was to convey to the Health Assembly the views expressed by the Board on items it had dealt with, and to explain the rationale behind any recommendations for the Health Assembly's consideration. Should the Committee debate those items, the Board's representatives were free to respond to any points raised whenever they felt that clarification of the position taken was required.

He drew the delegates' attention to document EB107/2001/REC/1, which contained the resolutions and decisions adopted by the Board in January 2001 and to which frequent reference would be made. He suggested that the Committee should meet from 9:00 until 12:30 and from 14:30 until 17:30, and he urged speakers to restrict the length of their interventions to no more than three or four minutes.

It was so agreed.

1 See page 303.
2 Decision WHA54(4).
3. **STAFFING MATTERS: Item 16 of the Agenda**

**Human resources: annual report: Item 16.1 of the Agenda (Document A54/28)**

The CHAIRMAN drew the delegates' attention to document A54/28 and asked Mrs Abel, on behalf of the Board, to inform the Committee of the discussion that had taken place on that item during the Board's session in January 2001.

Mrs ABEL (representative of the Executive Board) said that the Board had reacted positively to the second, more complete, annual report on the Organization's staffing profile, for the year 2000, which contained data on the overall situation and inherent costs, distribution of staff by sex, geographical representation, age and length of service, and on staff members holding short-term contracts. In response to requests from Member States and others, following presentation of the first report (document A53/23), information had also been provided on the distribution of the workforce across occupational groups, turnover statistics, external recruitment and internal reassignments and national professional officers. The data on occupational groups concerned posts and not staff competences. A solid information management system would nevertheless be established in order to make data on staff competences and professional qualifications more easily accessible and to enable the Organization to ensure that all occupations were equitably represented.

Ms VAN GINNIKEN (Netherlands), welcoming the attention given by the Director-General to human resource reform, said that she shared the Director-General's concern about the position of staff on short-term contracts, and expressed the hope that the issue would be thoroughly addressed in the human resources reform process.

Dr STAMPS (Zimbabwe) expressed concern at the slow progress towards gender parity in the distribution of staff in WHO. The representation of women among professionals had risen only 6% over the past six years. More rapid progress was needed in reducing discrimination against women.

Referring to Table 13 in the document, he suggested that the designation under category 1.P be reworded. He questioned the logic of geographical representation: some countries paid eight times as much as others but received the same allocation. He also drew attention to the continuing trend of appointing persons of European and specifically English-speaking origin to posts that dealt with the determination of policy and implementation. Health problems were largely concentrated in the developing world, particularly in Africa. He suggested that it was not possible to develop appropriate programmes or policies without representation from the areas the Organization purported to support.

Mr CHERNIKOV (Russian Federation), recognizing the responsible implementation of the resolutions adopted by the governing bodies, expressed his satisfaction regarding many elements of the current staff policy, in particular the moratorium on permanent contracts. It was necessary to continue the moratorium and eliminate so-called "career service appointments". He expressed the hope that further improvements of the system of human resources management would be suggested before the Executive Board began discussion of that subject at its January 2002 session. He pointed out that restructuring operations in organizations demanded investment. However, in view of the experience of other organizations, he could not support restructuring for its own sake and investments that did not yield concrete results.

Mr MAJORI (Italy), noting an increased percentage of women in the Organization, emphasized the need for improvement also in the levels of their appointment and their career development opportunities within the Organization.

As far as geographical representation was concerned, the desirable ranges had still not been reached, and there were still too many countries that were either under-represented or unrepresented and a high number of over-represented countries. Staff with an Anglo-Saxon background accounted...
for a large proportion of WHO staff members. While not denying their competence and skills, he suggested that other cultural backgrounds should be equally represented. Italy was still under-represented in WHO despite having good technical human resources that matched the staff profiles required. Steps should therefore be taken to improve recruitment procedures in the Organization so as to enhance the career development opportunities of potential candidates.

The very high number of short-term contracts issued in the past year had undoubtedly contributed to difficult working conditions in the Organization. Staff development and career management had failed to reach the expected quality level. Special efforts were therefore needed to ensure that all staff, and more particularly women, had a supportive working environment to enable them to perform their duties to the best of their ability. His delegation strongly supported the idea of individual development plans linked to individual performance assessment and of training to upgrade technical skills.

Ms FELIU ESCALONA (Cuba), referring to the need to achieve a staffing balance among occupational groups, expressed concern that the proportion of nurses appeared to have declined to only 2.9% of professional posts. That was not in accordance with the resolutions requesting Member States to recruit more nurses in the ministries and at professional levels. Neither was that position consistent with Member States' need for nursing advisory services, bearing in mind that nurses were the largest professional and technical group in the health services. Efforts should therefore be made to improve that situation in order to meet the expectations of Member States, many of whose populations lacked proper medical services or relied solely on nursing skills.

Mr TASAKA (Japan) emphasized the usefulness of information on human resources in WHO, such as was provided in the current and previous reports. Although the importance of equitable geographical representation had been underlined by Health Assemblies for the past two decades, and efforts had been made to improve the situation, many countries were still under-represented or unrepresented. He urged WHO to prepare a practical plan based on its report and to redouble its efforts to ensure that the representation of all Member States came within the appropriate ranges.

Mr VOIGTLÄNDER (Germany) welcomed the in-depth analysis of human resources in WHO. Unfortunately, as Table 3 showed, the position of many countries remained unsatisfactory: they were still either under-represented or unrepresented, including Germany, despite its efforts to improve its position. In view of the lack of substantial improvement over the years and the Organization's failure to comply with its own resolutions, every effort should be made in future to ensure that Member States were brought as close as possible to their desirable ranges. He warned that the sharp increase in the number of short-term contracts to offset the continued decline in the number of staff members holding long-term appointments might not ultimately be in the interests of the Organization. Experience and continuity were invaluable and the Organization needed to ensure that the right balance between short-term and longer-term appointments was maintained.

Dr SHANGULA (Namibia), referring to paragraph 10 of document A54/28, relating to geographical representation, pointed out that Namibia had only one member of staff in the whole of WHO. He therefore requested that Namibia be included under the column headed “Under-represented countries” in Table 3 on page 8. From Table 5 on page 19, it could be seen that the representation of professional staff from the African Region, the South-East Asia Region and the Eastern Mediterranean Region at headquarters was inadequate. A deliberate effort was needed to rectify that situation.

Mr MACPHEE (Canada), acknowledging the remarks made by previous speakers on the subject, said that, although some progress had been made in achieving a more equitable geographical representation, it was necessary to maintain that momentum. There had also been a modest increase in the percentage of women in the professional category, although the ultimate goal sought by Canada was gender parity in WHO, in line with the policy on the advancement of women that had been
adopted by the executive heads of all the United Nations specialized agencies. Canada also supported
the Director-General's call for countries to propose more women candidates to serve on
intergovernmental and expert bodies, as well as taking positions in the Organization. Although the
data on the distribution of posts were welcome, the low representation of nurses was a cause of
concern, as had been mentioned by the delegate of Cuba. Ultimately, WHO would only be able to
fulfil its mandate if it were able to draw upon a human resource base equal to that of the best managed
public and private organizations. Canada proffered its full support in the achievement of that end.

Dr TSHABALALA-MSIMANG (South Africa), referring to Table 3, noted that most of the
unrepresented or under-represented countries were developing countries, including South Africa.
WHO needed, as a matter of urgency, to devise a practical strategy and plan for addressing the issue,
which should be placed on the agenda at the Fifty-fifth World Health Assembly. There must be
genuine representation for developing countries and for women in those countries. Like previous
speakers, she regretted the slow progress in achieving gender parity. However, rather than merely
counting heads, it was more useful to look at the level at which women were working and to ensure
that there were adequate support systems in place to allow them to reach their full potential. Genuine
representation included the occupation of senior decision-making posts by women.

Another issue she would like to see discussed during the Fifty-fifth World Health Assembly was
the need to ensure that experts on development issues had real, first-hand experience of the
circumstances in which people, including women, in developing countries lived and worked.

The meeting rose at 17:20.
SECOND MEETING

Thursday, 17 May 2001, at 09:00

Chairman: Mr D.A. GUNNARSSON (Iceland)

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

Human resources: annual report: Item 16.1 of the Agenda (Document A54/28) (continued)

Mr BRODRICK (Australia) agreed that the report provided an invaluable picture of human resources within WHO and that congruence with the data relating to the programme budget cycle was particularly useful. Endorsing the Director-General’s efforts, he none the less echoed concerns regarding the continuing imbalance in gender distribution, a matter which still needed to be addressed.

Professor MASLIN (United Kingdom of Great Britain and Northern Ireland) emphasized the contribution that nurses and midwives made to health care, especially mental health and HIV/AIDS. However, the report on strengthening health services delivery (document A54/11) had stated that nursing and midwifery skills were put to limited use despite proven cost-effectiveness. Experience in the United Kingdom had shown that strong leadership was central in ensuring that nurses and midwives made an optimum contribution to health care. In allocating its budget, WHO must ask itself whether the nursing and midwifery allocation was sufficient to allow such professionals to contribute effectively to achieving WHO’s strategic objectives.

Ms CALLANGAN-RUECA (Philippines) applauded the Organization’s efforts to increase the number of female staff but wanted further progress towards parity. It would be desirable for staff on short-term contracts to move into longer-term employment, particularly if they had the necessary qualifications and skills. Employees were a prime asset and training to upgrade skills was valuable.

Dr KINGMA (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed the expansion of the report to address the concerns of delegates to the previous year’s Health Assembly. However, its figures showed inadequate and decreasing access to nursing expertise throughout the Organization: only 1.2% of all professional staff were nurses, as against 3.2% in 1992 and 1.6% in 1996. Such percentages bore no relation to the needs and realities of health systems worldwide. The absence of nursing expertise in technical and professional positions weakened WHO’s mandate to strengthen nursing and midwifery services. For years, calls to do so had gone unheeded. Once again, a resolution before the Health Assembly recognized the importance of nursing and urged Member States to increase the involvement of nurses and midwives in policy-making and planning, yet it was evident to nurses worldwide that such recommendations were not applied. That double message hampered efforts to reduce the global shortage of nurses. The International Council of Nurses was prepared to work with WHO. She asked what immediate measures WHO would take to strengthen the contribution of nurses.

In reply, Mrs STEWARD-GOFFMAN (Human resources services) said that feedback was invaluable. For example, Table 13 (Distribution of posts across main occupational groups) of document A54/28, based on a scheme adopted at common system level, had been added in response to requests from delegates. Some specialized jobs did not fit neatly into that scheme but she assured the delegate of Zimbabwe that the people in such jobs had their place in the Organization. The scheme
endeavoured to show jobs classified by a commonly understood coding; it did not represent the skills available in the workforce. As part of a broader approach, collection of data on such skills was planned. Discussions were being held to facilitate access of nurses and midwives to the workforce. Responding to the delegate of Namibia, she noted that "adequately represented" meant falling within the established range. Accepting that the word "adequate" might imply a value judgement, she agreed that the terminology needed to be reviewed. Geographical representation was calculated by means of a standard formula that took account of the scale of assessment, population size and gross national product. WHO was committed to achieving both geographical balance and gender parity, and was working on practical strategies to those ends. However, the issues were complex and a simplistic consideration of numbers would be unproductive. She agreed with the delegate of South Africa that the qualitative aspects of the recruitment and retention of staff also were important, and, in order to address some of those aspects, a pilot mentoring project had recently been introduced at headquarters. Turning to the point made by the delegate of the Netherlands, she said that human resources reform was being followed up at the highest levels in WHO. Progress had been reported to the Executive Board earlier in the year. In reply to the many comments on the employment of short-term staff, she noted that devising a contractual package based on a balanced mix of employment arrangements was a priority.

The Committee took note of the report.

Amendments to the Staff Regulations and Staff Rules: Item 16.2 of the Agenda (Document EB107/2001/REC/1, Annexes 3, 4 and 5)

Mrs ABEL (representative of the Executive Board), noting that the United Nations General Assembly had approved, with effect from 1 March 2001, a revised salary scale for professional and higher categories incorporating post adjustment into the salary scale, said that the Executive Board had recommended to the Fifty-fourth World Health Assembly a modification in the salaries of staff in ungraded posts which also implied an adjustment to the salary of the Director-General.

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB107.R10.

The draft resolution was approved.¹


The Committee noted the report.

Appointment of representatives to the WHO Staff Pension Committee: Item 16.4 of the Agenda (Document A54/30)

Mr CHAKALISA (Botswana) pointed out that Dr Mulwa, listed as an alternate in the second paragraph of the document, had retired from public service. He therefore queried his eligibility.

Mr MANI (Executive Director ad interim) offered to discuss the matter with Botswana later.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA54.3.
The CHAIRMAN proposed that discussion of the item be kept open.

It was so decided.

(For resumption of discussion, see section 4.)

2. **COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS**: Item 18 of the Agenda (Documents A54/32 and A54/32 Add.1)

Mrs ABEL (representative of the Executive Board) said that the Board, at its session in January 2001, had reviewed the reports by the Secretariat on collaboration within the United Nations system and with other intergovernmental organizations, and had noted the extensive and increased cooperation with a range of partners. That would enable WHO to improve its technical advice and services to countries, ranging from access to care and drugs and the Global Alliance for Vaccines and Immunization (GAVI) to important partnerships on Roll Back Malaria and AIDS. WHO had also increased its cooperation with a broad range of development partners, with the aim of intensifying efforts to target the main health problems affecting the poorest communities. The reports had presented only items deemed to be of immediate interest to the Executive Board, such as the newly expanded cooperation with the European Union; a more detailed report was contained in document A54/32 for consideration by the Health Assembly.

Ms VAN GINNIKEN (Netherlands) welcomed the report and the numerous collaboration projects to which it referred, in particular, GAVI, the Stop TB Initiative, Roll Back Malaria and the fight against AIDS. Her country hoped that WHO's openness might serve as an example to other organizations.

Mrs KARKKAINEN (European Commission) outlined the longstanding cooperation between the European Commission and WHO, which had been based on two exchanges of letters, the first between the Commission and the WHO Regional Committee for Europe in 1972, and the second between the Commission and WHO in 1982. A further exchange of letters and a memorandum of understanding, signed in December 2000, aimed to consolidate and intensify that cooperation. Areas of concern included the surveillance of communicable diseases, action to reduce tobacco consumption, including progress on the framework convention on tobacco control, mental illness, health threats from the environment, providing better information on health risks, guiding applicant countries to the European Union in tackling their major health problems, and finally, the development of synergistic activities in new areas, such as health telematics.

Following the latest exchange of letters, officials from both organizations had begun holding regular meetings. They were proving to be a useful forum and also provided a setting for discussions about priority areas for collaborative work in the near future. The main topics included communicable diseases, including revision of the International Health Regulations, access to medicines, mental health, human rights, antimicrobial resistance and tobacco. In April 2001, Commissioner Byrne had met with the Director-General in Geneva. The intention was that they would hold annual meetings, in addition to those of high-level officials.

Mr DÜRLER (Switzerland) voiced the concern of his delegation about alleged difficulties in cooperation between WHO and IAEA. Not only nongovernmental organizations but also Swiss members of parliament had criticized the relationship between the two organizations. He urged WHO to provide clarification in regard to those allegations. There had been calls to amend the agreement between WHO and IAEA, but he said that he did not consider revision necessary for the time being.
Other ways might be found to improve the current situation. The matter should be dealt with urgently and he asked the Director-General to report to Member States on the issue as soon as possible. It would enhance WHO’s image to address the health consequences of radiation, thereby helping governments to adopt appropriate measures and contributing to developing an objective public opinion on that question.

Dr LARIVIERE (Canada) supported the statement made by the delegate of Switzerland and said that his delegation wanted improved collaboration between WHO and IAEA. He was aware that there had been some criticism of their joint activities, but in his view the differences stemmed from personality conflicts or misunderstandings, rather than from difficulties encountered in implementing the 1959 agreement. His delegation would not be in favour of reconsidering that agreement, which had served both organizations well to date, but it would welcome an examination conducted by their respective executive heads, so as to improve relations between the two organizations.

Dr HANSSEN (Norway) agreed with the comments made by the delegate of Switzerland and asked for a written report on cooperation between WHO and IAEA.

Mrs KERN (Executive Director), replying to the debate, said that WHO was aware of the concern expressed by some nongovernmental organizations. Discussions were being held with delegations on the issue of relations between WHO and IAEA. The Director-General was happy to comply with the request to examine the issues.

The Committee noted the report.

The CHAIRMAN invited the Committee to consider the report on health emergencies contained in document A54/32 Add.1.

Mr CASTRO GRANDE (El Salvador) warmly thanked WHO for the emergency aid provided to his country after the major earthquake earlier in the year. The speedy assistance had constituted an excellent example of cooperation between various international organizations. He hoped that El Salvador would also be able to count on further help during the reconstruction phase.

Mr HUSSAIN (Pakistan) expressed concern regarding the situation in Afghanistan. He noted that the United Nations interagency appeal for Afghanistan for the year 2001 had earmarked US$ 250 million at the beginning of the year, which had then been revised to US$ 254 million because of increased needs and deterioration of the situation. He asked what contribution WHO had made in response to that appeal, which, according to figures available to his delegation, had been funded only up to 35% of the amount required. Reports by international relief agencies and nongovernmental organizations had referred to widespread famine and starvation and to the possibility of a serious outbreak of disease. The emergency had not only affected the Afghan people directly but had also had implications for neighbouring countries. Pakistan had received 170 000 Afghan refugees in recent months and the position was comparable in other countries in the region. Moreover, there was a risk of epidemic disease not only within Afghanistan but also in the refugee camps in Pakistan. He asked for a detailed account of WHO activities to date in that connection and an assurance that the Organization would actively address the situation in the region.

Dr SOMBIE (Burkina Faso) expressed appreciation of the cooperation between WHO and other organizations, and also of the cooperation with his own country, where WHO had been the lead agency in the partnership for health development. During the recent meningitis epidemic in Burkina Faso WHO had acted as the coordinating agency for assistance from other countries and organizations. He suggested that such collaboration should be decentralized as far as possible and thanked WHO for its ongoing support.
Mr MUHINDA (Uganda) thanked WHO for its rapid response with both logistical and personnel support to the outbreak of Ebola haemorrhagic fever in Uganda. He indicated that the death toll would have been more devastating without WHO’s intervention.

Mr BERMEJO (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that all emergencies, and health emergencies in particular, required responses from many participants working together across institutional and organizational boundaries. The necessary coordination was by no means easy and the Federation (IFRC) was proud to contribute to those efforts. As an international organization outside the United Nations system, IFRC participated in many established mechanisms for cooperation and coordination of response in health emergencies such as the Interagency Standing Committee. It saw further collaboration through those and other means as the way forward in assuring that emergency responses were adequately planned, implemented and monitored.

By way of example, he said that IFRC was participating with WHO, UNICEF and Médecins sans frontières in the international coordinating group on meningitis which dealt with epidemic outbreaks and vaccine supply. An emergency programme had been set up in which national societies carried out social mobilization and awareness campaigns. Vaccines had been provided to Ethiopia and further such activities were planned for West Africa, in particular Benin, Burkina Faso and Niger. Another example was IFRC’s work with WHO, UNICEF and a number of nongovernmental organizations towards the target of eradicating poliomyelitis by the year 2005, with a focus on countries where the target population was considered hard to reach operationally. In 2000, IFRC had trained 40,000 volunteers for poliomyelitis-related work and planned to train a further 80,000 volunteers during the current year, the United Nations International Year of Volunteers, for the same purpose. They were working, for example, throughout Afghanistan and in Iraq where the involvement of the Iraqi Red Crescent Society on the national immunization day had led to a request that IFRC would extend its activities to all 18 governorates.

IFRC welcomed the trend in recent years toward greater cooperation between it, its national societies and other organizations with specialized capacities and interests in order to reach out to the most vulnerable, and would work to ensure that such cooperation became a useful way for the delivery of assistance in health emergencies.

Turning to more institutional forms of cooperation, he mentioned the linkages between IFRC and the United Nations Disaster Assessment and Coordination (UNDAC) teams. IFRC, which had its own mechanism for the assessment and early management of disaster assistance, had a less cumbersome decision-making process than any United Nations body could have, and could therefore sometimes reach a stricken area before the UNDAC teams. That ability to support the United Nations and to help to pave the way for subsequent assistance provided by other larger agencies seemed an excellent basis for cooperation. He also referred to the Interagency Coordinating Committee for monitoring of and response to communicable diseases in the newly independent States of the former Soviet Union, which was based at the WHO Regional Office for Europe and currently chaired by IFRC. The International Federation recognized that that was an important function, particularly in relation to its own work in dealing with measles outbreaks in countries such as Albania and Romania and in planning for similar work in Kyrgyzstan. Such activities also provided a major opportunity for developing the role of the national societies in countries of the former Soviet Union in dealing with tuberculosis.

He assured WHO that IFRC looked forward to strengthening the already-good relationship directly, and in the setting of other coordination bodies.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) thanked the delegate of Pakistan for his observations regarding Afghanistan. Large numbers of refugees had sought refuge in Pakistan, whereas, previously, refugees who had been there for many years had begun to return. WHO was the only organization of the United Nations system that had offices in almost all the major areas.
of Afghanistan. These offices had been actively participating in every aspect of health including activities not normally in the domain of WHO, such as the supply of safe water in certain areas.

As part of its collaboration with the United Nations, WHO had been participating in a common appeal which had not, unfortunately, been favoured by many of the donors, and it was true to say that the amount received - or even pledged - had been not more than 35% of the amount needed. He appealed to the donor countries to ensure that basic health services, including food for Afghanistan, and especially for the refugees, would be provided by increasing the amount of money given. He hoped that WHO could actively participate in those efforts, but pointed out that Afghanistan was receiving one of the largest shares of the regular budget which was the maximum that could be provided.

Additional money was urgently needed in order to face the difficult situation in Afghanistan; there had been several outbreaks of cholera, which had been contained by improving the supply of safe water in most areas, as well as outbreaks of other disease.

Mrs KERN (Executive Director) endorsed the comments of the Regional Director for the Eastern Mediterranean, and indicated that WHO had received financing from Italy, Japan and Norway. She drew attention to the fact that WHO focused on the health situation in emergencies and suggested that a broader range of national organizations should look at the major health problems that arose in an emergency situation, rather than simply regarding it as a generic emergency situation.

She thanked previous speakers for their comments about WHO participation in tragic emergency situations. The Secretariat, but more particularly the individual staff members who participated in emergencies, appreciated such recognition of their efforts which, in turn, were greatly facilitated by the acceptance and support that they had been given within those countries, from the host governments and from the partners with whom they worked.

The Committee noted the report.

International Decade of the World's Indigenous People (Document A54/33)

Dr MATHESON (New Zealand) said that his country supported the call for the collection of more accurate data on indigenous people and applauded the leadership demonstrated by WHO in holding an international consultation on the health of indigenous people in 1999. However, he noted that, despite the request contained in resolution WHA51.24, no progress on national, regional or global plans of action was being reported. He therefore requested that the agenda item should be kept open; in association with other States, his delegation would be tabling a resolution requesting a commitment to fulfil the intent of resolution WHA51.24, bearing in mind that the International Decade of the World's Indigenous People would end in December 2003.

The recent decision to establish a Permanent Forum for Indigenous Issues under the aegis of the Economic and Social Council represented an historic milestone. He urged WHO to cooperate with specialized agencies, in particular the Office of the United Nations High Commissioner for Human Rights in its role as lead agency for establishment of the Forum, and with States in preparation for the inaugural meeting of the Forum in 2002. Given the envisaged mandate of the Forum, WHO had a significant part to play in ensuring that it would serve as an effective coordinating mechanism for the consideration of indigenous issues within the United Nations system and that it would deliver practical benefits to indigenous people.

Ms ROVIROSA (Mexico) said that her Government's strategy to improve the health services available to indigenous people was strengthened by the WHO initiative in that field. Mexico attached high priority to the health of indigenous people and had launched a programme for the improvement of health services for them. Her country would endeavour to implement the suggested measures of collecting data and conducting research that would lay the basis for improving the health of indigenous people. On that score, close cooperation with indigenous people themselves was essential
for the achievement of results that would help countries to formulate effective and consistent health policies for those people.

Dr LARIVIERE (Canada) said that the elaboration of a WHO plan of action for indigenous people's health would go far towards translating policy decisions into activities and expected results. His country would be pleased to share all its relevant information with a view to enabling WHO to complete that plan. He applauded the creation of the Permanent Forum for Indigenous Issues as a positive step that demonstrated the commitment of Member States to giving indigenous issues the level of priority needed to effect favourable changes in the lives of all indigenous peoples.

With reference to the Annex contained in document A54/33, he regarded as superfluous the word "People" contained in the phrase "First Nations People" which appeared in the first paragraph under the subheading "The Americas", as the expression "First Nations" was used in Canada instead of "indigenous peoples". In addition, under the subheading "Europe", the word "Inuit" in the phrase "life expectancy for an Inuit infant", which appeared in the first paragraph, should be replaced by "Inuk", the singular form of the word.

Ms BENNETT (Australia), recalling that her delegation had welcomed the opportunity in 2000 to cosponsor the draft resolution on the world's indigenous people, said that her Government was developing a specific strategy to improve substantially the health status of Aboriginal and Torres Strait Islander people, a goal which would nevertheless take time. Regional planning and partnership with indigenous people remained central to Australia's long-term strategic approach of fostering indigenous health in an environment where communities were empowered and also participated in the development and delivery of health care services. The ongoing enhancement and development of those services were based on regional planning processes for which forums in each individual jurisdiction in the country were responsible.

Together with New Zealand and others, her delegation was currently elaborating a new draft resolution that built on resolution WHA53.10 by including the issues of improved collection and reporting of statistics and cooperation with the Office of the United Nations High Commissioner for Human Rights in its role as the lead agency for the establishment of the Permanent Forum for Indigenous Issues. Improving the evidence base and promoting the use of effective policy remained a key part of her Government's strategic approach to the health of indigenous people, in which connection considerable work was being undertaken in partnership with Commonwealth, State and Territory agencies and indigenous organizations to improve statistics. She supported the request that the agenda item should be left open.

Ms SUNDREHAGEN (Norway) expressed disappointment at the lack of progress over the past year; in particular, the global plan of action to improve the health of indigenous people called for in resolution WHA53.10 had not yet been outlined. With a view to advancing the preparation of that and other regional plans of action, she therefore supported the proposal to use the definition of indigenous people set out in document A54/33. Norway had taken more active steps to improve the health of its own indigenous people, the Sami, such as establishing a centre for research on Sami health, and would be pleased to share its experiences in that connection. It welcomed the agreement to establish the Permanent Forum for Indigenous Issues, although care should be taken to ensure that it would not ultimately be regarded as a body that would undertake the obligations incumbent on United Nations agencies in respect of those issues. She encouraged WHO to maintain close contact with the Forum and provide it with the necessary information.

A global strategy to improve the health of indigenous people should focus on the eradication of poverty and increasing equity within and across the boundaries of Member States. To that end, the global plan of action could include elements such as integration of the indigenous perspective in WHO programmes, the establishment of partnership mechanisms between WHO and indigenous people's interest groups, mechanisms to spread best practices regarding health services to indigenous communities and individuals, and the improvement of research and mapping strategies to be
implemented by Member States. Lastly, she requested a briefing on means of enhancing WHO activities for indigenous people in the coming year, as well as information on any financial implications beyond the estimates set forth in the budget proposal for 2002-2003.

Mr NACUVA (Fiji) said that, with improved reporting and more intensive research, the poor health status of indigenous people could prove to be much worse than previously thought. He associated himself with the draft resolution currently being prepared on the International Decade of the World's Indigenous People; it was timely and significant, particularly in view of the milestone in the history of the United Nations embodied in the agreement to establish the Permanent Forum for Indigenous Issues. Moreover, given the approaching end of the International Decade of the World's Indigenous People in 2003, it was prudent to renew regional and international efforts to develop global and regional plans of action for indigenous health that would represent WHO's contribution to the Decade.

Mr YANG Xiaokun (China) noted that, within the United Nations system, there was no agreed definition of indigenous people. The definition set out in document A54/33 should therefore be used with prudence, if not altogether avoided, particularly since WHO was not a Party to the Convention concerning Indigenous and Tribal Peoples in Independent Countries adopted by the International Labour Organization from which the definition had been taken. WHO should endeavour to devise its own definition.

Mr SINGH (India) said that a distinction between indigenous and non-indigenous people was hardly possible in the Asian context. India had therefore constantly underscored the need for a definition of indigenous people that should not include extraneous elements. Without a clear definition, the interests of the genuine indigenous people would suffer. Use of the definition set out in document A54/33, on which there was no agreement among Member States, would lead to confusion and future complications. Lastly, noting the specific reference to his country contained in the Annex to that document, he emphasized that all citizens of India were indigenous. He requested that that error be corrected and that his delegation's statement be fully taken into account in the preparation of documents.

Mrs KERN (Executive Director) said that the comments made by several speakers, in particular the delegate of India, indicated the need for discussions with the delegates of Member States. However, the structures that had been put in place within United Nations had clearly been welcomed by many Member States, and there existed a structure at WHO. In response to the remarks by the delegate of Norway she noted that considerable voluntary contributions would be required to finance the additional work that Member States were requesting. Acknowledging the importance of regional and global plans of action, which had been called for in resolution WHA53.10, she noted that the Director-General, when she took office, had emphasized that such plans should be based on evidence. Without such a basis she felt that successful implementation would probably not be possible. Referring to the comments on the definition of indigenous people, she stressed that that was a prerequisite to preparation of a sound evidence base. WHO had made more progress than was reflected in the report, in particular in collating data on indigenous people from various sources in countries, but in the absence of prior discussion of the information it had been considered premature to make it available to the Health Assembly. She said that she looked forward to taking these matters forward and reaching agreement with Member States on the key issues referred to.

The CHAIRMAN noted that requests had been made for the agenda item to be kept open and asked whether that would be agreeable to the Committee.

The Committee agreed to keep the agenda item open.
3. USE OF LANGUAGES IN WHO: Item 19 of the Agenda (Document A54/INF.DOC./2)

Mr CHERNIKOV (Russian Federation) noted with satisfaction the measures that had been taken to ensure equality of treatment among the official languages of WHO and to increase the numbers of languages used, as reflected in the report. He commended the significant progress that had been made and stressed the need to continue efforts to work towards the ultimate objective of ensuring the fully international character of the Organization and to achieve full equality among the official languages. Expressing appreciation for the implementation in the year 2000 of resolution EB105.R6 regarding, inter alia, publication of The world health report in the six official languages of the Organization, he asked that the necessary steps be taken to apply the same approach to the Bulletin of the World Health Organization and, before the end of the year 2001, to introduce summaries in Russian of articles published therein. He also requested the Secretariat to implement the recommendation of the United Nations Joint Inspection Unit regarding observance of the Organization's language policy on the Internet and to include a Russian language page on the WHO web site.

Mr DÜRLER (Switzerland) said that Switzerland attached considerable importance to equality among the official languages of WHO, although for practical and financial reasons some flexibility in applying that principle might be necessary. Switzerland welcomed the measures described in the report, in particular concerning language training for personnel, activities related to radio and the press, and the appointment of a Special Coordinator for the promotion of multilingualism in WHO.

Mr TASAKA (Japan) said that his delegation recognized the importance of multilingualism and appreciated WHO's efforts in that regard, but that consideration should not be allowed to delay the distribution of documents. There was a need to distinguish between published material, such as The world health report, intended for a large audience, and working papers, such as programme budgets, which were required well in advance of a meeting. Consequently, his delegation considered that greater emphasis should be given to the rapid delivery of documents than to multilingualism. The financial implications of multilingualism should also be considered.

Mr TELLIER (Canada), conveying the satisfaction of his country at the measures taken by the Secretariat during the year, said that Canada fully endorsed the importance of multilingualism in the Organization not only to facilitate more effective participation on the part of Member States but also to enable its work and activities to be more accessible worldwide. He was pleased to note that WHO had become one of the United Nations organizations that had recognized, through concrete action, the significant contribution that multilingualism could make to the attainment of its objectives. However, it would be necessary to remain vigilant and encourage the Organization to seek new ways of improving multilingualism in WHO.

Mr YANG Xiaokun (China) underlined the importance of multilingualism and recalled that equality among languages had long been a priority for WHO and many Member States. China appreciated the substantial progress that had been made since January 2000, but noted that the strengthening of multilingualism in line with the needs of Member States was a long-term task. In that regard, certain differences that had been noted in the arrangements for simultaneous interpretation at regional meetings indicated that there was still room for improvement. His delegation was ready to discuss that issue with the Special Coordinator at an appropriate time.
Dr PROST (Special Coordinator) assured the delegate of the Russian Federation that the Director-General’s objective remained equality among the official languages. Recalling that the Bulletin of the World Health Organization had previously been published in Russian he confirmed that that language version would be resumed when certain contractual difficulties that had arisen had been resolved. With respect to the Internet, the WHO web site was currently accessible in French and Spanish; other languages would follow when the technical difficulties involved had been overcome. The most recent edition of WHO Basic documents was already available on the Internet in three official languages as were governing body documentation and records. Replying to the delegate of Japan, he gave an assurance that strict procedures ensured that translation never caused delay in the distribution of documents. Also, the financial implications of the policy announced by the Director-General were carefully monitored. Referring to the point raised by the delegate of China, he emphasized that all the regional directors attached great importance to the question of languages and cited the example of the African Region where training in the English, French, and Portuguese languages was being made available to the staff. Multilingualism was thus a matter that concerned the whole Organization.

The Committee noted the report.

4. STAFFING MATTERS: Item 16 of the Agenda (resumed)

Appointment of representatives to the WHO Staff Pension Committee: Item 16.4 of the Agenda (Document A54/30) (resumed from section I)

The CHAIRMAN invited the Committee to appoint two members and two alternate members of the WHO Staff Pension Committee in accordance with the rotational schedule set out in document A54/30. He noted that Mr M. Chikalisa (Botswana) had been proposed as an alternate member to replace Dr J.W. Mulwa (Botswana), who had retired.

In the absence of comments he said that he would take it that there were no objections and that the Committee wished to convey the following draft decision to the plenary:

Decision: The Fifty-fourth World Health Assembly re-nominated Dr J. Lariviére of the delegation of Canada as a member and Dr Shyam P. Bhattacharai of the delegation of Nepal as an alternate member, each for a period of three years.

The Fifty-fourth World Health Assembly also nominated Mr L. Rokovada of the delegation of Fiji as a member, and Mr M. Chikalisa of the delegation of Botswana as an alternate member, for the remainder of the term of office of Dr L. Malolo and Dr J.W. Mulwa respectively.

The Fifty-fourth World Health Assembly also nominated Dr J.K. Getrik of the delegation of Denmark as an alternate member, for the remainder of the term of office of Dr E. Krag.

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

The meeting rose at 11:10.

1 Transmitted to the Health Assembly in the Committee’s first report and adopted as decision WHA54(9).
THIRD MEETING
Thursday, 17 May 2001, at 14:30

Chairman: Mr D.Á. GUNNARSSON (Iceland)

FINANCIAL MATTERS: Item 15 of the Agenda

Revised Financial Rules (Document A54/34)

The CHAIRMAN explained that the revised Financial Rules were transmitted to the Health Assembly for information.

Mr WARRINGTON (United Kingdom of Great Britain and Northern Ireland) referring to Regulation VI, paragraphs 6.5 and 6.6 of the Financial Regulations, said his country was concerned about the financial incentive scheme, and in particular about the setting of a date for payment later than 1 January. It believed that the value of financial incentive schemes had not been proven, and that rewards should be given only to those who had gone beyond the legal requirements for payment of contributions. He urged that the Executive Board should review the scheme as soon as possible to establish whether it was effective.

The CHAIRMAN said that in the absence of any other comments he would take it that the Committee took note of the revised Financial Rules contained in document A54/34.

It was so agreed.

Reports: Item 15.1 of the Agenda

Unaudited interim financial report on the accounts of WHO for 2000 and comments thereon of the Administration, Budget and Finance Committee (Documents A54/20, A54/20 Add.1, A54/20 Add.1 Corr.1, A54/35, A54/INF.DOC./3 and A54/INF.DOC./9)

Dr THIERS (representative of the Executive Board), speaking on behalf of the Chairman of the Administration, Budget and Finance Committee (ABFC), said that at its meeting on 11 May ABFC had heard a report from the Chairman of the Audit Committee of the Board and had considered reports from the External Auditor, the Internal Auditor and the United Nations Joint Inspection Unit. The Chairman of the Audit Committee had stated that the External Auditor's interim report indicated that satisfactory progress was being made by the Organization with regard to the implementation of several of his recommendations, and that in general the financial records of WHO were reliable and well maintained and that adequate internal controls had been implemented.

After having considered the unaudited interim financial report on the accounts of WHO for 2000, ABFC had noted the following points: comprehensive information on the implementation of the programme budget was included in the report for the first time, and the overall level of implementation at 31 December 2000 for all sources of funds was 71%; extrabudgetary contributions had increased by 40%, or US$ 208 million, giving a total extrabudgetary income of US$ 731 million for 2000; and the 87% rate of collection of assessed contributions was the highest for 15 years.

ABFC had suggested that a review be made of the level of implementation at the end of the first year of the biennium in relation to the full financial period, with a view to establishing appropriate
parameters or targets. With reference to the WHO financial framework (document A54/INF.DOC./3) ABFC had found the glossary of financial and budgetary terms commonly used in WHO contained in Annex 2 helpful, and had asked for it to be expanded to include further terms and a graph illustrating the flow of funds from different sources through the Organization. ABFC had noted the continuing trends: levels of income and of implementation were rising, the rate of collection of assessed contributions was improving and the levels of internal borrowing and of arrears of assessed contributions were falling.

ABFC had recommended that the Fifty-fourth World Health Assembly accept the Director-General’s unaudited interim financial report for the year 2000.

Ms WILD (Financial services) said that the main financial report (document A54/20) provided information on all sources of funds, income and expenditure and included a balance sheet, or statement of assets and liabilities. The detailed reporting in the annex (document A54/20 Add.l) enabled donors to see how their funds had been spent, and in many cases served as an official financial report to them. It also showed the total contributions made by all donors, both Member States and others, of extrabudgetary funds. The programme budget 2000-2001 reflected the new strategic focus of the Organization, taking the process started by the Director-General in July 1998 a step further. That process had continued into the Proposed programme budget 2002-2003. For the first time, the financial report included comprehensive information on implementation for all sources of funds in comparison with the programme budget. It also showed that the financial position of the Organization had continued to improve during 2000. The annex (document A54/20 Add.l Corr.1) had been issued to correct four pages showing extrabudgetary contributions from the Republic of Korea to the Voluntary Fund for Health Promotion.

Document A54/INF.DOC./9 highlighted significant financial developments in 2000, the first year of the biennium. The overall level of implementation for all sources of funds had been 71%; total income had increased by 18% and total expenditure by 40% on an annualized basis; and expenditure had increased by a higher percentage rate than income, which meant that the rate of implementation had increased and the overall fund balances decreased. Extrabudgetary contributions had continued to grow strongly in 2000, totalling 40% more than in 1999, with Voluntary Fund for Health Promotion contributions increasing by 54%. The position of the regular budget could be summarized as follows: the rate of collection of assessed contributions was 87%, the highest in 15 years; US$ 56 million was outstanding from assessments due for 2000 as compared to US$ 94 million for the 1998-1999 biennium; and total outstanding assessments were US$ 21 million lower than at the end of 1999.

The liquidity position of the Organization was strong. As at 31 December 2000 there had been no internal borrowing. The Working Capital Fund was drawn down by US$ 14 million, leaving US$ 17 million available to finance the difference between regular budget funds available and regular budget expenditure incurred. That improvement in the fund’s position resulted from the reduction in arrears of Members’ assessed contributions and the change in accounting application of those arrears, as recently approved by the Health Assembly and reflected in the new Financial Regulations.

The statement of assets, liabilities and fund balances contained in document A54/20 showed that the level of deposits and securities had increased to almost US$ 1300 million at 31 December 2000. That was the result of increased extrabudgetary contributions, the improved rate of collection of assessed contributions in 2000, an increase in the level of payments made in advance for assessed contributions due in 2001 and an increase in funds held by WHO on behalf of associated entities.

Concerning financial implementation of the 2000-2001 programme budget for the first year of the biennium, i.e. 2000, information had been provided by appropriation section at headquarters and regional levels and by country or territory. The approved regular budget for 2000-2001 had been adjusted by transfers within the Director-General’s authority and the exchange rate facility to arrive at an effective regular budget of US$ 837 million for 2000-2001. The regular budget rate of implementation for 2000 had been 66%, as planned in the first year of the biennium, reflecting the Organization’s financial policy of charging expenditure for salaries for the whole biennium at the
beginning of that biennium. That had had the effect of showing a significant deficit in the regular budget, because the corresponding assessed income for 2000 was not recorded until 1 January 2001. An amount of US$ 958 million had been included in the programme budget 2000-2001 for expenditure financed from other sources: at the end of 2000, the level of such expenditure had been 75%. Taking all sources of funds, the overall level of expenditure had been 71%.

Regarding the "other sources" component, the level of expenditure for a particular appropriation at headquarters might seem low, but high at regional and country level. That was because when the budget was prepared expenditure had been shown as for headquarters, but a proportion of it had in fact taken place in part in regions and countries. The significant growth in extrabudgetary income had further contributed to the high level of expenditure at the regional and country level. The overall rate of expenditure for other sources, 75%, reflected the increase in income referred to earlier, and the faster rate of implementation.

The implementation rate was in some cases lower than average, and ABFC had asked the Secretariat to consider establishing parameters for financial implementation at the end of the first year of a biennium. In doing so, it would take into consideration timeframe and other factors affecting planned activities, in order to be able to address the question of any significant variances outside the parameters established. In view of the growth in income in 2000, the "other sources" expenditure figure for 2000-2001 had been revised upwards to US$ 1100 million in the Proposed programme budget 2002-2003. In comparison with that revised budgeted expenditure figure, actual expenditure for 2000 represented just under 66%, which was very much in line with the level of expenditure for the regular budget.

She confirmed that the Organization was continuing to move in the right direction, as the representative of the Executive Board had pointed out. In short, the trend that had begun in 1998-1999 was being sustained in the 2000-2001 biennium.

Mr KNEZEVIC (Yugoslavia) pointed out that the reference on page 48 of document A54/20 was to the former Yugoslavia. As his country had not become a Member of WHO until 28 November 2000, its assessed contribution had yet to be established under agenda item 15.6, a point confirmed by Ms WILD (Financial services).

Mr CHUN (Republic of Korea) expressed appreciation for the prompt action taken to correct errors relating to two extrabudgetary contributions from his country.

The CHAIRMAN drew attention to the draft resolution recommended by ABFC contained in paragraph 10 of document A54/35.

The draft resolution was approved.

Interim report of the External Auditor (Document A54/21)

Mr FAKIE (External Auditor) said that the purpose of his interim report was to inform the Health Assembly in a timely manner of salient matters arising from the external audit and thereby to enhance accountability. He noted with particular pleasure that the Audit Committee had endorsed the continuation of the practice of issuing interim reports. He emphasized that no opinion was expressed on the Unaudited interim financial report for the year 2000 and that his report did not contain comments or observations related to that report.

The audit had included a strategic planning phase, analytical tests of transactions and balances, and procedures to test compliance with the Financial Regulations and legislative authority. His staff had been able to continue to build on the core of expertise specific to WHO which they had developed

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA54.4.
during the first term of their appointment, and to follow through with initiatives identified during their

At its meeting in the previous week, the Audit Committee had considered his interim report in
detail. The Chairman of the Audit Committee had provided feedback to ABFC, whose report would be
considered by the Executive Board. The Audit Committee was also tracking the status of
implementation of external audit recommendations as a standard agenda item, thus clearly indicating
that the matters raised were being actively followed up.

The interim work performed had revealed that, in general, the financial records were reliable
and well maintained, and that an adequate system of internal control had been implemented by the
Organization. The significant reform measures currently under way, especially in the areas of financial
framework, strategic budgeting, programme implementation, monitoring and evaluation, and human
resources management, had also been recognized. However, he had noted in his interim report some
areas where improvements should be made.

With regard to outstanding assessed contributions, he had previously highlighted the trend in the
collection of assessed contributions and the potential negative effects of late payments. Although it
was encouraging that the highest collection rate in the past decade had been achieved during 2000 and
that the total amount of outstanding contributions had continued to decrease, the level of outstanding
contributions relating to previous financial periods remained an area of concern. The new provisions
in the Financial Regulations and Financial Rules, which allowed Member States to pay their assessed
contributions in local currencies subject to specific guidelines and limits, together with the proposals
made for the handling of requests for special arrangements for Member States that were in arrears,
should assist in the collection of arrears.

With regard to extrabudgetary contributions, he noted that an important current trend was the
continued increase in extrabudgetary income, as against a static level of regular budget funding. That
trend might have a disproportionate effect on the overall level of administrative and support work
funded by the regular budget. While measures had been taken to improve efficiency, it was
foreseeable that, if the trend continued and the appropriate level of resources for such administration
and support costs could not be made available, further imbalances might be difficult to sustain. More
details of such costs were required for the effective management of that risk and evaluation of the
sustainability of the increase in extrabudgetary resources.

The reform of the budgetary process and the implementation of an integrated plan for
programme implementation, monitoring and evaluation were important initiatives. A significant step
in the former was the compilation of the Proposed programme budget 2002-2003, which incorporated
the principles of results-based budgeting. Committee A had reviewed that document the previous day.
Standardized business rules and procedures for programme implementation and monitoring had been
developed and implemented with effect from January 2000. In a review of a sample of work plans
compiled at headquarters and at a regional office, his staff had noted that compliance with the
standardized business rules and procedures could be improved. He submitted that implementation of
measures for regularly monitoring the allocation of staff costs to the respective elements or activities
would ensure more accurate cost information regarding programme outputs. That was particularly
significant in view of the fact that staff costs were the largest individual expenditure type.

At both headquarters and in the region visited, certain issues pertaining to the integration of the
Administration and Finance System with the Activity Management System (AMS), used for
programme implementation and monitoring, still needed to be resolved in order to ensure that the
financial information as recorded on the AMS was reliable. Some users considered that AMS was not
user friendly and was too time-consuming. Reviews of both the coding practice and the AMS
functionality had already been initiated. It had been envisaged that monitoring reports would be
prepared for the Regional and Executive Directors on a six-monthly basis, but reports had not been
compiled for the first six-month period of 2000. He had been informed subsequently that the reports
were to be prepared for the 12-month period ending 31 December 2000 and were due at the end of
Other matters dealt with in his report included delegation of authority, the WHO Manual, inventory, allotment control and unliquidated obligations, personal accounts and liaison offices.

In the area of human resources, in particular performance evaluation, a review of the personnel files had revealed many instances where the necessary performance evaluations had not been performed, but the annual within-grade step increase had nevertheless been awarded. The Secretariat had undertaken to address the matter.

Two value-added reviews had been completed during the interim period: the first was a review of the internal audit function. Its purpose was to provide an objective assessment of the Office of Internal Audit and Oversight (IAO). Key findings included the fact that the organizational structure and mandate of IAO allowed it to render impartial and unbiased service and that the qualifications, experience and skills of staff were generally appropriate. However, in several areas IAO had not kept pace with developments in the internal auditing field or should reconsider some of its practices in the light of management expectations: for instance, risk assessment, the focus of IAO, the audit approach and methods, the approach to report writing and the use of formal continuous improvement techniques and approaches. He had made several high-level recommendations in his report, which, if implemented, should improve the efficiency and effectiveness of IAO. The Director-General’s Office had indicated that it would be studying the recommendations carefully with a view to developing a plan of implementation based on that report.

The second review was the computer audit of the general control environment at a regional office. In the previous financial period, his staff had performed a comprehensive computer audit of the general control environment at headquarters, drawing attention to some significant weaknesses; those were being addressed, and considerable progress had been made. The audit findings at the regional office had indicated that, although some controls were in place, significant weaknesses existed in the control environment as a whole and his report summarized areas where improvements could fruitfully be implemented. The regional office should address some of those issues, while others should be addressed by WHO globally. A detailed response had been received from the Regional Director, outlining the steps already taken or those that were envisaged. He had also been kept informed of the progress made in implementing improved general controls at headquarters.

The process of change and reform could be difficult. When such a process was embarked upon, it must be supported by a clear implementation plan adhered to with discipline and commitment. The Organization had such a plan, and he strongly urged the Director-General to ensure that the momentum of the process was maintained.

Mr CHERNIKOV (Russian Federation) urged the Secretariat fully to implement the recommendations of the audit and oversight bodies. He shared the External Auditor’s assessment of the positive outcome of the Audit Committee’s work in general and, in particular, its system for monitoring compliance with the recommendations of both the Internal and the External Auditor.

Mr CHAKALISA (Botswana), noting that the External Auditor’s report referred to instances in which annual performance appraisals had not been undertaken and the officers concerned had still been awarded the annual increment, asked what measures would be put in place to ensure that the annual increment was awarded only to deserving officers.

Ms VAN GINNIKEN (Netherlands), commenting on all three reports under agenda item 15.1, said the findings had been generally positive regarding the Organization’s functioning and the improvement of its financial situation. She welcomed the availability of US$ 17 million in the Working Capital Fund, the substantial increase in extrabudgetary resources, and the rise in the rate of collection of assessed contributions to the highest level for 15 years. However, she remained concerned about the arrears in contributions, and underscored the importance of full, timely, unconditional payment of contributions. She also expressed concern about the impact of the increase in extrabudgetary funds on the Organization’s administrative and support costs, which were funded from the regular budget. That issue required review.
Mr MACPHEE (Canada), expressing support for the view of the Russian Federation, said that the information on such key areas as communication and accountability, outstanding and extrabudgetary contributions, and human resources was useful. He supported the emphasis placed on the importance of timely payment of contributions. Although the improved collection rate was encouraging, the level of outstanding contributions from prior financial periods continued to cause concern, since late payment imposed a significant burden on the Organization, tying up resources that could be used more productively. His delegation urged all Member States to honour their international obligations and to pay their dues in full and without delay.

Mr HUSSAIN (Pakistan) commended the high level of financial integrity and discipline in WHO. However, his delegation shared the External Auditor's concern, particularly as reflected in paragraphs 32-37 and 48 of his report, that the important function of oversight investigation had been excluded from the scope of the review of internal audit function, since it concerned wrongdoing, which included violations of rules and regulations, mismanagement, misconduct and waste, abuse of authority and unlawful conduct by staff or firms doing business with the Organization. If such key areas were not reviewed, the audit process would be vitiated. He therefore urged WHO to permit oversight investigations to be included in the review of the internal audit function. He also encouraged it fully to implement the recommendations made in the report, and particularly to ensure the financial discipline of its regional offices, which, like those of other United Nations agencies, displayed a degree of laxity.

Mr TASAKA (Japan) welcomed both the internal and external audit reports, which contained points relevant to budget efficiency, such as the incomplete functioning of the management support units. He urged the Secretariat to respond appropriately to the audit findings and to report to the Member States on the measures taken.

Mr FAKIE (External Auditor), speaking at the invitation of the CHAIRMAN, took note of the concerns raised by delegations, some of which would be incorporated in the audit risk and testing procedures.

Mr MANI (Executive Director, ad interim), responding to the query from the delegate of Botswana, recalled the reorganization and restructuring at headquarters, resulting in frequent changes of both supervisors and supervised. The situation had stabilized, and no undeserving staff member would receive an increment. In reply to the Japanese delegate, the audit evaluation of the management support units was currently being reviewed; the Director-General would then determine what changes, if any, should be made, and report accordingly to the Executive Board and the Health Assembly.

The Committee noted the report.

Report of the Internal Auditor (Document A54/22)

Mr LANGFORD (Internal Auditor), said that his report had been prepared independently and transmitted without change to the Health Assembly through the Director-General, following detailed discussion in the Audit Committee of the Executive Board. WHO's Financial Rules guaranteed his Office full and free access to the Organization; there had been no difficulties in that regard during the previous year, nor had the Secretariat imposed any limitation on the scope of his Office's work. The results obtained indicated that the overall system of internal control continued to provide reasonable assurance that in the normal course of business significant irregularities would be prevented or disclosed.

Emphasis continued to be placed on evaluative audit work relating to operational, managerial and value-for-money issues, complemented by a review of compliance with established financial and administrative controls. Audit work had covered regional offices, country offices, headquarters
programmes, central services and management support units, interregional and intercountry programmes, and information systems. Resources had been allocated on the basis of a risk analysis of each area of work, since an audit might cover discrete units or cut across offices and programmes on a functional basis.

Work at the Regional Office for Europe had raised issues relating to the liaison office network in eastern Europe. The audit had disclosed problematic areas relating to the liaison officers' status, a budgetary disparity in situations where there was a dual WHO presence in the country, and areas of potential for overlapping work. That review, coupled with the current audit of liaison office operational controls, should provide the Regional Office with a solid evidence base for remedial action.

At the Regional Office for Africa, encouraging improvement had been noted in the manner of operation from an administrative, financial and audit perspective. However, specific balances, largely attributable to the 1997 civil unrest in Brazzaville, required attention. The audit had identified items, totalling slightly over US$ 1 million, that might need to be written off during the current biennium. Efforts were under way to deal with the situation and recover funds where possible.

In WHO country offices, work had focused on the application of the principles of country work discussed by the Executive Board in January 2000. The aim had been to measure the extent to which WHO policy on working with and in countries had been translated into action at the field level. With the office of the WHO Representative in the Philippines as a test case, it was found that substantial work was still needed to translate the corporate strategy into an action framework. That audit approach for country offices would be continued and applied to a cross-section of such offices across the regions.

At headquarters, WHO's involvement in the Iraqi oil-for-food programme had been reviewed. The programme was significant because of both its monetary value and the exceptional requirements placed on the Organization to take an operational role. The review had disclosed a basic handicap in the Organization's handling of the programme, mainly because of the inconsistency between a complex long-term emergency situation and a corporate culture based on development-oriented technical and normative functions. The nature, size and complexity of the programme required a special project approach to manage its implementation effectively.

The audits of the eight management support units at headquarters had confirmed that their basic control structures were effective. However, further work was needed to strengthen controls in certain areas. Specifically, clarification was needed to resolve the conflict between their control and service functions.

The Office continued to place emphasis on follow-up and implementation of its audit recommendations, which had in general been received positively by senior management. He was satisfied with the overall disposition of significant audit recommendations.

Mr MACPHEE (Canada) reiterated his delegation's remarks in Committee A on the proposed programme budget. The Internal Auditor's report provided a valuable source for identifying efficiency savings. Its more than 20 recommendations were designed to improve managerial approach, efficiency and effectiveness, add value, increase economy in operations, and ensure greater accuracy and reliability of financial and managerial information. He encouraged WHO to make full use of the report so as to maximize its full potential for efficiency savings, and urged the Internal Auditor to continue to identify areas for improvement. The Secretariat should address those matters in a timely fashion.

Mr VOIGTLÃNDER (Germany), referring to the Internal Auditor's comments regarding the liaison offices attached to the Regional Office for Europe, asked where the danger of overlapping lay, as that information did not appear in the report.

Mr CHERNIKOV (Russian Federation) endorsed the comments by the Canadian delegate and emphasized the importance of implementing the Internal Auditor's recommendations.
Mr LANGFORD (Internal Auditor), replying to the German delegate, said that the potential for overlap would exist where there was a dual WHO presence, normally as the result of an emergency, as in the case of the WHO Liaison Office in the Balkans and the Emergency and Humanitarian Action Programme.

Dr SAMBA (Regional Director for Africa), referring in particular to paragraph 21 of the Internal Auditor's report, explained that in June 1997 the Brazzaville office had had to be abandoned at a moment's notice because of the proximity of the civil war and everything, including personal property, had been left behind. On their return, the staff had found that everything of value had disappeared. Efforts had subsequently been made to recuperate and reclaim as much as possible, but four years on the Internal Auditor's advice would have to be followed and the necessary steps taken to write off the money involved. Every effort would be made to see that all the Internal Auditor's recommendations were implemented.

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 15.2 of the Agenda (Document A54/23)

Mrs ABEL (representative of the Executive Board) said that the Executive Board had heard the report of its Administration, Budget and Finance Committee (ABFC) which had considered a report on the status of collection of assessed contributions, including Members in arrears to an extent which would justify invoking Article 7 of the Constitution. The Board had noted from the report of the Chairman of ABFC that the rate of collection for 2000 had been the highest for 15 years, and that the US$165 million outstanding at 31 December 1999 had fallen to US$144 million at 31 December 2000. The efforts of certain countries to reduce or repay their arrears in full had been applauded. Thirty-two countries had already paid their assessed contributions for 2001 in full, double the number that had paid in advance for 2000. The voting privileges of 22 Member States had remained suspended under Article 7, because of the level of their arrears.

Dr THIERS (representative of the Executive Board), speaking on behalf of the Chairman of ABFC, added that contributions in full had been received from 119 of the 193 Member States. As at 31 March 2001, collections of contributions due in 2001 in respect of the regular budget had amounted to 23%, and had risen sharply to 57% by 11 May, the date of ABFC's meeting, compared with 53% the previous year. ABFC had also heard that since 31 March, the date of the status report it had reviewed, a further 22 Members had paid their contributions for 2001 in full and 11 Members had made part payments. All those members were listed in ABFC's report (document A54/23). The total due for previous years' contributions had decreased, to US$123 million, as against US$157 million in 2000.

There were three groups of Members in arrears to an extent that would justify invoking Article 7 of the Constitution. The first group, consisting of 22 Members, were those whose voting privileges had already been suspended under Article 7. Of these, Comoros had indicated its intention to propose a special arrangement for the settlement of its arrears. The second group consisted of two Members for which voting privileges had been suspended from the opening of the Fifty-fourth World Health Assembly, pursuant to resolution WHA53.2. The third group consisted of nine Members that were included in the draft resolution recommended by ABFC, and whose voting privileges would be suspended from the opening of the Fifty-fifth World Health Assembly in 2002 unless sufficient payments would have been received before its opening. ABFC had recommended that the draft resolution contained in paragraph 10 of document A54/23 be adopted by the current Health Assembly.
Ms WILD (Financial services) added that more payments had been received since ABFC’s meeting on 11 May. Madagascar and Papua New Guinea had paid their contributions for 2001 in full. Mauritania had paid the full amount due up to the end of 2000 and should therefore be deleted from the list of Members appearing in paragraph 8 of document A54/23, and from operative paragraphs 1 and 2 of the draft resolution recommended by ABFC.

Two Members, Poland and Senegal, had paid part of their contributions for 2001. A payment had been received from the Libyan Arab Jamahiriya representing the balance due for 1999 and part of its contribution for 2000.

The Dominican Republic, Gambia and Nigeria had indicated their intention to make payments in the near future or to put forward proposals for consideration by the Fifty-fifth World Health Assembly for special arrangements for the payment of their arrears. Peru had also indicated that the funds were available to permit the payment of a substantial sum which, if received, would be sufficient to preclude it from the provisions of Article 7 without the need for special arrangements.

Dr SHANGULA (Namibia) welcomed the improvement in the collection of contributions and the efforts being made by a significant number of Members to liquidate their arrears. Nevertheless, the payment of contributions was an obligation of every Member State of WHO, and it remained a matter of concern that some of those arrears dated back to 1994 and 1995. Payments were often made just as a Member State was about to be declared subject to the provisions of Article 7. Given that prompt payment of a country’s obligations enhanced the functioning of the Organization, every Member State should strive to ensure that its contribution was paid both in full and on time. The recent decision enabling States to make payment in local currency would greatly enhance the collection of funds.

Some Member States had made an effort to pay their contributions in advance. Other Members should endeavour to emulate that example wherever possible. The Secretariat, for its part, should make a specific effort to contact all Member States when their contributions became due.

Dr NZIL’KOUE (Central African Republic) said that his country, which had not yet paid its assessed contributions in full, had welcomed the rescheduling of the payment of its arrears. The Government had been aware of the situation since the previous year and, had it not been for changes on the eve of the Health Assembly, would have proposed more appropriate arrangements for the payment of its arrears. The new Prime Minister had given high priority to health matters and as a gesture of goodwill had agreed that a delegation should attend the Health Assembly at a time when missions abroad had been banned. The delegation was anxious that contact should be maintained and that action was taken on its return to bring the country’s contributions up to date.

Dr SOMBIE (Burkina Faso) informed the Committee that on 15 May his country had brought its contributions up to date and had also made an advance payment for 2002. Despite its limited resources, his Government’s effort was an acknowledgement of the extent to which it had benefited from WHO’s support.

Mr CHAKALISA (Botswana) said that his country would be paying its assessed contribution for 2001 imminently; the delay in payment was due to the way its financial year was structured.

Mr AL-SAKKAF (Yemen) pointed out that Yemen had paid its assessed contribution for 2001. The list of countries that had not yet paid in full, contained in paragraph 3 of document A54/23, should be amended accordingly.

Ms WILD (Financial services) confirmed that, since the status report annexed to document A54/23 had been issued as of 31 March 2001, the Secretariat had received payments in respect of the assessed contributions for 2001 from Burkina Faso and Yemen. The payments had been recorded in the accounts and had also been noted in the report of ABFC.
The CHAIRMAN invited the Committee to consider the draft resolution recommended by ABFC in paragraph 10 of document A54/23, as amended.

The draft resolution, as amended, was approved.¹

**Special arrangements for settlement of arrears: Item 15.3 of the Agenda (Resolution EB107.R3; document A54/24)**

Mrs ABEL (representative of the Executive Board) said that the Board had considered a draft resolution proposed by ABFC in response to a suggestion made at the Fifty-third World Health Assembly that there should be a standard procedure for handling requests from Member States for special arrangements for the settlement of arrears in the payment of assessed contributions. Such a procedure would permit those countries that were in arrears and subject to Article 7 to reschedule the payment of their arrears as part of an arrangement to have their voting privileges restored. The draft resolution had described the proposed procedure.

The Board had welcomed ABFC's proposal but had suggested the following amendments to the procedure: (i) the request by a Member State for a special arrangement for payment of assessed contributions should include an indication of the minimum amount that the Member was able to pay each year; and (ii) the request could include background information concerning the reasons for the financial difficulties experienced by the Member, though such information would not be mandatory.

The Board had noted that the new procedure also asked Member States seeking special arrangements to indicate whether the Member expected to make payments in local currency, as permitted by the new Financial Regulations and Rules.

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Executive Board in resolution EB107.R3.

The draft resolution was approved.²

**Real Estate Fund: Item 15.4 of the Agenda (Document EB107/2001/REC/1, Annex 1)**

Mrs ABEL (representative of the Executive Board) said that the Board had considered a four-part report by the Director-General on the status of projects financed by the Real Estate Fund (document EB107/2001/REC/1, Annex 1). The Board had noted the status of projects approved for the period ending on 31 May 2001 and had considered the new project submitted by the Director-General for the period 1 June 2001 to 31 May 2002, which consisted in renovating the WHO/PAHO building in Washington DC. Historically, WHO had contributed 25% towards real estate projects related to the WHO/PAHO main building.

The Board had recommended adoption by the Health Assembly of the draft resolution contained in its resolution EB107.R5, which provided for the appropriation to the Real Estate Fund of US$ 2,689,712 from casual income.

The Board had also noted the reported growing difficulties regarding accommodation for WHO and UNAIDS. The Board had recommended that the Director-General pursue her negotiations with the Swiss authorities regarding the construction of a building adjacent to WHO's present premises.

Dr SAMBA (Regional Director for Africa), referring to paragraph 1 on page 27 of the document, pointed out that the building in Harare into which the Regional Office for Africa had moved, far from requiring "minor repair and renovation", had in fact needed extensive work.

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¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA54.5.
² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA54.6.
Nevertheless, the Government of Zimbabwe had borne the full cost of the repairs and he requested that the wording in paragraph 1 be amended to reflect its action.

The CHAIRMAN invited the Committee to consider the draft resolution on the Real Estate Fund contained in resolution EB107.R5.

The draft resolution was approved.¹

Casual income: Item 15.5 of the Agenda (Resolution EB107.R4; document A54/25)

Mrs ABEL (representative of the Executive Board) said that the Executive Board had noted that ABFC supported the proposals for the appropriation of casual income as set out in document EB107/R11. The Board had also been informed that it might be the last such casual income report. If the new Financial Rules were confirmed by the Board, the new Financial Regulations, which had been approved by the Fifty-third World Health Assembly in May 2000, would come into effect. During the transition period, items of income and expenditure would move from casual income to miscellaneous income. The integration of miscellaneous income into the programme budget would provide a more inclusive and consolidated view of the WHO financial framework.

The Board had noted that the estimated balance of casual income as at 31 December 2000 was US$ 22.2 million and that the report on casual income to the Health Assembly contained in document A54/25 would be finalized when the interim financial report for 2000, covering the financial period 2000-2001, had been completed in March 2001. The Board had supported the proposal to replenish the Working Capital Fund by the amount of arrears of contributions received during 2000, which would be consistent with the revised Financial Regulations approved by the Fifty-third World Health Assembly.

The Board had adopted resolution EB107.R4 in which it recommended a draft resolution for adoption by the Health Assembly. That draft resolution should be amended to include the actual figures as at 31 December 2000, which were contained in document A54/25.

The CHAIRMAN invited the Committee to consider the draft resolution on casual income contained in resolution EB107.R4, as amended in document A54/25.

The draft resolution, as amended, was approved.²

Assessment of new Members and Associate Members: Item 15.6 of the Agenda (Document A54/26)

The CHAIRMAN invited the Committee to consider the draft resolution on the assessment of the Federal Republic of Yugoslavia contained in paragraph 6 of document A54/26.

The draft resolution was approved.³

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

The meeting rose at 16:30.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA54.7.
² Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA54.8.
³ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA54.9.
FOURTH MEETING

Friday, 18 May 2001, at 9:45

Chairman: Mr D.Á. GUNNARSSON (Iceland)

1. FIRST REPORT OF COMMITTEE B (Document A54/46)

Dr KUNENE (Swaziland), Rapporteur, read out the draft first report of Committee B.

The report was adopted.¹

2. FINANCIAL MATTERS: Item 15 of the Agenda (continued from the third meeting)

Scale of assessments for 2002-2003: Item 15.7 of the Agenda (Documents A54/27 and A54/36)

Dr THIERS (representative of the Executive Board), speaking on behalf of the Chairman of the Administration, Budget and Finance Committee (ABFC), said that ABFC had noted that the principles and criteria applied in calculating the WHO scale of assessments were described in document A54/27, and that the WHO scale of assessments proposed for 2002-2003 followed that adopted by the United Nations for 2001-2003, as adjusted for differences in membership between WHO and the United Nations. In view of the changes in the United Nations scale and bearing in mind the principle established by previous Health Assemblies to follow that scale as closely as possible, the Committee had concluded that the important issue of scale of assessments would need to be examined by the Fifty-fourth World Health Assembly.

Ms BALOCH (Pakistan) sought clarification as to whether the Executive Board had recommended a change in or review of the scale of assessments.

Dr SADRIZADEH (Islamic Republic of Iran) said that, as the new scale for the years 2002-2003 would have significant economic consequences for a great number of developing countries, including his own, WHO should keep the same scale as in previous years.

Mr TOPPING (Legal Counsel) explained that the Board had placed the question of the scale of assessments for 2002-2003 on the agenda of the Health Assembly because the previous scale would expire at the end of 2001 and the Health Assembly needed to adopt a new scale. ABFC had reviewed the document A54/27, which reflected changes in the United Nations scale of assessments as adopted by the General Assembly. It had noted that in view of the importance of those changes the Fifty-fourth World Health Assembly would need to examine the issue.

Ms BALOCH (Pakistan) asked whether that meant that the Board had not made any recommendation in that connection, but had simply placed the issue on the Health Assembly’s agenda.

¹ See page 307.
Mr TOPPING (Legal Counsel) replied that the Board had not recommended any specific change. By placing the item on the Health Assembly's agenda, the Board had considered that the scale of assessments needed to be reviewed, since a new scale had to be adopted.

Mr MORA GODOY (Cuba), speaking on behalf of the Group of 77 and China, said that the proposed new scale of assessments contained in document A54/27 was based on United Nations General Assembly resolution 55/5, with the suggestion that WHO should follow the scale adopted by the General Assembly. That would mean that the maximum assessment rate would be reduced from 25% to 22%, with substantial reductions in the contributions of just a few Members, so that the other States Members would have to shoulder the burden of the 3% shortfall. It was apparent from document A54/27 that many major contributors from the developed countries were having their assessments reduced, with a resulting increase in contributions for developing countries. Yet the commitment to international cooperation was incumbent upon the developed, not the developing countries, a point that was particularly relevant to WHO's field of activity.

However, there was no mention in document A54/27 of the terms of United Nations General Assembly resolution 55/5 C, paragraph 3, which read "... stresses that the reduction of the maximum assessment rate referred to in paragraph 1 of resolution B above shall apply to the apportionment of the expenses of the United Nations and should have no automatic implication for the apportionment of the expenses of the specialized agencies or the International Atomic Energy Agency". In that respect, the Group of 77 and China considered that WHO had its own characteristics, its own membership and its own clearly defined objectives.

Furthermore, the Group of 77 and China considered that they had had insufficient time to consider the proposal in document A54/27, which would require a more extensive exchange of views including the technical and legal aspects of the question, in order to reach a consensus. He reminded the Committee that Rule 98 of the Rules of Procedure of the Health Assembly provided that:

No proposal for a review of the apportionment of the contributions among Members and Associate Members for the time being in force shall be placed on the agenda unless it has been communicated to Members and Associate Members at least ninety days before the opening of the session, or unless the Board has recommended such review.

In the present case, he understood that there had been no recommendation by the Board for a review of the scale of assessments. In the view of the Group of 77 and China, the Health Assembly should therefore adopt the same scale for the biennium 2002-2003 as for the biennium 2000-2001. They also requested that, before any review of the scale, the Secretariat submit a document showing the real differences in monetary terms in the amount each Member would have to pay.

Mr MOLANDER (Sweden), speaking on behalf of the European Union, stressed the importance of the principle that the United Nations scales did not automatically apply to United Nations agencies such as WHO. Each agency was empowered to decide on the matter in accordance with its own procedures. The scales of assessment decided by the United Nations General Assembly in December 2000, for the years 2001-2003, were the result of a complex package which had made consensus possible. One element of that package was that the reduction of the maximum assessment rate, from 25% to 22%, should only apply to the United Nations and should have no automatic implication for the scales of the specialized agencies. The European Union took the view that the terms of that package deal should be respected. Accordingly, the draft scale of assessments for WHO's 2002-2003 budget should be based on the United Nations scales adopted in December 2000, with the necessary adjustment for differences in membership. That did not imply that the European Union believed that WHO should implement the entire General Assembly resolution, merely the scales. Certain provisions, such as the concept of capping, might create difficulties elsewhere in the system.

The European Union consequently proposed that in the draft resolution contained in document A54/27 paragraph 1(b), paragraph 2, and the text from "subject" to "above" in paragraph 3 should be deleted.
He reiterated the European Union's strong commitment to WHO, and sought consensus on the issue. Collectively, the Union was the largest contributor, and its assessed rates exceeded its share of world GNP by almost 25%; Member States belonging to the Union thus assumed an important financial responsibility, which they had honoured. Due note had been taken of the United States' plan for paying the arrears in its contributions to the United Nations. On the assumption that the proposed new scale of assessments would be adopted by the Health Assembly, the Member States belonging to the Union trusted that the United States administration would expedite the payment of its arrears and assessed contributions to WHO. A move to that effect had recently been made in Washington DC and the European Union would closely monitor developments in that regard.

Mr TASAKA (Japan), commenting on the proposal by the Group of 77 and China, said that, although the United Nations scales of assessments did not automatically apply to WHO, that did not prevent WHO from adopting a new scale based on those scales, in line with its longstanding practice. The new United Nations scales had been adopted after intense discussion, with a view to reflecting the economic situation of each country correctly and fairly. All Member States, including the Group of 77 and China, had approved those scales, for which not only health experts, but also governments as a whole were responsible. Secondly, the United Nations scales were used in most of its organizations and bodies. If a different scale were implemented in WHO, the consistency of assessment scales among United Nations organizations might be destroyed, with possible unexpected and unwanted consequences. Thirdly, it would be time-consuming and would require immense efforts and energy to reach consensus on a new scale totally independent of the United Nations scales.

Japan's assessment rate was greater than its share of world GNP. Nevertheless, and despite its current economic difficulties, it strongly supported the new scale. However, if it had to pay contributions at a higher rate than the United Nations level, it would be difficult to obtain the approval of the Japanese people. He consequently supported the proposal set out in document A54/27.

Mr CHUNG (Republic of Korea) said that his country had made substantial contributions to WHO in the past and would increase its support to the greatest possible extent in the future. However, his Government had serious difficulty with the new scale proposed in document A54/27. The maximum contribution should be reduced gradually, in consideration of the financial implications for Members whose rates would be drastically increased. He noted that the reference to non-automatic application in United Nations General Assembly resolution 55/5 set a precedent for the specialized agencies to adopt individual positions.

Under the proposed new WHO scale of assessment, his Government's contribution would increase by almost 100%. In monetary terms, its biennial contribution would rise from US$ 8.2 million in 2000-2001 to US$ 15.3 million in 2002-2003. The economy of his country was currently experiencing a significant slow-down. Moreover, the budget for the fiscal year 2002 had already been drafted, and his country's administrative procedures did not allow for any drastic change. Under such circumstances, it would be extremely difficult, if not impossible, for his Government to justify any drastic increase in its financial contributions to WHO.

Mr BRODRICK (Australia) said his Government supported the consideration in the Health Assembly of a new scale of assessments. Like the European Union, it did not believe that the United Nations scale should be applied automatically and without debate within agencies. However, as document A54/27 made clear, the latest available United Nations scales of assessments had been used as the basis of the WHO scale for more than 30 years, with the practice entrenched since the Twenty-fourth World Health Assembly. He was not aware of any compelling reasons to depart from such a longstanding practice.

Australia supported the principle of capacity to pay as the basis for assessing financial contributions to the United Nations. Although the latest United Nations scale did not strictly reflect that principle, it was based on a negotiated agreement that balanced difficult considerations. Importantly, it ensured that assessments were levied according to agreed indicators, on the basis of the
latest economic data. Although Australia would pay a higher proportion of WHO’s regular budget under the scale proposed in document A54/27, many Member States would be assessed at a lower rate than under the current scale. He expressed the hope that the adoption of the proposed scale would allow the United States of America to settle its arrears quickly, and urged all Member States to pay their assessed contributions in full and on time.

He therefore supported the draft resolution in document A54/27, and could accept the amendments proposed by the European Union.

Mr WESTDAL (Canada) also supported the draft resolution. Although WHO had to make its own decisions on the scale of assessments, it was the longstanding practice of all United Nations specialized agencies to use as their basis the latest United Nations scale of assessments. As noted in document A54/27, that principle had been established and reaffirmed for WHO in resolutions WHA8.5 and WHA24.12. He saw no compelling reason to depart from that practice, which had served the Organization and its Member States well.

The decision to adopt the latest United Nations scale of assessments had been reached by consensus, after close scrutiny and thorough analysis. The new scale reflected more accurately current global economic realities. He supported the amendments to the draft resolution in document A54/27 proposed by Sweden on behalf of the European Union, and urged Member States to reach a consensus on the scale of assessments. WHO had much more important substantive issues with which to contend than divisive confrontations over the United Nations scale.

Mr SELIM LABIB (Egypt) joined the unanimous position of the Group of 77 and China as set out by the Cuban delegate. The General Assembly’s decision to amend the scale of assessments did not necessarily apply to the specialized agencies; its extension to them could only be on a case-by-case basis. The present situation raised difficulties that had not arisen in the past. The proposed new scale would result in the reduction of the WHO assessments of nine developed countries and an increase in the assessments of 52 developing countries. He endorsed the Cuban delegate’s request for a document showing the relevant figures.

Mr LIU Peilong (China), underlying the importance of the report on the WHO scale of assessments, said that it not only affected many countries but also referred to the issue of maximum contributions and had implications for other specialized agencies. The outcome of the long and arduous discussions at the fifty-fifth session of the United Nations General Assembly had contained various conditions, one of which was that the United Nations scale was not automatically applicable to its specialized agencies. WHO had its own characteristics, and it was not appropriate to base its scale of assessments solely on the United Nations scale.

Under the scale proposed in document A54/27, more than 80 Members would have their assessments raised, most of them in developing countries, while decreases would be mostly among developed countries. The burden of developed countries would thus be shifted to developing countries, which would be contrary to the principle of payment according to ability.

The scale of assessments was a complex issue. Rule 98 of the Rules of Procedure provided that any proposal to adjust the scale should be notified to Members 90 days before the Health Assembly, or should have been recommended by the Executive Board. Any such recommendation should have been included in the records of its January 2001 session. Time was needed to study the question, and he endorsed the proposal put forward by the Cuban delegate for the Group of 77 and his own country.

Mr COSTI SANTAROSA (Brazil) sought clarification as to whether the conditions established by Rule 98 of the Rules of Procedure had been met. Brazil supported the statements on behalf of the Group of 77 and China as well as the statements by China and the Republic of Korea. Brazil had been making an effort to pay its arrears to various organizations, and it would be a burden to experience an average increase of 40% throughout the United Nations system. With regard to document A54/27, he stressed the importance of the principle that the United Nations scale of assessments did not
automatically apply to other agencies such as WHO, as clearly stated in General Assembly resolution 55/5. Consensus on that resolution had only been achieved through agreement on certain issues, including that principle, which had been part of a package that should be respected.

He suggested a debate on the subject, conducted in a timely manner and meeting all procedural requirements, with, as suggested by the Group of 77 and China, a report showing the specific amounts to be paid by each country. For the time being, the only solution was to adopt the previous year's scale of assessments. It would be difficult for many countries to convince their legislative bodies to depart from the package agreed in the United Nations. Any such departure might have implications in numerous specialized agencies, with an increase in contributions for all developing countries in the United Nations system. More time must therefore be allowed for discussion.

Dr AMA T FORES (Cuba) observed that, if the Committee required compliance with the Rules of Procedure, it was in a difficult position. The WHO scale of assessments could not be discussed if Rule 98 had not been complied with. In the present case, the proposal had not been communicated to Members at least 90 days before the session, since document A54/27 was dated 26 March 2001. Moreover, the proposal had not been discussed in any democratic setting, nor had the difficulties it would cause the developing countries been discussed.

The practice in WHO was to use the latest United Nations scale as a basis, but not as an obligation. The process of reaching agreement in the General Assembly had been long, complex and arduous. That applied equally in WHO. The subject required analysis and discussion, and delegations needed to have full information so that they could participate responsibly in the decision-making process in a democratic and transparent manner. Yet all they had was the report containing the draft resolution, with little time for discussion.

He endorsed the Brazilian delegate's comment that applying the WHO proposal to all the United Nations agencies would cause great difficulties to developing countries. All budgetary decisions should be taken collectively, on the basis of information provided ahead of time, thorough analysis of documents, and full discussion. Unfortunately, those conditions had not been met.

Under the proposal in document A54/27 the developed and more powerful countries would have their contributions to the WHO budget reduced and, despite strong economies and well developed industries, were apparently unwilling to pay for the present system. Those reductions, in WHO at least, would be paid for by 52 poorer, developing countries which would not only shoulder that increase but those in other organizations as well. Those countries already had serious problems with unfair foreign debts and appalling situations such as the HIV/AIDS epidemic, and were not receiving the 0.7% of GDP in development aid to which the developed countries had committed themselves.

If the developed countries had problems with their economies, it was obvious that the increases would cause even greater difficulties for most developing countries. As a matter of principle, the developing countries could not accept any kind of "blackmail" by accepting a proposal that ran counter to their interest. Those developed countries that were behind in their payments yet had expressed commitment to the United Nations should admit that, if the proposal was not accepted, they would pay neither their contributions nor their arrears.

He proposed that a scale of assessments like the present scale be extended over the next year, bearing in mind that WHO need not automatically follow the approach taken by the United Nations. The coming year could then be used to undertake studies, provide information and explanations, hold meetings, and build a consensus on the basis of full knowledge and agreement of all. In any case, the fact that procedures had not been complied with invalidated the presentation of the present proposal. Once the necessary steps had been taken, the Health Assembly could accept either the proposed scale of assessments or some other scale. He fully agreed with the statement of the Group of 77 and China.

Mr TOPPING (Legal Counsel), commenting on the application of Rule 98 of the Rules of Procedure, drew particular attention to the words "for a review of the apportionment of the contributions ... for the time being in force". For the biennium 2002-2003 there was no apportionment of contributions in force. The Executive Board had put the item on the agenda of the Health Assembly
because there needed to be an apportionment of the contributions. He pointed out that Rule 98 had been designed to apply to a mid-biennium change, when an apportionment of the contributions was in force; that interpretation had been consistently given to it. Every scale of assessments or apportionment of the contributions for a biennium would involve some change in the apportionment, either as a result of changes in membership from one biennium to the next, or - at least since the Eighth World Health Assembly had decided to follow the most recently available United Nations scale - because of adjustments in the United Nations scale in accordance with that organization's calculations.

He provided examples from the previous four bienniums. In 1993, the Health Assembly had considered a scale of assessment for the biennium 1994-1995 for which the document was issued by the Secretariat on 30 April; the Board had done no more in that year than to include the scale of adjustments as an agenda item. Similar procedures had been followed during subsequent bienniums: for the 1996-1997 budget, considered in 1995, the document had been issued on 29 March; for the 1998-1999 budget, it had been issued on 1 April; and for 2000-2001, the document had been issued on 30 March. In each of those cases, the total action of the Executive Board had consisted of placing the item on the agenda of the Health Assembly. He reiterated that it had been the consistent interpretation and practice of the Health Assembly not to consider Rule 98 as applying to a new biennium, but rather to a current biennium when an apportionment of the contributions had been for the time being in force.

Dr AMAT FORES (Cuba) expressed surprise at the interpretation being given to Rule 98 in the present case. The Health Assembly was considering a proposal that was unlike those approved in previous years, since it was reviewing the scale of assessments currently in force. If the Legal Counsel's interpretation were to be accepted, for the purposes of discussion only, he would need to know when the matter had been dealt with by the Executive Board and what positions had been taken. Yet the Committee had been told earlier that the matter had not been dealt with by the Board. Presumably the report had come directly from the Secretariat to the Health Assembly as an agenda item, making it difficult for countries needing to take decisions and invalidating the procedures being followed in order to reach a conclusion. If his delegation had been able to analyse the matter, it might have reached a different conclusion. However, it could not accept the interpretation offered because it seemed to be completely fallacious: the proposal was clearly to modify a scale of assessments currently in force.

Mr TOPPING (Legal Counsel) said that, in line with the practice followed in previous years, the Executive Board had simply placed the item on the agenda without making any specific recommendation for a change in the apportionment of the scale of assessments from one biennium to the next. Any other interpretation of Rule 98 of the Rules of Procedure would thus represent a departure from previous practice.

Mrs LE THI THU HA (Viet Nam) strongly supported the proposal made by the delegate of Cuba on behalf of the Group of 77 and China, and shared the view that the United Nations scale of assessments should not automatically apply to the specialized agencies. If the new scale of assessment were adopted, Viet Nam's contribution for the next biennium would increase by 105%, which would have serious economic implications. More time was therefore needed to study the matter.

Mr ROKOVADA (Fiji), noting that new scales of assessment had been discussed extensively at previous Health Assemblies, supported the proposed scale of assessments for the period 2002-2003, which was fair, equitable and transparent. He therefore endorsed the draft resolution, together with the amendments proposed by the delegate of Sweden on behalf of the European Union. He joined the delegate of Australia in calling on countries such as the United States of America to pay their arrears of contributions.
Ms BALOCH (Pakistan) stated that her position was the same as that of the Group of 77 and China. She asked whether the reaffirmation made in paragraph 1 of the draft resolution contained in document A54/27 was in line with the practice followed in previous resolutions on the subject, and what were the implications of the proposal to delete paragraph 1(b). She disagreed with the interpretation of Rule 98 of the Rules of Procedure given by the Legal Counsel, since, in her opinion, the words “for the time being in force” meant in this case “in force in 2001”.

Ms WILD (Financial services) said that the wording of the draft resolution was consistent with that used in many previous bienniums, and that the deletion of paragraph 1(b) would have no impact on the figures, which would remain the same.

Ms WARANYA TEOKUL (Thailand) pointed out that the maximum contributions established in the first three resolutions referred to in paragraph 2 of document A54/27 were 33.3%, 30% and 25% respectively, and that it had taken five years of operation to bring down the rate. In accordance with United Nations and WHO practice, the assessment of the highest contribution had been reduced as a result of the admission of new Members. Although Thailand was willing to honour its commitment to the Organization, it would be extremely difficult for it to meet the proposed scale of assessments in view of its current economic crisis. It therefore supported the position adopted by the Group of 77 and China.

Ms CALLANGAN-RUECA (Philippines) recalled that the United Nations scale of assessments did not automatically apply to other organizations. Further consideration of the important and complex matter of the scale of assessments was essential, given the effect of its application on many developing countries. In view of the lack of time for any substantive discussion of the issue, the current scale of assessments for 2001 should stand until the matter could be resolved by consensus.

Dr POUTASI (New Zealand) expressed support for the draft resolution. WHO was an autonomous organization with its own constitution and resolutions adopted by the General Assembly of the United Nations were not binding upon it. However, it had been agreed in the past that the latest available United Nations scale of assessments should be used as a basis for determining the WHO scale, taking into account the different membership and the establishment of minima and maxima. She stressed the importance of the principle of basing assessments on the capacity of Member States to pay, and of the principle that assessed dues should be paid on time, in full and without conditions. She urged all Member States to pay outstanding arrears without delay.

Mr CHAKALISA (Botswana) asked why the item had again appeared on the agenda of the Health Assembly without having first been discussed by the Executive Board, particularly since the same issue had already been debated at length in 2000, and why the 90-day notice rule referred to in Rule 98 of the Rules of Procedure had not been observed. He agreed that maximum efforts should be made to encourage Member States that were in arrears to pay their dues.

Dr SHANGULA (Namibia) endorsed the remarks of the previous speaker, and asked why the necessary measures had not been taken following the prolonged debate held in 2000 on the issue of WHO’s failure to comply with its own Rules of Procedure. He too disagreed with the Legal Counsel’s interpretation of Rule 98: past practice should not be followed as a matter of course once it was recognized that it was not in compliance with the Rules. Any subsequent discussion would be invalidated by failure to follow the correct procedure. He therefore proposed that the matter be referred to the Executive Board for thorough consideration with a view to being brought before the Health Assembly at a later stage.

Mr TOPPING (Legal Counsel) said that the debate of the previous year on the application of Rule 98 had concerned an adjustment to the apportionment of contributions then in force, which
constituted a mid-biennium change. The view at that time had been that the issue could not simply be placed on the agenda of the Health Assembly without substantive prior consideration by the Executive Board. The current debate concerned a different issue, namely an apportionment of contributions which would apply only for the next biennium. If the Health Assembly did not adopt a new apportionment of contributions, there would be no decision on who would have to pay for the budget. To decide that Rule 98 was applicable even between biennia would represent departure from a practice followed consistently for years, and it would be difficult for the Organization to function in circumstances where the interpretation of its rules was changed from year to year.

Mr ERNST (Chile) fully supported the proposal made on behalf of the Group of 77 and China for the reasons stated by earlier speakers.

Mr COSTI SANTAROSA (Brazil) associated himself with the statement made by the delegate of Namibia and disagreed with the views expressed by the Legal Counsel, which reflected budgetary considerations. A practice that ran counter to written rules could not take precedence over those rules. Brazil had anticipated that the scale of assessments for contributions would remain unchanged for the next biennium. In the event of a review, however, Rule 98 should apply. In his view, it was not consistent with good legal practice for a rule to be applicable only every two years.

Dr VIVAS (Uruguay) added her full support to the statement made on behalf of the Group of 77 and China. The interpretation of procedure was a matter for the Member States and not for the Secretariat. In the interests of a proper debate, she requested details of the actual amounts, in dollars, which Member States would have to pay under the proposed new scale of assessments. She was perplexed by the drastic increase of more than 68.8% which the new scale heralded for her own country and by the equally drastic decreases envisaged in the contributions of certain developed countries. Such changes would require extensive consultation with the Member States involved. If, as they claimed, the developed countries had difficulty in continuing to pay the contributions they used to pay, how would the developing countries fare when they were already making major domestic sacrifices in order to make timely payment at current rates of assessment? Some governments would be unable to accept such increases in view of the financial and economic difficulties they faced. She urged that more time should be allowed for consideration of the issue.

She could not accept the version of the draft resolution proposed by the European Union, which appeared to contain inconsistencies. Referring to paragraph 2 of the draft resolution contained in document A54/27, she pointed out that “as closely as possible” indicated that WHO was not required automatically to apply the United Nations scale of assessments. She asked for clarification of the phrase “as a matter of principle” in paragraph 2(a).

Mr SUTOYO (Indonesia) shared the view that the United Nations scale of assessments should not be automatically applied to WHO. He urged that, in addition to the global economic situation, the economic and financial crisis in his own country should be taken into account in any adjustment of the WHO scale of assessments. He fully supported the statement made by the Cuban delegate on behalf of the Group of 77 and China, and considered that any draft resolution on the scale of assessments for the period 2002-2003 should be adopted by consensus. His delegation would prefer the current scale to remain unchanged.

Mr JHA (India) said that his delegation associated itself with the position of the Group of 77 and China. He saw no justification for automatically applying the scale of assessments adopted in General Assembly resolution 55/5 in order to establish the apportionment of contributions for the specialized agencies. He noted that maintaining the level of the regular budget while at the same time revising the scale of assessments would adversely affect the developing countries. More time was needed to consider the matter, and in the meantime the scale of assessments for the current biennium should be maintained for the biennium 2002-2003.
Mr GUILLEN (Peru) also supported the position of the Group of 77 and China. There appeared to be consensus on the principle that the United Nations scale of assessments need not automatically be applied to the specialized agencies. A change as drastic as the one proposed called for a longer period of consideration and a careful analysis of the implications.

Ms BENAVIDES COTES (Colombia) joined in supporting the proposal put forward by the delegate of Cuba on behalf of the Group of 77 and China. The procedures and time constraints set out in the Rules of Procedure of the Health Assembly were intended to ensure transparency and adequate consultation between WHO and its Member States in order to arrive at a constructive solution that reflected financial realities. The Legal Counsel had clarified the practice followed in establishing the WHO scale of assessments, but it would appear that errors might have been made in the past which should be corrected. Several speakers had pointed out that a United Nations resolution was not automatically applicable to the specialized agencies, and in her view the scale for the current biennium should be maintained while the proposed new scale received further consideration. Developing countries were already making major efforts to meet their obligations and to settle their arrears. For Colombia the increase in contribution was significant, and it would be unable to meet it in the light of its current financial situation.

Mr RODRIGUEZ-SAN MARTIN (Bolivia) recalled that the General Assembly resolution in question had emerged from lengthy negotiations between Member States, following which it had been agreed that it should not be automatically applicable to the specialized agencies. He did not agree with the interpretation of Rule 98 provided by the Legal Counsel. He considered that the information provided was insufficient and unclear, and, supporting the proposal put forward on behalf of the Group of 77 and China, requested that figures be provided showing what the actual increases in contributions would be.

Dr HAMID (Iraq) noted that his country was listed in the annex to document A54/23 as being in arrears in the payment of its contributions. Iraq had attempted to pay its contributions but its cheque had not been passed by the United Nations Sanctions Committee. Other attempts in the context of the arrangements under the Memorandum of Understanding on oil for food had also failed, as the matter was still pending before the Security Council. There was a need to distinguish between those Member States that wanted to pay but were prevented from doing so and those that were deliberately withholding payment.

Mr VARELA (Argentina) said that application of the criteria inherent in General Assembly resolution 55/5 would lead to substantial increases in the level of assessed contributions of developing countries, many of which, including Argentina, were not only experiencing economic difficulties but were also affected by the adverse global economic climate. These were compelling reasons for adhering to the status quo. He urged that the proposal made by Cuba on behalf of the Group of 77 and China be adopted.

Mr HERNANDEZ (Venezuela) also endorsed that proposal. Since 1991 Venezuela had made major efforts to pay its contributions despite budgetary difficulties, which increases in its assessed contributions to other United Nations organizations had compounded. He urged that the scale of assessments for the current biennium be maintained until the possible implications of the proposed adjustments had been studied.

Mr MOLANDER (Sweden), speaking on behalf of the European Union, pointed out that two separate issues were involved: the proposed new scale of assessments and the interpretation and application of Rule 98 of the Rules of Procedure. On the first issue, the European Union had already stated that it was ready to adopt the proposed scale, together with the deletion from the text of the related draft resolution of certain elements which it believed might create difficulties in other
international organizations. On the second issue, it supported the interpretation of Rule 98 given by the Legal Counsel. If the interpretation favoured by Cuba were to be applied, there was a risk that by the end of the year 2001 there would be no scale of assessments in force, because the proposal to maintain the current scale had not been available to Members 90 days before the Health Assembly.

Ms JOHNSON (United States of America), while recognizing the autonomy of the specialized agencies, pointed out that 30 years before in adopting resolution WHA24.12 the Health Assembly had decided, for reasons of fairness and efficiency, to use the latest available United Nations scale of assessments as a basis for determining the WHO scale of assessments. The latest United Nations scale had been adopted by consensus after long and intensive negotiations, and rejection of it would burden WHO with a task it was neither financially or technically equipped to handle and would divert considerable resources from more appropriate programmatic uses. She concurred with the Legal Counsel's interpretation of Rule 98 of the Rules of Procedure, and urged delegates to adopt the draft resolution contained in document A54/27 as amended.

Dr BELLO DE KEMPER (Dominican Republic), with reference to the appeal by the delegate of Botswana for countries in arrears to settle their outstanding obligations, said that her country had submitted a plan for the rescheduling of its arrears. The proposed new scale would entail an increase of more than 50% in the contribution of her country, which would severely jeopardize its ability to comply with that payment plan.

Dr MOSOTHO (Lesotho), recalling that the subject had already been debated at previous Health Assemblies, noted that two positions had emerged: that of delegates who wanted to adopt the proposal with minor amendments and that of delegates who, while not objecting to the essence of the proposal, wanted the procedural aspects to be respected, in particular regarding application of Rule 98 of the Rules of Procedure. He proposed that the matter be put to the vote.

Ms HOCHSTETTER (Guatemala) fully supported the proposal made by Cuba on behalf of the Group of 77 and China, and endorsed the views of earlier speakers concerning the applicability of General Assembly resolution 55/5 to the specialized agencies. The scale of assessments adopted in that resolution was a compromise intended to alleviate the financial crisis of the United Nations, and would represent a major financial burden for developing countries, including her own. More time was required to consider the proposed new scale.

Dr ADAM (Kenya) said that his country would suffer the same consequences as other developing countries in the event of adoption of the new scale. In view of the lack of agreement regarding the interpretation and application of Rule 98 of the Rules of Procedure, he sought the Chairman's guidance as to whether the debate should continue.

Dr AMAT FORÉS (Cuba) pointed out that his proposal did not involve any modification of the scale of assessments currently in force, and therefore the argument put forward by the delegate of Sweden was invalid.

Ms BALOCH (Pakistan) proposed that the new paragraph 2 of the text proposed by the delegate of Sweden on behalf of the European Union should be further amended to read “DECIDES that the scale of assessments for the years 2002 and 2003 shall be the same as the scale in force for the current financial year”.

Ms BU FIGUEROA (Honduras) joined in supporting the statement made by the delegate of Cuba on behalf of the Group of 77 and China. She was concerned by the unjustified and inequitable increase in the contributions of developing countries, and was unable to support the draft resolution proposed in document A54/27. She urged that the current scale of assessments be maintained, and that
consultations between Member States be held with a view to reaching agreement on a solution that would take account of the capacity of developing countries to pay.

Mr COSTI SANTAROSA (Brazil) agreed that two different issues were under discussion. He asked for clarification from the Legal Counsel of the first, namely the applicability of Rule 98, before proceeding to deal with the second. He was not clear as to how a rule of procedure could be applicable in some years but not in others. In any event, the proposal made by the delegate of Cuba could not be considered as subject to Rule 98, since it was for the maintenance of the existing scale of assessments.

Mr TOPPING (Legal Counsel), in reply to an earlier point raised by the delegate of Brazil, said that it was not a question of whether practice should prevail over a conflicting rule, since the practice followed by WHO over the years was in fact consistent with the wording of Rule 98. The rule had been interpreted – consistent with its wording – as applying only when there was a scale of assessment in force during a biennium that needed to be changed. In reply to the most recent point raised by the delegate of Brazil, it was possible to have a rule of procedure that applied in some years but not in others, depending on the wording of the rule and the circumstances that existed in any particular year. The rules dealing with the appointment of the Director-General and with the admission of new Member States were two examples that easily came to mind. In reply to a question put by Ms BALOCH (Pakistan), he said that the scale of assessments adopted in resolution WHA52.17 applied only to the years 2000-2001. Therefore, no scale of assessments was in force for the years 2002 and 2003.

Mr AITKEN (Senior Policy Adviser) said that for many years WHO had based itself upon the work done by the United Nations in New York in respect of revision of the scale of assessment. On the current occasion that work had involved two issues: reaching a solution in line with a political requirement for reform of the United Nations scale to apply a new maximum level and a normal revision of the United Nations scale based on new financial and economic information about countries. It was difficult to separate those two issues. The new scale of assessments received from New York would mean that some countries would see an increase in their contribution and some a decrease. There were developing and developed countries in both categories. The Secretariat would be willing to give the Committee a table showing such increases and decreases. Earlier that year, as was customary, the Secretariat had asked the Executive Board if it wanted to place the new scale of assessments on the agenda of the Health Assembly; the Board, as also was customary, had not substantively reviewed the scale. He pointed out that the Secretariat did not have the capacity to recalculate the United Nations scale, although it would be able to provide some additional data.

Dr AMAT FORÉS (Cuba) proposed that the draft resolution be amended to read:

1. NOTES the United Nations General Assembly resolution 55/5 on the scale of assessments;

2. DECIDES, by virtue of the United Nations General Assembly resolution 55/5, section C, paragraph 3, that the Executive Board should make an evaluation of the scale of assessments of the United Nations, bearing in mind the characteristics of WHO and after a process of coordination with the Member States, and submit its recommendations to the Fifty-fifth World Health Assembly.

The CHAIRMAN noted that most speakers sought to achieve consensus. He therefore proposed that an informal working group should be convened to discuss the issue on the basis of a new document to be produced by the Secretariat and to report to the Committee at its seventh meeting.
Mr AITKEN (Senior Policy Adviser), in reply to a request for clarification, said that the document could show the amount of each country's contribution under the scale of assessments for 2000-2001 as compared to the proposed scale for 2002-2003 for both a zero nominal growth and a zero real growth budget.

Dr AMAT FORÉS (Cuba) said that, while he appreciated the offer to produce a background document, a matter of such complexity could not be resolved by a working group in a single day. Most delegates were agreed that more time was needed, and that a review should be carried out within WHO for submission to the next Health Assembly.

Ms BALOCH (Pakistan) considered that there was no need to wait for a background document and that the matter should be debated by the Committee rather than by a working group.

Dr SHANGULA (Namibia) supported the Chairman's proposal to form a working group.

Mr SELIM LABIB (Egypt) endorsed the statements made by the delegate of Pakistan and by the delegate of Cuba on behalf of the Group of 77 and China. He too supported the convening of a working group.

Ms BENAVIDES COTES (Colombia) said that the Committee needed to discuss not the proposed new scale of assessments in general, but rather the specific amendments to the draft resolution contained in document A54/27 that had been proposed by the European Union, Cuba and Pakistan. She was not clear what purpose would be served by discussing those amendments in a working group.

Mr MOLANDER (Sweden), speaking on behalf of the European Union, also requested clarification as to the mandate of the working group.

The CHAIRMAN suggested that in order to give a balanced representation of the regions, Australia, Botswana, China, Cuba, India, Namibia, Pakistan, Sweden and the United States of America should participate in the working group.

Mr COSTI SANTAROSA (Brazil) said that the amendments should be discussed either by an open-ended group or by the full Committee.

Ms BALOCH (Pakistan) agreed that, since formal proposals had been made, they should be considered by all Member States, not by a selected few, in accordance with the proper procedure. If no consensus could be reached, the Committee should proceed to a vote.

Dr AMAT FORÉS (Cuba) supported that view. He requested that the Committee be provided with a text of the proposed amendments.

Mr AITKEN (Senior Policy Adviser) said that a document containing the text of the amendments could be made available to members of the Committee the following morning.

The meeting rose at 12:55.
FINANCIAL MATTERS: Item 15 of the Agenda (continued)  
Scale of assessments for 2002-2003: Item 15.7 of the Agenda (Documents A54/27 and A54/36) (continued)

The CHAIRMAN recalled that, in view of the proposal made by the European Union at the fourth meeting of the Committee regarding the scale of assessments and amendments to that proposal submitted by Cuba and Pakistan, most delegations had been in favour of setting up an open-ended working group to reach a consensus for presentation to the Committee at its seventh meeting. He proposed to give the floor to the seven speakers still on his list after presentation of that agreed position and that the Committee should in the meantime consider the supplementary agenda item, “Effective functioning of the governing bodies in WHO”.

Mr COSTI SANTAROSA (Brazil) did not recall that agreement had been reached on setting up an informal working group. The speakers on the Chairman's list should be consulted as to whether they would agree to speak later. The important issue of the scale of assessments should not be postponed until the penultimate day of the Assembly, and he advocated that the deliberations be concluded at the current meeting.

Mr SELIM LABIB (Egypt) concurred and said that the positions of various countries were clear: the Cuban delegation had proposed an amendment on behalf of the Group of 77 and China, and Pakistan and the European Union had made further proposals. The remaining speakers should state their views before a working group was set up.

Mr MORA GODOY (Cuba) agreed with the two previous speakers and reiterated that the Group of 77 had submitted a proposal to retain the current scale of assessments for the coming biennium. There was little room for negotiation. Bearing in mind that little time was available to the Committee and that the United Nations had taken three months to negotiate a new scale, it would not be possible to introduce a scale different from that for the 2000-2001 biennium.

Ms BALOCH (Pakistan) made a formal proposal that the amendments that had been tabled be discussed.

Mrs LAMBERT (South Africa) fully supported the position of the Group of 77. Failure to accept the proposal for a new scale of assessments would not create a legal vacuum as the previous dispensation would continue to apply. She urged the meeting to resolve the matter. Many developing countries, including South Africa, might shortly be making contributions to the proposed global AIDS and health fund. Any additional financial commitments would have to be examined carefully and should not be made at short notice or under any kind of pressure.
Dr AL KHRABSEH (Jordan) supported the position of Cuba and Pakistan that a working group should not be set up. The majority opinion seemed to be that the current scale of assessments should be retained. He asked that the matter be put to a vote.

Ms JOHNSON (United States of America) said that no hasty decision should be taken on the important issue before the Committee. She supported the Chairman’s proposal to establish a working group, which would give delegations time to consult their capitals.

Mr DÜRLER (Switzerland), supported by Ms STA VAS (Sweden), speaking on behalf of the European Union, said that the weekend break could be used for informal talks. He therefore proposed that the Committee should take up other agenda items and resume discussion of the assessment scales at its seventh meeting. He would be opposed to a vote at the current meeting.

Mr WARRINGTON (United Kingdom of Great Britain and Northern Ireland) supported the views expressed by Sweden on behalf of the European Union and the position of Switzerland. He pointed out that, although his country would have to pay considerably more under the new scale, that did not affect his position on the point of principle. He thought it sensible, convenient and practical to have one scale of assessment throughout the United Nations system; a decision to break WHO away from the common scale would have major long-term consequences. If the scales for 2000-2001 were retained over the long term, it would at some point be necessary to negotiate new scales, which would be very time-consuming. Also, there was a danger of a spill-over effect to other agencies. He would be happy to participate in a working group. Consensus was preferable to a vote, but no vote should in any case be taken until the seventh meeting of the Committee.

Ms BALOCH (Pakistan) noted the comments about the desirability of a single scale throughout the United Nations system and the danger of a spill-over but recalled the gentlemen’s agreement when United Nations General Assembly resolution 55/15 had been adopted that the provisions would not apply to United Nations agencies, and that was what the Group of 77 was urging. She called for a vote to decide whether consideration of the question should be postponed.

Mr MORA GODOY (Cuba) said that matters with long-term consequences could not be decided over a weekend. He supported the motion by Pakistan under Rule 63 of the Rules of Procedure and requested a roll-call vote.

Dr SHANGULA (Namibia) concurred with the calls of Cuba and Pakistan to put the matter to a vote. It had been his understanding that the proposed working group was simply to have incorporated the suggested amendments in the draft resolution. If in fact its role was to renegotiate, he could not agree to its constitution. Only once the proper procedures had been followed could the substance of the issue be discussed. That would not occur during the lifespan of the current Health Assembly.

Mr TASAKA (Japan) supported the proposal by the delegates of the United States of America and of Sweden on behalf of the Member States of the European Union to postpone the discussion on the item until the following week. The issue of the scale of assessments affected several international organizations and had serious financial implications for his country. Delegations needed time to consult their capitals.

The DIRECTOR-GENERAL urged the Committee not to decide on the scale of assessments by a vote before exploring all other possibilities of reaching a consensus. WHO was the first specialized agency to consider the issue since the decision of the United Nations General Assembly, and it was important that Member States should make every effort to overcome the divergence of views by consultation. She therefore proposed that the meeting should be suspended to allow her time to consult some of the delegations that had taken different positions on the issue.
The CHAIRMAN, on the advice of Mr TOPPING (Legal Counsel), asked whether the Committee was prepared to agree to suspend the meeting.

Ms BALOCH (Pakistan) and Mr MORA GODOY (Cuba) said that their delegations could agree to suspend the meeting. The latter did so on the understanding that, when the meeting was resumed, the Committee would decide whether to proceed to a vote.

The meeting was suspended at 15:30 and resumed at 17:00.

The CHAIRMAN, summing up the situation, said that the Committee had before it a draft resolution to which Sweden on behalf of the European Union had proposed an amendment, which in turn was the subject of proposed amendments by Cuba and Pakistan. At the Committee's fourth meeting, many countries had requested additional information about the scale of assessments, including a comparison of scales and an indication of the implications of the proposed amendments for the scale of assessments. There had been extensive discussion at both the fourth and the present meeting about the establishment of an informal working group.

On the advice of Mr TOPPING (Legal Counsel), the CHAIRMAN asked the Committee whether it was prepared to agree to the establishment of a working group to work over the weekend, with new information from the Secretariat, in an effort to find a consensus solution.

Mr MORA GODOY (Cuba) said that the Group of 77 and China were against the establishment of a working group. Many delegations were leaving over the weekend and would be unable to participate in the important decision the following week. None of the proposed measures alleviated the concern of the Group of 77 and China that automatic application of the current United Nations scale of assessment would have a negative impact on the economies of many developing countries. He therefore proposed that the Committee act on Pakistan's motion under Rule 63 to close the debate and move to a vote.

Mr MOLANDER (Sweden), expressing regret that an attempt was being made to impose a vote before the Committee had done everything possible to solve the issue, proposed that the debate on the item be adjourned under Rule 62.

Mr COSTI SANTAROSA (Brazil), speaking on a point of order, asked whether Cuba's proposal under Rule 63 to close the debate on the item should not take precedence over the later request by Sweden under Rule 62.

Mr TOPPING (Legal Counsel) drew the Committee's attention to Rule 64, which set down the order of precedence of different procedural motions.

The CHAIRMAN said that, in the light of Rule 64, the Committee should first consider Sweden's proposal to adjourn the debate on the item under discussion. He invited one delegation to speak in favour and one delegation to speak against the motion.

Mr DÜRLER (Switzerland) supported Sweden's proposal to adjourn the debate on the item.

Mr MORA GODOY (Cuba) said that the Group of 77 and China opposed Sweden's proposal to adjourn the debate. There should be no further suspensions, and the Committee should proceed without delay to a vote on the draft resolution.

Mr MOLANDER (Sweden), speaking on a point of order, asked for a vote on the proposal to adjourn the debate to be held by roll-call.
Mr BÁRCIA (Portugal) supported the proposal for a roll-call vote.

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

The result of the vote was as follow:

In favour: Australia, Austria, Belgium, Bulgaria, Canada, Croatia, Cyprus, Czech Republic, Denmark, Fiji, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Kenya, Latvia, Lesotho, Lithuania, Luxembourg, Netherlands, New Zealand, Norway, Palau, Papua New Guinea, Poland, Portugal, Republic of Korea, Romania, San Marino, Slovakia, Spain, Sweden, Switzerland, Tonga, Turkey, Uganda, United Kingdom of Great Britain and Northern Ireland, United States of America, Zimbabwe.

Against: Algeria, Angola, Argentina, Bahama, Bahrain, Bangladesh, Bhutan, Bolivia, Botswana, Brazil, Burkina Faso, Cambodia, Chile, China, Colombia, Congo, Côte d’Ivoire, Cuba, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Guatemala, Guinea, Honduras, India, Indonesia, Islamic Republic of Iran, Jordan, Lebanon, Madagascar, Malaysia, Maldives, Morocco, Mozambique, Myanmar, Namibia, Nicaragua, Oman, Pakistan, Paraguay, Peru, Philippines, Qatar, Saudi Arabia, Singapore, South Africa, Sri Lanka, Sudan, Swaziland, Syrian Arab Republic, Thailand, Tunisia, United Arab Emirates, United Republic of Tanzania, Uruguay, Venezuela, Viet Nam, Yemen.

Abstaining: Belarus, Jamaica, Mexico, Russian Federation, Senegal.

Absent: Albania, Andorra, Barbados, Belize, Benin, Brunei Darussalam, Burundi, Cameroon, Cape Verde, Cook Islands, Costa Rica, Democratic People’s Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominica, Estonia, Ethiopia, Gabon, Ghana, Grenada, Guyana, Haiti, Kiribati, Kuwait, Lao People’s Democratic Republic, Libyan Arab Jamahiriya, Malawi, Mali, Malta, Mauritania, Mauritius, Monaco, Mongolia, Nepal, Panama, Rwanda, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Sao Tome and Principe, Seychelles, Sierra Leone, Slovenia, Solomon Islands, The former Yugoslavia Republic of Macedonia, Togo, Trinidad and Tobago, Tuvalu, Uzbekistan, Vanuatu, Yugoslavia, Zambia.

The proposal was therefore rejected by 60 votes to 45, with 5 abstentions.

Mr BÁRCIA (Portugal), in an explanation of vote, said that his delegation had voted in favour of the motion not with respect to the scale of assessments but because there appeared to be no wish to reach an agreement through dialogue, which ran contrary to the very principles upon which the Organization and the United Nations system were founded. Having recourse to a vote was sometimes necessary as a last resort, but he expressed the hope that in this case delegates, irrespective of the position they had adopted on the scale of assessments, could be prevailed upon to agree to the proposal to establish a working group.

The CHAIRMAN explained that, under Rule 63 of the Rules of Procedure, one speaker could still speak against Cuba’s motion to close the debate. However, there would need to be at least three further votes, and provision had been made for only another fifteen minutes of interpretation. He therefore suggested that the item be postponed.

Mrs LAMBERT (South Africa), speaking on a point of order and supported by Dr SOMBIE (Burkina Faso), Dr SHANGULA (Namibia), Dr AMAT FORÉS and Mr MORA GODOY (Cuba), Professor ABOUO N’DORI (Côte d’Ivoire) and Mr COSTI SANTAROSA (Brazil), considered that
the Chairman's suggestion to postpone the debate ran contrary to the result of the vote that had just been taken.

Mr MORA GODOY (Cuba) added that the Group of 77 countries and China, whose views he was representing, were under the impression that an attempt was being made to override the decision that had been taken by a majority of the Committee, namely, not to adjourn the meeting, but to proceed to a vote.

Mr SAINT-PAUL (France), speaking on a point of order and supported by Mr WARRINGTON (United Kingdom of Great Britain and Northern Ireland), Mr WESTDAL (Canada) and Mr BOTZET (Germany), observed that certain issues could come up during a vote that might require an explanation, in particular, from Legal Counsel. Therefore, if no interpretation was available it would be better not to continue with the vote. Furthermore, postponing the meeting for 48 hours might restore the spirit of reconciliation when the Committee resumed its work.

Mr MOLANDER (Sweden), speaking on a point of order, said that it was essential to find a satisfactory solution that would enable the Committee to extricate itself from what had become a highly regrettable situation. His motion to adjourn the debate had been made in the hope that diplomacy would prevail and that confrontation could be avoided. Furthermore, in order to be able to proceed to a vote, it would be necessary for the Secretariat to prepare a document containing all the proposals and amendments that had been put forward. It was important to recognize that what was at stake was the credibility of the Organization and its ability to finance health programmes in the future for those most in need.

Mr MORA GODOY (Cuba), rising on a point of order, said that an attempt was being made to reopen the debate after the voting cycle had started, in violation of Rule 76 of the Rules of Procedure of the Health Assembly. As the delegate of Sweden had said, the way the meeting was proceeding was indeed lamentable. Certain delegations were resorting to tricks and traps to subvert decisions that the Health Assembly should rightly take on the issues under discussion. His delegation had proposed a draft resolution, and that should be decided upon within the Rules of Procedure.

Mr MOLANDER (Sweden), speaking on a point of order, as the originator of what the delegate of Cuba had described as tricks and traps, pointed out that the Chairman had not in fact announced a vote. His delegation opposed the motion by the delegate of Cuba to close the debate in accordance with Rule 63. If the Committee was prepared to vote on the Cuban motion, he respectfully submitted a motion for adjournment of the meeting, under Rule 61, the vote on which took precedence.

Mr TOPPING (Legal Counsel), responding to a request from Mr COSTI SANTAROSA (Brazil) about the order of precedence of motions, said the delegate of Sweden had spoken against the motion of the Cuban delegation in accordance with Rule 63 and had then proposed the adjournment of the meeting in accordance with Rule 61. The correct procedure was to move immediately to a vote on the latter proposal.

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

The result of the vote was as follows:

In favour: Australia, Austria, Bahamas, Belarus, Belgium, Bulgaria, Canada, Croatia, Cyprus, Czech Republic, Denmark, Fiji, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Kenya, Latvia, Lesotho, Lithuania, Luxembourg, Netherlands, New Zealand, Norway, Palau, Papua New Guinea, Poland, Portugal, Republic of Korea, Romania,
San Marino, Slovakia, Spain, Sweden, Switzerland, Turkey, Uganda, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Yugoslavia, Zimbabwe.

Against: Algeria, Angola, Argentina, Bahrain, Bangladesh, Benin, Bhutan, Bolivia, Botswana, Brazil, Cambodia, Chile, China, Colombia, Cuba, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Guatemala, Honduras, India, Indonesia, Islamic Republic of Iran, Jordan, Madagascar, Malaysia, Mexico, Morocco, Myanmar, Nicaragua, Oman, Pakistan, Panama, Paraguay, Peru, Philippines, Qatar, Saudi Arabia, South Africa, Sri Lanka, Sudan, Swaziland, Syrian Arab Republic, Thailand, Tunisia, United Arab Emirates, Uruguay, Venezuela, Viet Nam, Yemen.

Abstaining: Burkina Faso, Congo, Côte d'Ivoire, Guinea, Jamaica, Mali, Russian Federation, Senegal, Singapore.

Absent: Albania, Andorra, Barbados, Belize, Brunei Darussalam, Burundi, Cameroon, Cape Verde, Cook Islands, Costa Rica, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominica, East Timor, Fiji, Gabon, Ghana, Grenada, Guyana, Haiti, Kiribati, Kuwait, Lao People's Democratic Republic, Lebanon, Libyan Arab Jamahiriya, Malawi, Maldives, Malta, Mauritania, Mauritius, Monaco, Mongolia, Mozambique, Nepal, Rwanda, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Sao Tome and Principe, Seychelles, Sierra Leone, Solomon Islands, The former Yugoslav Republic of Macedonia, Togo, Tonga, Trinidad and Tobago, Tuvalu, Uzbekistan, Vanuatu, Zambia.

The motion was therefore rejected by 53 votes to 48, with 9 abstentions.

The meeting was suspended at 19:15 and resumed at 19:30.

The DIRECTOR-GENERAL said that, following a discussion with representatives of the Group of 77, she had decided to withdraw the draft resolution contained in document A54/27. The Secretariat would prepare new proposals that she believed would allow the delegates to reach a consensus.

Mr MORA GODOY (Cuba) pointed out that there had not been sufficient time to consult all the countries of the Group of 77 and requested a suspension to allow them to consult on the Director-General's proposal to withdraw the draft resolution.

Mr AKRAM (Pakistan) thanked the Director-General for her bold decision. Although it was true that not all delegations had been consulted, he considered that the Director-General's decision to withdraw her proposal presented the Committee with a new situation. Pakistan would be happy to participate in consultations both in the Group of 77 and with other delegations with a view to moving towards an amicable solution.

Mr MOLANDER (Sweden) said his delegation also appreciated the Director-General's step. His delegation and those of other Member States of the European Union would be prepared to contribute to those consultations.

Dr AMAT FORÉS (Cuba) said that the Director-General's decision reflected her ability to assess the reaction of the countries making up the Group of 77 and China. He trusted that the solution that she would propose would take account of that reaction. The underdeveloped and poor countries had tried to make it clear that they could not accept a situation that would place an even heavier burden on their economies. He asked that the proposal be considered from that point of view. Those
countries did not want to be accused subsequently of trying to undermine WHO; on the contrary, for the Organization to function well, the Member States had to consider that it represented their interests and not just those of one group of countries which, in the present case, were not those in the most difficult situation.

Professor ABOUO N'DORI (Côte d'Ivoire) congratulated the Director-General on finding a wise compromise solution and asked the Committee to agree to discuss another proposal.

Mr CHUNG (Republic of Korea) complimented the Director-General on her courage and leadership. He asked that his delegation's request for a gradual and incremental adjustment be taken into consideration.

Professor ONGERI (Kenya) welcomed the Director-General's suggestion that the Secretariat draft a proposal that would be seen to be equitable and fair by all delegations, so enabling consensus.

The meeting rose at 19:40.
SIXTH MEETING

Monday, 21 May 2001, at 10:00

Chairman: Mr. D. Á. GUNNARSSON (Iceland)

1. **FINANCIAL MATTERS**: Item 15 of the Agenda (continued)

Scale of assessments for 2002-2003: Item 15.7 of the Agenda (Document A54/49) (continued)

The CHAIRMAN drew the attention of the Committee to a new proposal by the Director-General on the scale of assessments for 2002-2003 contained in document A54/49, in response to the Committee’s extensive discussions at its fifth meeting.

The DIRECTOR-GENERAL, introducing the document (A54/49), said that on account of the profound differences of view between delegations as to the correct basis for determining Member States’ financial contributions to WHO's budget for the coming biennium, the original draft resolution had been withdrawn. New proposals had been prepared to help delegations reach a consensus during the current Assembly, in order to ensure that WHO had sufficient funds to implement its activities as set out in the strategic programme budget for 2002-2003.

Although it had been hoped that delegations might have agreed to a small increase in the budget for the biennium to take account of cost increases, it appeared that once again a zero nominal growth budget for the biennium would be approved when the appropriations resolution was discussed later in the day. Such a budget would limit the Organization’s ability to address some of the newer imperatives that required attention. Strenuous efforts would have to be made to take resources from the planned programmes of work to finance the continued negotiations for the framework convention on tobacco control, and further savings would have to be made to finance the improvement in the Organization’s capacity to help Member States to intensify their efforts to confront HIV and other health problems that affected poor countries in particular.

The situation would be far more serious, however, if delegations were unable to agree on the financing of even a zero nominal growth budget. Various positions needed to be taken into account: first, the position of delegations that considered that WHO and other specialized agencies of the United Nations should be moving towards the new United Nations scale of assessments that would come into effect in 2002; secondly, the position of those delegations that accepted the need for the change but wanted it to be gradual; and thirdly, that delegations that did not want to see any change at all and wanted WHO to continue to use the current scale of assessments.

With regard to the latter, it was clear that, if the Health Assembly were to vote for no change to the scale of assessments, several countries, particularly those that would have expected to pay substantially less had WHO adopted the new United Nations scale, might not be able to pay the difference. That was not to be seen as a north-south issue as many developing countries would be paying less under the new scale and many developed countries would be paying more. If the current scale were maintained, the loss to WHO over the biennium would seriously hinder the Organization’s capacity to implement the planned 2002-2003 programme.

In order to mitigate the added burden on some countries, therefore, it was proposed that any Member whose contribution was reduced by application of the 2002 United Nations scale would be expected to pay only that reduced figure. The contributions from Members classified as least developed countries would be assessed at the 2001 level unless application of the 2002 United Nations scale resulted in a lower contribution, in which case they would be expected to contribute at that lower
level. In addition, the burden of the increased contributions that Members might face as a result of applying the 2002 United Nations scale would be mitigated by the application of relief measures. The proportion of the increase subject to relief would be the same for all non-least developed countries, as any other approach would be complex to implement and might well prove contentious. Members not wanting to take advantage of the relief provisions would be invited to consider contributing an equivalent amount to miscellaneous income.

The proposed level of relief for 2002-2003 required a delicate balance. The higher the degree of relief provided, the greater the difficulty for the Organization in securing sufficient funds to implement its programmes. For 2002, therefore, countries facing an increase in contributions would be given 100% relief; in other words, they would not have to pay any of the increase for that year. For 2003, countries facing an increase in contributions would be given 75% relief, and would only have to pay 25% of the increase. If that proposal were approved, the funding gap for 2002 would amount to almost US$ 21 million and that for 2003 to almost US$ 16 million. The shortfall, some US$ 37 million for the biennium, would be met by using miscellaneous income to support the regular budget. Some pressures would thereby be created, however, as considerable amounts from miscellaneous income had been destined for key programmes.

Information had been received that at least one country with significant payment arrears would expect to be able to remit them promptly to WHO. Those funds would be credited against miscellaneous income for the 2002-2003 biennium. It was also understood that several countries were prepared to pay more, or even all their relief back to WHO as miscellaneous income for the biennium. The search for unconditional donations to WHO that could be accepted into miscellaneous income would be intensified. The additional resources needed to meet other calls generally made on miscellaneous income and to cover some of the unforeseen expenditure on priorities that was bound to arise might also be found.

It was therefore to be hoped that delegations would agree to the new scale together with the plan to soften its impact through the application of 100% and 75% relief in 2002 and 2003, respectively. The basis for the scale of assessment to be used by WHO during the coming biennium and beyond would undoubtedly be reviewed by the Executive Board in January 2002 and by the Fifty-fifth World Health Assembly.

Detailed tables were annexed to document A54/49, illustrating the difference, for each Member State, of contributions assessed at the level for 2001 and on the basis of the 2002 United Nations scale, with the usual minor adjustments to reflect the differences in membership between the two organizations. The effects of applying 100% and 75% relief were also shown. The results of applying 50% relief were provided for information.

The proposals might usefully be discussed at the Committee's meeting that afternoon, to give delegations time for consideration and discussion among themselves.

The CHAIRMAN proposed that, as the item was closely linked to the budget, it should be considered later in the day at a joint meeting of Committees A and B, after which the budget would be discussed.

It was so agreed.

Dr WANCHAI SATTAYA WUTHIPONG (Thailand) asked why his country's contribution for 2001 was shown as US$ 703,616 in document A54/49, whereas in an official letter from WHO headquarters dated 19 February 2001 it was shown as US$ 695,020.

Mr AITKEN (Senior Policy Adviser) replied that from time to time some countries received small and variable rebates, on an individual basis, for example, under the financial incentive scheme, which were taken into account in the amounts actually paid but which were not shown in the official published scale.
2. **HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE:** Item 17 of the Agenda (Documents A54/31, A54/INF.DOC./5, A54/INF.DOC./6 and A54/INF.DOC./7)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegations of Algeria, Austria, Bahrain, Belgium, Cuba, Denmark, Egypt, Finland, France, Germany, Greece, Iraq, Ireland, Italy, Jordan, Kuwait, Malaysia, Netherlands, Oman, Pakistan, Palestine, Portugal, Qatar, Spain, Sweden, Syrian Arab Republic, Tunisia, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland and Yemen, which read as follows:

The Fifty-fourth 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 health conditions in the occupied Arab territories;

Recalling the convening of the International Peace Conference on the Middle East (Madrid, 30 October 1991) on the basis of the United Nations Security Council Resolutions 242 (1967), 338 (1973) and 425 (1978), as well as on the basis of the principle of “land for peace” and the subsequent agreements between the Palestinian and Israeli sides, the latest of which is the Sharm El-Sheikh Agreement;

Reaffirming the inalienable, permanent and unqualified right of the Palestinian people to self-determination, including their right to establish their sovereign and independent Palestinian State;

Expressing deep concern at the deterioration of health conditions as a result of the escalation of violence since September 2000, which continues to cause high numbers of deaths and injuries, mostly among Palestinians;

Expressing deep concern also at the closure of and within the Palestinian areas, seriously affecting health programmes and the provision of health services to the Palestinian population, especially child and mother programmes, immunization and control of epidemics, school health, control of water safety, insect control, mental health and health education;

Emphasizing the urgent need fully to implement the Declaration of Principles and the subsequent Accords between the Palestine Liberation Organization and the Government of Israel;

Expressing grave concern about the ongoing Israeli settlement policies in the Palestinian occupied territory, including East Jerusalem, in violation of international law, the Fourth Geneva Convention and of relevant United Nations resolutions;

Stressing the need to preserve the territorial integrity of all the occupied Palestinian territory and guarantee the freedom of movement of persons and goods within the Palestinian territory, including the removal of restrictions of movement into and from East Jerusalem, and the freedom of movement to and from the outside world having in mind the adverse consequences of the closure of the Palestinian territory on its socioeconomic development, including the health sector, particularly in the current situation;

Expressing deep concern at the serious deterioration of the economic situation in the Palestinian territories and the resulting threat to the Palestinian health system, aggravated by the withholding by Israel of funds due to the Palestinian Authority;

Recognizing the need for increased international support and health assistance to the Palestinian population in areas under the responsibility of the Palestinian Authority and to the Arab populations in the occupied Arab territories, including the Palestinians as well as the Arab Syrian population;
Reaffirming the right of Palestinian patients and the medical staff to be able to benefit from health facilities available in the Palestinian Health Institutions in occupied East Jerusalem;

Recognizing the need for support and health assistance to the Arab populations in the areas under the responsibility of the Palestinian Authority and in the occupied territories, including the occupied Syrian Golan,

1. LOOKS FORWARD to the resumption of peace talks in order to bring about a just, lasting and comprehensive peace in the Middle East;

2. DEEPLY REGRETS the escalation of violence and the resulting high number of casualties, especially the excessive use of force against Palestinians;

3. AFFIRMS the need to support the efforts of the Palestinian Ministry of Health to secure emergency services, to continue delivering health programmes, and to face the present additional burden of casualties and resulting physical and mental disabilities;

4. CALLS ON Israel not to hamper the Palestinian Ministry of Health in carrying out their full responsibility for the Palestinian people, including in occupied East Jerusalem, to lift the closures of and within the Palestinian areas, and to release the funds due to the Palestinian Authority;

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

6. THANKS the Director-General for her effort, and requests her:
   (a) to take urgent steps in cooperation with Member States to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties, and in particular so as to guarantee free circulation of those responsible for health, of patients, of health workers and of emergency services, and the normal provision of medical goods to the Palestinian medical premises, including those in Jerusalem;
   (b) to continue to provide the necessary technical assistance to support health programmes and projects for the Palestinian people, and to encourage the provision of emergency humanitarian assistance to meet needs arising from the current crisis;
   (c) to take the necessary steps and make the contacts needed to obtain funding from various sources including extrabudgetary sources, to meet the urgent health needs of the Palestinian people;
   (d) to continue her efforts to implement the special health assistance programme and adapt it to the health needs of the Palestinian people, taking into account the health plan of the Palestinian people;
   (e) to report on implementation of this resolution to the Fifty-fifth World Health Assembly, and to include an evidence-based, comparative assessment of the health situation in the occupied territory in light of the current crisis;

7. EXPRESSES gratitude to all Member States, intergovernmental organizations and nongovernmental organizations and calls upon them to provide the assistance needed to meet the health needs of the Palestinian people.

Mrs ABOULNAGA (Egypt) said that the draft resolution was being proposed by Arab and other countries including Member States of the European Union. It reflected the health conditions in the occupied Arab territories, which had deteriorated to an unprecedented degree since September 2000 when the Israeli Army had stepped up its offensive against the Palestinian people. Recent reports
had been issued by the Office of the High Commissioner for Human Rights, the International Commission of Inquiry, the Director of Health, UNRWA (document A/54/INF/DOC./5), UNICEF, ILO and the International Committee of the Red Cross. The latest report of that Committee had referred to the Israeli settlements in Palestinian territory as a clear violation of the Fourth Geneva Convention for the Protection of Civilians in Times of War. All the reports described the negative consequences of the violations on the health of the Palestinian people. There had been an unprecedented increase in the number of casualties leading to permanent disability, particularly among children. The whole world had been shocked by the use by Israel several days previously of F-16 fighter aircraft against unarmed civilians in Gaza. Nevertheless, the draft resolution refrained from condemnation and instead urged that talks between the Palestinian Authority and Israel be resumed in order to bring about a just, lasting and comprehensive peace, that assistance should be provided in the achievement of health development of the Palestinian people, and that the Palestinian Ministry of Health should not be hampered in its efforts to secure emergency services and to continue delivering health programmes. Palestine and its Arab neighbours were eagerly awaiting the forthcoming visit of the Director-General, which would provide an opportunity for her to review the deteriorating health conditions of the Palestinian people. She expressed the hope that the draft resolution would be adopted by consensus.

Mr MOLANDER (Sweden), speaking on behalf of the Member States of the European Union, said his delegation was cosponsoring the draft resolution because it was constructive, with a clear focus on the health situation in the occupied Arab territories, and because the continued violence had had severe consequences for the Palestinian health sector. WHO had an important role to play in helping to set up an effective and sustainable health system for the Palestinian people on the basis of, inter alia, an assessment of the health situation in the occupied Arab territories in the light of the current crisis.

Dr TARAWIYEH (Palestine) said that the escalation of aggression by Israel had been hampering the Palestinian Ministry of Health in its efforts to improve the health conditions of the Palestinian people. Despite such difficulties, Palestine had managed to attain several of the goals set out in its first five-year health plan, although most health efforts currently had to be focused on providing emergency care. However, the fragmentation of Palestinian territory, which curtailed freedom of movement, had made it increasingly difficult for the sick to gain access to medical care. The Gaza Strip and the West Bank had been sealed off both from each other and from the outside world, and a curfew had been imposed in all Palestinian cities and camps. That policy had had serious repercussions on health services as it had led to the curtailment of numerous programmes, including that for immunization. Moreover, preventing workers from moving outside their own villages and the confiscation of funds by the Israeli Government were having grave economic consequences, which ultimately affected spending on health. The Israeli authorities continued to obstruct and attack ambulance vehicles and medical teams, and many seriously ill patients and pregnant women had died as a result of delays at checkpoints. Furthermore, as a result of inadequate solid-waste disposal facilities and poor water quality, Palestinians were at risk for diseases such as West Nile fever and cholera. The recent decision by the Israeli Government to use even greater force against civilians would inevitably lead to a further deterioration in the physical and mental health conditions of the Palestinian people. He expressed the hope that, with the support of the international community, a just and lasting peace could be achieved that would finally put an end to the suffering of the Palestinian people.

The CHAIRMAN observed that Indonesia and Luxembourg had asked to be added to the list of sponsors of the draft resolution.

Mr DÜRLER (Switzerland) stated that his delegation would also like its name to be added to the list of sponsors. He urged all the Member States to follow suit so that the draft resolution could be
adopted by consensus. Switzerland was concerned at the deteriorating situation in Israel and in the occupied Arab territories and called upon all the parties to the conflict to cease the violations and exercise restraint. He expressed the hope that both sides would resume talks in order to bring about a just and lasting peace in the area.

Mr YANG Xiaokun (China) expressed concern at the continued plight of the Palestinian population and said that China would also like to cosponsor the draft resolution.

Mr LEVY (Israel) said that he regretted the casualties that had occurred on both sides. Suffering was not limited to Palestinians; Israelis were also suffering as a result of the violence, psychologically as well as physically. People were afraid to ride on buses, which were frequently the target of Palestinian suicide bombers. If freedom of movement were restored, it would be even easier for suicide bombers to enter Israeli territory; nevertheless, Israel currently issued daily permits to 21,000 Palestinian workers to enter the country.

Politicized resolutions adopted by international bodies such as WHO would not put an end to the violence. The draft resolution had little to do with the work of WHO. Moreover, the text contained numerous errors, distortions and one-sided views. For example, it made no mention of attacks on Israeli ambulances and medical teams on their way to treat the wounded of both sides. The only way to stop the violence was for the Palestinian leadership to give a clear, unequivocal order to that effect to its military and paramilitary police.

In recent years, Palestine, Israel and other Arab nations had worked closely together to improve public health. Joint committees had been established on environmental health, food control and drugs. Two other major areas of cooperation included the provision of complementary medical services to Palestinians in Israeli hospitals and training programmes in Israel for Palestinian physicians and health personnel. Unfortunately, such cooperation had been stopped, and the number of Palestinian patients referred to Israeli hospitals had significantly decreased, placing an additional burden on international organizations. Although the Palestinian Authority rejected supplies of drugs or medical equipment from Israel, it was willing to accept similar items imported into Israel for Palestinian use, and the Israeli Ministry of Health had authorized the importation of such items into Palestine-controlled areas. Although little trust existed between the two sides at governmental level, Palestinian and Israeli associations responsible for providing emergency services were continuing to cooperate. His country would cooperate with any assistance programme for Palestinians introduced by Member States. If WHO wanted to be constructive, it should focus its attention on substantive health issues. He therefore urged the Committee to reject the draft resolution.

Ms BJERKE (Norway) requested that her delegation be added to the list of cosponsors of the draft resolution. She commended the efforts of UNRWA and WHO to improve the health situation of the Arab population in the occupied Arab territories. The international community must continue to give financial support to the health sector in order to help to alleviate the physical and psychological damage arising from the escalation of the conflict. In addition to supporting the establishment of the WHO Office in Gaza, Norway had contributed substantially to UNRWA and had decided early on that a large share of its bilateral financial contribution should be allocated to emergency rescue operations initiated by the International Committee of the Red Cross and Norwegian People's Aid.

Ms DE ARMAS ÁGUILA (Cuba) recalled that the numerous resolutions that had emanated from various United Nations bodies, including WHO, were based on Security Council resolutions 243 and 338, which called for respect for territorial integrity and political independence. The States Parties to the Constitution of WHO, including Israel, had declared and accepted that one principle basic to the happiness, harmonious relationships and security of all peoples was enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being without any distinction. They had also accepted that health for all was a prerequisite of peace and security.
Israel had provoked a highly explosive situation in Palestine and the occupied Arab territories and had unleashed a new spiral of violence and terror in order to crush inevitable reaction of a people rebelling against long years of occupation and seeking their freedom and fundamental rights to life and health. The Palestinian Authority's claim of increasingly devastating effects on health, in violation of successive resolutions by United Nations bodies, had been corroborated by the highest officers of many United Nations organizations. Hundreds of Palestinian civilians had died and thousands had been wounded, including infants, women and old people, through the indiscriminate use by Israeli forces of live ammunition, including heavy weapons. Up to half of the Palestinian dead and wounded were under 18. Prompt medical attention was impeded by attacks on ambulances and the virtually permanent restrictions on the movement of Palestinians.

She urged the Health Assembly to take firm, effective steps to enforce its resolutions, put an end to the continued Israeli occupation that undermined the Arab population's health and threatened their lives, and take urgent measures to increase technical, material and financial support to the Palestinian health services. Cuba was a cosponsor of the draft resolution and had supported all resolutions on that important issue.

Mr ALLOUCH (Morocco) said that the health situation in the occupied Arab territories, especially in Palestine, had always been of concern to the Kingdom of Morocco, but particularly so since the bloodshed in the area in recent weeks. His delegation urged WHO to spare no effort in assisting the Palestinian Authority in performing its legitimate role of improving the health of the Palestinian people. It also called on the international community to give effect to all the relevant resolutions adopted by the Organization. His country wanted to cosponsor the draft resolution.

Mrs RUSTAM (Indonesia) also noted with concern the effects of the deteriorating conditions in the occupied Arab territories on the physical and mental health of the inhabitants, and called for immediate and decisive action. She reiterated that emergency services, drugs and ordinary consumables were not reaching the population. Her delegation emphasized the need for a halt to hostilities and the resumption of peace talks for a just, lasting and comprehensive solution to the conflict. Assistance from Member States and intergovernmental and nongovernmental organizations to meet the health needs of the Palestinian people remained a priority. Her delegation therefore wanted also to cosponsor the draft resolution.

Mr MOOSE (United States of America) said his delegation deeply regretted the introduction by the cosponsors of the draft resolution of political issues that fell outside the Health Assembly's sphere of competence. His country shared with other delegations a deep concern about the situation in the region, especially the most recent events, and was troubled by the terrible toll that the continuing violence was taking on Palestinians and Israelis alike. His country had already provided US$ 70 million to the Palestinian people for child survival and maternal health programmes and would continue such support. He enjoined both parties to use maximum restraint, so as to create an atmosphere conducive to a meaningful peace dialogue. The way in which they did so was outside the scope of WHO's mandate. Adoption of the draft resolution would only complicate the efforts under way and would serve neither the cause of peace nor the cause of health. Unfortunately, as the draft resolution interjected political issues, his delegation opposed its adoption.

Mr GUDMUNDSSON (Iceland) said that, while the purpose of the Health Assembly was not to discuss political issues, the health conditions of Palestinians in the occupied Arab territories were so severely affected that his delegation wanted to cosponsor the draft resolution.

Mrs ABOULNAGA (Egypt) deeply regretted that the delegation of the United States had opposed the draft resolution. To clarify certain points she said that expressions of sympathy for the Palestinian people no longer sufficed, given the daily tragedy of their lives. The draft resolution called on WHO to implement its mandate as a health forum. The Israeli delegate's statement impugned the
intelligence of other delegations by playing the same broken record that nobody believed any longer. The delegate of Israel had not mentioned its country’s aggression against unarmed civilians, in which not even infants were spared. She reiterated the warning from the President of Egypt that excessive use of force against the Palestinians would lead to a point of no return. Despite Israel’s obfuscation, the only path to peace was to end the 50 years of Israel’s occupation of Arab territories; that land must be returned to its rightful owners. The politics of arrogance would not bear fruit. There would be Palestinian resistance as long as there was Israeli occupation and until the Palestinians enjoyed the same peace and security that Israel sought for itself. The content of the draft resolution was indeed germane to WHO’s work.

Mr LEVY (Israel), regretting that the truth sounded like a broken record to the delegate of Egypt, asked how so-called unarmed civilians had caused the deaths of 85 Israelis. It was unfortunate that the Egyptian delegate sought to legitimize the placing of bombs on buses by terming it “resistance”. He proposed that the draft resolution be put to a vote at the end of the debate.

Mr AQUARONE (UNRWA) said that the difficulties encountered by all health care providers in the occupied Arab territories had been compounded by the unprecedented emergency situation that had arisen in September 2000. UNRWA, which provided health care to some 50% of the population of the Gaza Strip and the West Bank, had had both to respond to the emergency and to sustain its regular programmes. Its response to the emergency was outlined in document A54/INF/DG/5. UNRWA had launched three emergency appeals up to May 2001, receiving pledges of US$ 67 million. It had worked closely with the Ministry of Health of the Palestinian Authority and nongovernmental organizations to supply much-needed drugs and medical supplies and prevent the breakdown of services in remote areas that had been sealed off for long periods from the rest of the world.

The two major challenges were to ensure a sustainable level of funding to help the most needy Palestinians cope with suffering and privation, and to address the long-term consequences of the situation, while remaining prepared for unknown future events. By mid-April, more than 400 persons had been killed and more than 14 000 injured; many of the latter might develop permanent disabilities. There was evidence of large-scale post-traumatic stress disorders in children, adolescents and women, who could not be treated for lack of qualified staff. The population’s health status was deteriorating further, and there had been a drop in the use of preventive services. Staff had been held at checkpoints, and patients had had difficult access to UNRWA primary health facilities and to hospitals. Restrictions on traffic into the Gaza Strip was delaying medical supplies at the UNRWA warehouse in Jerusalem, and Israeli army security measures had obstructed the transport of emergency food aid.

UNRWA was the only operational United Nations organization on the ground that had the staff, infrastructure and means to mobilize immediate emergency assistance. It had a positive track record in its 50 years of existence, a performance it would maintain as long as necessary. It called on the international community and Member States to support its emergency appeals and to take urgent steps to protect the privileges and immunities of the Agency so that its work, consistent with Health Assembly resolutions, would not be hindered.

The CHAIRMAN said that Malta, Swaziland and Turkey wanted to be added to the list of cosponsors of the draft resolution. The Committee would proceed with a vote on approval of the draft resolution, as requested by the delegation of Israel.

Mrs ABOULNAGA (Egypt) said that the importance of the issue deserved a roll-call vote.

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

The result of the vote was as follows:
In favour: Algeria, Andorra, Angola, Argentina, Austria, Bahrain, Bangladesh, Belgium, Benin, Bhutan, Bolivia, Botswana, Brazil, Bulgaria, Burkina Faso, Cambodia, Chile, China, Colombia, Congo, Côte d'Ivoire, Croatia, Cuba, Czech Republic, Democratic People's Republic of Korea, Denmark, Ecuador, Egypt, El Salvador, Finland, France, Gabon, Germany, Greece, Guinea, Hungary, Iceland, India, Indonesia, Ireland, Italy, Japan, Jordan, Kuwait, Latvia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malaysia, Maldives, Mali, Malta, Mexico, Morocco, Mozambique, Myanmar, Namibia, Netherlands, New Zealand, Norway, Oman, Pakistan, Peru, Philippines, Poland, Portugal, Qatar, Russian Federation, San Marino, Saudi Arabia, Senegal, Slovakia, South Africa, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, Thailand, Tunisia, Turkey, Uganda, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, Uruguay, Venezuela, Viet Nam, Yemen, Zimbabwe.

Against: Israel, Palau, United States of America.

Abstaining: Australia, Canada, Guatemala, Honduras, Kenya, Lesotho, Papua New Guinea, Republic of Korea, Romania, Samoa, Singapore.

Absent: Albania, Bahamas, Barbados, Belarus, Belize, Brunei Darussalam, Burundi, Cameroon, Cape Verde, Cook Islands, Costa Rica, Cyprus, Democratic Republic of the Congo, Djibouti, Dominica, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, Ghana, Grenada, Guyana, Haiti, Islamic Republic of Iran, Jamaica, Kiribati, Lao People's Democratic Republic, Lebanon, Malawi, Mauritania, Mauritius, Monaco, Mongolia, Nepal, Nicaragua, Panama, Paraguay, Rwanda, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Sao Tome and Principe, Seychelles, Sierra Leone, Slovenia, Solomon Islands, Swaziland, The former Yugoslav Republic of Macedonia, Togo, Tonga, Trinidad and Tobago, Tuvalu, Uzbekistan, Vanuatu, Yugoslavia, Zambia.

The draft resolution was therefore approved by 92 votes to 3, with 11 abstentions.  

Mr WESTDAL (Canada), speaking in explanation of vote, strongly endorsed the basic thrust of the draft resolution. He had abstained because of the political elements contained in preambular paragraph 4. While he supported the right of the Palestinian people to self-determination, he believed that it was in their interest to exercise that right through negotiation. In general, he expressed great concern at the politicization of WHO's work. The inadequately balanced approach to the crises in the region expressed in the draft resolution undermined its impact.

Ms LIANG (Singapore), speaking in explanation of vote, said that her abstention was not related to the merits or demerits of the issue. Her delegation considered that such questions should not be raised in the Health Assembly, a technical forum, but in the United Nations General Assembly.

Dr TEMU (Papua New Guinea) associated himself with the comments of the delegations of Canada and Singapore.

Mr YOKOMAKU (Japan), in an explanation of vote, said that his delegation had voted in favour of the resolution because it had been seriously concerned about the situation in Palestine since September 2000. His Government had made contributions for emergency assistance in order to mitigate the impact of the deteriorating situation. He urged all parties to return to negotiation as soon as possible.

1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA54.15.
3. **COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS:** Item 18 of the Agenda (continued)

**International Decade of the World's Indigenous People (Document A54/33)** (continued from the second meeting, section 2)

Dr POUTASI (New Zealand) introduced the draft resolution sponsored by her delegation and by those of Argentina, Australia, Canada, Chile, Denmark, Fiji, Guatemala, Mexico, the Netherlands, Norway and Peru, which read as follows:

The Fifty-fourth World Health Assembly,

Recalling resolutions WHA47.27, WHA48.24, WHA49.26, WHA50.31, WHA51.24 and WHA53.10 on WHO's contribution to achieving the objectives of the International Decade of the World's Indigenous People (1994-2003);

Further recalling United Nations General Assembly resolution 50/157, which adopted the programme of activities for the International Decade, in which it is recommended that "specialized agencies of the United Nations system and other international and national agencies, as well as communities and private enterprises, should devote special attention to development activities of benefit to indigenous communities"; that focal points for matters concerning indigenous people should be established in all appropriate organizations of the United Nations system; and that the governing bodies of the specialized agencies of the United Nations system should adopt programmes of action for the Decade in their own field of competence, "in close cooperation with indigenous people";

Welcoming the decision by the United Nations Economic and Social Council in its resolution 2000/22 of 28 July 2000 to establish a Permanent Forum on Indigenous Issues as an advisory body to the Council with a mandate to discuss indigenous issues within the mandate of the Council relating to economic and social development, culture, the environment, education, health and human rights, thereby fulfilling an important objective of the Decade;

Commending the progress made in the Region of the Americas on the Initiative on the Health of Indigenous People of the Americas;

Deeply concerned about the disparities in health conditions of indigenous people in comparison to the overall population,

1. **URGES** Member States:

   (1) to recognize and protect the right of indigenous people to enjoyment of the highest attainable standard of health within overall national development policies;

   (2) to make adequate provisions for indigenous health needs in their national health systems, including through improved collection and reporting of statistics and health data;

   (3) to respect, preserve and maintain traditional healing practices and remedies, and to seek to ensure that indigenous people retain this traditional knowledge and its benefits;

2. **REQUESTS** WHO's regional committees to give urgent attention to the adoption of regional plans of action on indigenous health that take into account the conclusions and recommendations of the "International Consultation on the Health of Indigenous Peoples" (Geneva, November 1999);

3. **REQUESTS** the Director-General:

   (1) to strengthen the partnership with indigenous people in all relevant WHO activities;

   (2) to collaborate with partners in health and development for protection and promotion of the right of the world's indigenous people to enjoyment of the highest
attainable standard of health, including through the use of accurate and up-to-date information on health status;

(3) to complete, in close consultation with national governments and organizations of indigenous people, a framework for a global plan of action to improve the health of indigenous people, with particular emphasis on an approach geared to the needs of those in developing countries and the determinants of health, for submission to the Fifty-fifth World Health Assembly with the aim of finalizing the global plan of action by the end of the Decade;

(4) to cooperate with and to support the Secretary-General of the United Nations and the Office of the High Commissioner for Human Rights, in its role as lead agency for the establishment of the Permanent Forum on Indigenous Issues, and with other specialized agencies and Member States, in preparation for the Forum’s inaugural meeting in 2002, including by submission of information on indigenous health issues.

She drew the Committee’s attention to operative paragraph 3(4) of the draft resolution, which called for the establishment of a permanent forum on indigenous issues, including economic and social development, culture, the environment, education, health and human rights. The draft resolution also urged the adoption of global and regional plans of action on indigenous health. She urged the Committee to approve the draft resolution by consensus.

Mr CASTRILLÓN (Ecuador) and Mr COSTI SANTAROSA (Brazil) asked that their delegations be added to the list of cosponsors of the draft resolution.

Mr PEAY (United States of America) expressed strong support for the draft resolution. He suggested the following amendments: in paragraph 1(1), the words “as provided for in the WHO Constitution” should be added after the phrase “the highest attainable standard of health”.

In paragraph 1(3), he proposed that the words “consistent with nationally and internationally accepted standards” be added after the words “healing practices and remedies”.

In paragraph 2, the words “as appropriate” should be added after the words “take into account”, and the word “health” should be added before the words “conclusions and recommendations”.

In paragraph 3(1), he proposed that the word “relevant” should be replaced by “appropriate”.

Paragraph 3(2) should be amended to read: “to collaborate with partners in health and development for protection and promotion of the right of the world’s indigenous people to enjoyment of the highest attainable standard of health, as provided for in the WHO Constitution, including through the use of accurate and up-to-date information on indigenous health status.”

Ms BALOCH (Pakistan) suggested that the phrase “as provided for”, which the delegate of the United States had proposed for insertion in paragraphs 1(1) and 3(2), should be replaced by “as mentioned in”.

The CHAIRMAN noted the agreement of the United States delegation to that suggestion.

Mrs ADAM (Switzerland) expressed support for the draft resolution. She hoped that it would be approved by consensus.

The draft resolution, as amended, was approved.¹

The meeting rose at 12:30.

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA54.16.
1. **FINANCIAL MATTERS:** Item 15 of the Agenda (continued from the sixth meeting of Committee B, Section 1)

Scale of assessments for 2002-2003: Item 15.7 of the Agenda (Documents A54/36 and A54/49) (continued)

The CHAIRMAN called for consideration of the proposal that had been submitted by the Director-General (document A54/49), which contained a draft resolution that read as follows:

The Fifty-fourth World Health Assembly

1. DECIDES that the assessed contributions of Members for the biennium 2002-2003 shall be as per the attached listing [amounts in column D of the Annex for 2002 and amounts in column E of the Annex for 2003];

2. FURTHER DECIDES to review the scale of assessments for 2003 at its Fifty-fifth session, after review by the Executive Board.
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<td><strong>421,327,000</strong></td>
<td><strong>421,327,000</strong></td>
</tr>
</tbody>
</table>

*See document A54/49, paragraph 5.1. \ See document A54/49, paragraph 5.2. \ See document A54/49, paragraph 5.3.
Mr MORA GODOY (Cuba), speaking on behalf of the Group of 77 and China, thanked the Director-General for having provided an avenue towards a possible consensus. They would accept the proposal, with several modifications.

As had been reiterated, United Nations General Assembly resolution 55/5, C, paragraph 3, stated that the scale of assessments applied to the apportionment of the expenses of the United Nations did not automatically apply to its specialized agencies.

The Group of 77 and China noted with concern the last sentence of paragraph 6 of document A54/49, that “This use of miscellaneous income reduces the amount available for priority programmes.” As those priority programmes and the requisite resources were of paramount importance for developing countries, he asked that no effort be spared to ensure that the programmes were fully implemented. In that connection, he sought assurance that those developed countries that would see a reduction in their assessed contributions under the proposal would consider the possibility of contributing an amount equivalent to their reduction to the fund for miscellaneous income. Greater efforts should be made to solicit voluntary contributions and payments in arrears.

Turning to the draft resolution, he proposed the following amendments. Paragraph I would read: “DECIDES that the assessed contributions of Members for the biennium 2002-2003 shall be as set out in the table in accordance with the Financial Regulations”.

Paragraph 2 would read: “FURTHER DECIDES, on the basis of paragraph 1, to review the assessments for 2003 at its Fifty-fifth session, after review by the Executive Board”.

Although the information presented in the Annex had been requested by several countries, he proposed that only columns D and E be included in the draft resolution, listing the assessments for 2002 and 2003, respectively.

Dr AL KHARABSEH (Jordan) described the new proposal as equitable, moderate and reasonable, even though the contribution of Jordan would still be increased. He supported the modifications proposed by the delegation of Cuba but asked for clarification of the procedures for review mentioned in paragraph 2.

Mrs ROVIROSA (Mexico) considered that the new proposal reflected the concerns that had been expressed by various delegations. A decision about the WHO scale of assessments was essential if the Organization was to receive enough resources to enable it to implement its programmes, undertake new activities and achieve its strategic objectives. Her delegation supported the proposal.

Mr MOLANDER (Sweden), speaking on behalf of the Member States of the European Union, recalled that the scale that had been agreed at the United Nations General Assembly the previous December reflected new economic realities in many countries. On the new scale, the majority of those who would pay less were poorer countries, and the majority of high-income countries would pay more. Within the European Union, some countries would pay more and some less, but the Union as a whole would pay more. He stressed the importance of taking a decision by consensus. The new proposal was not ideal; it placed the Organization in a difficult financial situation, but the alternative was worse. However, the European Union was prepared to accept it.

Turning to the amendments that had been proposed by the Cuban delegation on behalf of the Group of 77 and China, he asked that the Annex be amended to make it clear that column D applied to the first year of the 2002-2003 biennium and column E to the second year. He asked why the words “on the basis of paragraph 1” were to be added to paragraph 2. Deletion of the words “scale of” in paragraph 2 was acceptable to the European Union.

Mr AKRAM (Pakistan) said that the position of his delegation had been based on the perception that the original proposal had not been fair to developing countries. The impact on Pakistan had been minimal; that had not been the issue. His delegation had recognized the necessity of avoiding a
solution based on a divisive vote within the Committee. Although the developing countries had had overwhelming support for their position the previous Friday, they had accepted the Director-General's decision to withdraw the original proposal and to prepare a compromise. The positive response of the Group of 77 and China to the new proposal and the wisdom displayed by all sides were a source of satisfaction. His delegation supported the draft resolution with the changes proposed by Cuba on behalf of the Group of 77 and China and urged its adoption by consensus. He expressed the hope that, notwithstanding the eventual decision on the issue, WHO would benefit from the generosity of countries with a larger capacity to support its programmes.

Mr TASAKA (Japan) considered that the proposed solution should be temporary and exceptional and should apply only to those countries currently in severe economic difficulties. He urged WHO not to abandon the principle of adopting the United Nations scales of assessment for the next biennium.

Although the common understanding was that miscellaneous income was used in the interests of all Member States, his delegation recommended that it be used only to benefit those in economic difficulties and that countries that could contribute should do so according to the United Nations scale and without relief. He encouraged delegates to achieve consensus on the draft resolution.

Mr CHUNG (Republic of Korea) reiterated that the United Nations General Assembly resolution stated that the apportionment of expenses did not automatically apply to its specialized agencies. His delegation had already asked that special consideration be given to countries that would have a drastic increase in their assessed contribution, so that those increases were gradual and incremental. Although the assessed contributions for 2002-2003 would represent a heavy burden for his country, in a spirit of compromise his delegation supported the proposal, if it were not prejudicial to its assessments beyond 2003.

Professor ZELTNER (Switzerland) said that his country, like some others, was committed to applying the United Nations scale of assessments, if not in 2002-2003, at least in subsequent years. He deplored the continuing gap between WHO's resources and the task given to it, and he was grateful for the solution that had been proposed. His delegation supported the draft resolution.

In answer to Cuba's request for a guarantee that major donors would contribute funds to Miscellaneous income, he said that the final decision in his country rested with the Parliament. Probably, part of its extrabudgetary contribution would be diverted to Miscellaneous income and would therefore be allocated not to priorities but to general running costs. That was not optimal but, for two years, would be an acceptable compromise. Switzerland considered that extrabudgetary resources should be used to start priority programmes and to respond to unforeseen needs. He agreed with the delegate of Sweden that an explanation was required for the proposed addition to paragraph 2 of the words "on the basis of paragraph 1".

Mr CHAKALISA (Botswana) supported the draft resolution with the amendments proposed by Cuba. He congratulated the Chairman on his skilful handling of a difficult subject.

Mr WASLANDER (Netherlands) supported the statement of the delegation of Sweden on behalf of the European Union. His delegation considered that achieving consensus in regard to the scale of assessments and to the proposed appropriation resolution would demonstrate that responsibility for the priorities and actions of WHO was shared by all Member States. His country, as the third largest donor to multilateral institutions, hoped to continue its practice of giving non-earmarked voluntary contributions that could be used by the Director-General for agreed priorities.

In response to the request for a gesture of appreciation on the part of richer countries, his country would agree to waive its use of the relief facility, if a consensus were achieved on the matter
and on a budget to be shared by all. The Netherlands would have to pay about US$ 1 million more than in the current biennium, and, on condition that consensus was achieved, it was to be hoped that the extra money would be used for global priorities. In the Annex to the draft resolution, it should be indicated clearly that column D would apply to the first year and column E to the second year of the biennium. If there was to be agreement on the budget for the two-year period, the income of the Organization should be specified. The Netherlands attached great importance to consensus on the draft resolution and would bear the financial consequences.

Mr KENGOUYA (Congo) expressed his country’s full support for the compromise proposed. He agreed that the scale of assessments should be evaluated by the governing bodies, at which time improvements could be made or the system discontinued. It was natural that reform entailed a change in the budget base. The United Nations was the reference point for each agency in the system, and it was in WHO’s interest to conform with the United Nations scale of assessments.

Dr AL-JABER (Qatar) noted that the scale of assessments presented appeared to be a combination of the United Nations and WHO systems. He noted also that the United Nations scale of assessments would be applied only to certain countries. That should be regarded as an exceptional measure, and he expressed the hope that there would be no impact on the priority programmes. He asked, furthermore, whether it was possible to apply the United Nations scale of assessment only to certain countries. The scale appeared to be balanced from a political point of view but less so from an economic one; it should be reviewed in order to make it more transparent, and the questions should be examined by the Executive Board at its session in January 2002. He also asked whether the United Nations scale of assessment would be applied to all countries in 2004-2005 or only to some, as at present. That should be made clear in the draft resolution so that countries would know where they stood. Qatar supported the amendments proposed by Cuba.

Dr SHIVUTE (Namibia) supported the draft resolution and the amendments proposed by Cuba.

Dr UPUNDA (United Republic of Tanzania) supported the draft resolution. He said that he was pleased that the richer countries had spoken favourably of the Director-General’s proposal, and that he hoped, for the sake of humanity in general and the developing world in particular, that the proposal would be endorsed by all.

Mr COSTI SANTAROSA (Brazil) noted that there appeared to be general agreement that specialized agencies of the United Nations, in accordance with their own rules and regulations, could depart from the United Nations scale of assessments when circumstances so required. He emphasized the importance of bearing in mind all the points raised in discussions, including the ability of countries to continue honouring their commitments and paying their contributions in arrears, when the Fifty-fifth World Health Assembly reviewed the scale of assessments for 2003. His delegation therefore endorsed the amendments proposed by the delegate of Cuba for the Group of 77 and China regarding the Annex to the draft resolution: columns D and E should show only the amounts of the assessed contributions for 2002 and 2003, respectively, and no reference should be made to relief, in other words, whether the figures represented a reduction or an increase.

Mr MORA GODOY (Cuba) remarked that the economic problems of developing countries would not have permitted them immediately to apply to WHO the scales of assessments approved by the United Nations. The proposal would, moreover, allow a more detailed analysis to be made for 2003. Developed countries appeared to be increasingly aware that they had a moral commitment to WHO in relation to its programmes to improve the health status of developing countries, and it was
gratifying that some developed countries had stated that the poorest countries could rely on their support and cooperation.

Dr AMAT FORÉS (Cuba), referring to the Annex to the draft resolution, said that the proposal of the Group of 77 and China was that column D should be headed “2002” and column E headed “2003”; any reference to columns A, B, C and F would be eliminated. The reason for the proposal to add in paragraph 2 the words “on the basis of paragraph 1” was to ensure that the amounts shown for the biennium 2002-2003 would serve as a reference point and form the basis of discussions.

Mr MOLANDER (Sweden) asked the delegation of Cuba to explain why it proposed to amend the headings of columns D and E to read “2002” and “2003”, respectively, when that information was already contained in brackets in paragraph 1.

Mr MORA GODOY (Cuba) said that elimination of columns A, B, C and F would make it clear that the assessed contributions of Member States for 2002 and 2003 were those set out in columns D and E. The proposed additional words in paragraph 2 would make it clear that, in addition to deciding on the amounts, the scale of assessments for 2003 would be reviewed by the Fifty-fifth World Health Assembly, after review by the Executive Board.

Professor ZELTNER (Switzerland) said that the proposal made by the delegation of Cuba would show clearly that there were two scales of assessment, that for 2003 representing an increase over that for 2002. However, paragraph 6.1 of the Financial Regulations stipulated that the assessed contributions should be divided into two equal annual instalments. The current proposal was therefore, in his view, not in line with the Financial Regulations, and he questioned the advisability of adding the words “in accordance with the Financial Regulations” to paragraph 1.

Mr MORA GODOY (Cuba) said that he failed to understand why the proposal he was submitting on behalf of the Group of 77 and China, which was in accordance with the Financial Regulations, should cause such concern. The purpose of the proposal, which had been made with no ulterior motive, was simply to set out the figures for both years and to request a subsequent review of the scale of assessments for 2003 once it had been approved at the current session.

Mr AITKEN (Senior Policy Adviser) agreed that the Financial Regulations called for the total amount of the biennial payments to be paid in two equal annual instalments. The Health Assembly, was, however, a sovereign body and could decide for a particular reason at a particular time to make an exception to the Financial Regulations. In the Director-General’s proposal, the amounts calculated for 2002 and for 2003 were shown in columns D and E. Addition in paragraph 1 of the words “in accordance with the Financial Regulations”, as proposed by the delegate of Cuba on behalf of the Group of 77 and China, would underline the applicability of the Financial Regulations and, in the present context, that Member States would be billed the total amount for the biennium in two equal instalments. Member States therefore had the choice of two bills, each showing an equal amount, or one bill for the amount corresponding to 2002 and a bill for another amount, in 2003, the latter being an exception to the Financial Regulations.

Dr STAMPS (Zimbabwe) said that it was clear that the assessments for 2002 and 2003 would remain different but the bills should be equal. He was concerned by the suggestion that the Financial Regulations could be ignored, whereas a solution could be found by recognizing the different years’ assessments while still adhering to those Regulations. He pointed out that any reference to columns D and E by inference included a reference to columns A, B and C, if not F. However, the Group of 77 was adamant that it wished to have no allusion to the other columns.
Mr MORA GODOY (Cuba) made it clear that his proposal had been put forward on behalf of the Group of 77 and China. In response to the comments made by the delegation of Zimbabwe, he said that his delegation had no problem in withdrawing the reference to the Financial Regulations.

Mr MOLANDER (Sweden) asked that the amended text of the draft resolution be read out.

Mr MORA GODOY (Cuba) said that, if there was general agreement that no reference should be made to the Financial Regulations, the proposal of the Group of 77 and China was that paragraph 1 read:

“DECIDES that the assessed contributions of Members for the biennium 2002-2003 shall be as set out in the Annex;”

and paragraph 2 read:

“FURTHER DECIDES, on the basis of paragraph 1, to review the assessments for 2003 at its Fifty-fifth session, after review by the Executive Board.”

The Annex would contain only two columns, i.e. column D headed “2002”, with the figures for each country, and column E headed “2003”, with the figures for each country.

Ms BALOCH (Pakistan) said that, as a member of the Group of 77, her delegation fully supported the proposal made by the delegate of Cuba. She had not heard any delegation opposing the reference to the Financial Regulations; if there were no objection, she would prefer to retain that reference.

The draft resolution, as amended, was approved.¹

Professor Ongeri took the Chair.

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

Proposed programme budget for 2002-2003: Item 12.2 of the Agenda (Documents PB/2002-2003, A54/5, A54/5 Corr.1 and A54/37) (continued from the second meeting of Committee A)

Part I. Policy and budget for one WHO (continued)

The CHAIRMAN drew the attention of the Committee to the following text of the draft resolution, which read as follows:

The Fifty-fourth World Health Assembly

1. COMMENDS the Director-General on the further progress in budget reform with the integrated presentation of the proposed programme budget for 2002-2003;

¹ Transmitted to the Health Assembly in the second report of Committee B and adopted as resolution WHA54.17.
2. NOTES with satisfaction that the proposed programme budget for 2002-2003 has been developed on the basis of a strategic approach to results-based budgeting, and thus complies with earlier resolutions by the Executive Board and the World Health Assembly in this regard;

3. NOTES FURTHER that significant improvements have also been made in the transparency, accountability and effectiveness of the Organization's financial systems in accordance with best management practice, as requested by resolution WHA52.20;

4. RESOLVES to appropriate for the financial period 2002-2003 an amount of US$ 935 654 000 under the regular budget as follows:

<table>
<thead>
<tr>
<th>Appropriation section</th>
<th>Amount US$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communicable diseases</td>
<td>50 892 000</td>
</tr>
<tr>
<td>2. Noncommunicable diseases and mental health</td>
<td>40 170 000</td>
</tr>
<tr>
<td>3. Family and community health</td>
<td>33 372 000</td>
</tr>
<tr>
<td>4. Sustainable development and healthy environments</td>
<td>47 368 000</td>
</tr>
<tr>
<td>5. Health technology and pharmaceuticals</td>
<td>34 982 000</td>
</tr>
<tr>
<td>6. Evidence and information for policy</td>
<td>94 132 000</td>
</tr>
<tr>
<td>7. External relations and governing bodies</td>
<td>44 746 000</td>
</tr>
<tr>
<td>8. General management</td>
<td>139 459 000</td>
</tr>
<tr>
<td>9. Director-General, Regional Directors and independent functions</td>
<td>21 528 000</td>
</tr>
<tr>
<td>10. Country programmes</td>
<td>336 005 000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>842 654 000</strong></td>
</tr>
<tr>
<td>11. From miscellaneous income:</td>
<td></td>
</tr>
<tr>
<td>11.1 Exchange rate hedging (in lieu of the facility under Financial Regulation 4.4)</td>
<td>10 000 000</td>
</tr>
<tr>
<td>11.2 Real Estate Fund</td>
<td>3 000 000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>13 000 000</strong></td>
</tr>
<tr>
<td><strong>Effective working budget</strong></td>
<td><strong>855 654 000</strong></td>
</tr>
<tr>
<td>12. Transfer to Tax Equalization Fund</td>
<td>80 000 000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>935 654 000</strong></td>
</tr>
</tbody>
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*After further review of the exchange rate facility and funds required for hedging, the proposed resolution contained in document A54/A/Conf.Paper No.3 has been amended. Based on a modified hedging approach, US$ 10 000 000 is now required for section 11.1.*
B. Amounts not exceeding the appropriations approved under paragraph A shall be available for the payment of obligations incurred during the financial period 1 January 2002 to 31 December 2003 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 2002-2003 to sections 1 to 11.

C. Notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between appropriation sections 1 to 10 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 2002-2003. Any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.3.

D. The amount required to meet payments under the financial incentive scheme in accordance with Financial Regulation 6.5, estimated at US$ 3 000 000, shall be financed from miscellaneous income.

E. The appropriations approved under paragraph A shall be financed by assessments on Members and miscellaneous income in accordance with the provisions of resolution WHA 54.xx (reference scale of assessments). In establishing the amounts payable by individual Members in respect of their contributions, there shall be a reduction for the amount estimated in respect of the programme support costs payable by UNDP estimated at US$ 500 000; 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, and amounts earned under the financial incentive scheme.

5. WELCOMES efforts under way to effect efficiency savings in pursuance of resolution WHA 52.20, and requests that such efforts should continue also in 2002-2003, to be applied towards the required adjustments for cost increases and currency fluctuations of US$ 16 172 000;

6. WELCOMES further the assurance by the Director-General to provide budget information on staffing and categories of expenditure resulting from the operational planning for 2002-2003 to the Executive Board, at its 109th session;

7. REQUESTS that the Executive Board and the Health Assembly should also be regularly informed of other aspects of reform under way, notably in the area of programme monitoring and evaluation;

8. NOTES the estimated expenditure in the programme budget for 2002-2003 to be financed from sources other than the regular budget in an amount of US$ 1 380 000 000, leading to a total budget under all sources of funds of US$ 2 235 654 000.

Mr AITKEN (Senior Policy Adviser) said that the appropriation resolution before the Committees in joint session was fully compatible with the decision that they had taken on the scale of assessments. It proposed a budget of US$ 842 654 000 for programmes and proposed the use of Miscellaneous income up to an amount of US$ 13 million.
Mr COMENDEIRO HERNÁNDEZ (Cuba) proposed that subparagraph C of paragraph 4 be replaced by the following:

"In order to conform with paragraph 4.3 of the Financial Regulations, the Director-General shall submit proposals to make transfers between appropriation sections 1 to 10 to the Executive Board which will be held on 23 and 24 May in order to obtain its prior consent, as established."

Mr AITKEN (Senior Policy Adviser) said that, since the Executive Board met only periodically, the proposal of the delegation of Cuba would substantially restrict the flexibility that was traditionally granted to the Director-General in moving monies between appropriation sections, and the 10% limitation had always been found to be a reasonable one.

Mr COMENDEIRO HERNÁNDEZ (Cuba), while accepting the need for the Director-General to be given discretion in moving monies, said that his delegation nevertheless considered that the Executive Board should know, when it met, of any proposal that the Director-General might have.

Mr AITKEN (Senior Policy Adviser) said that the summary record of the meeting would record the fact that the Executive Board would be informed of any proposal.

Mr COMENDEIRO HERNÁNDEZ (Cuba) accepted that suggestion.

The draft resolution was approved.¹

Dr TROOP (United Kingdom of Great Britain and Northern Ireland) welcomed the proposals made by the Director-General in relation to both contributions and appropriations, which had reconciled the differences among delegations and had enabled a consensus to be achieved. Since those decisions would leave a shortfall in the budget, her delegation would not take advantage of the relief provision and would, on an exceptional basis, contribute the equivalent amount of approximately US$ 2 million to Miscellaneous income for use on priority programmes. That contribution would not affect her country's contribution to extrabudgetary funding.

Mr WASLANDER (Netherlands) recalled that his delegation had said that, if consensus was reached on the draft resolutions on the scale of assessments and appropriation, his delegation would forego the right to apply for the relief provision. His country would therefore contribute the equivalent amount of US$ 950 000 to Miscellaneous income for use on priority programmes.

The CHAIRMAN thanked Member States for having reached consensus on the two draft resolutions.

(For continuation of the tenth meeting of Committee A, see p. 154.)

The meeting was suspended at 16:25.

¹ Transmitted to the Health Assembly in the fifth report of Committee A and adopted as resolution WHA54.20.
3. EFFECTIVE FUNCTIONING OF THE GOVERNING BODIES IN WHO: Supplementary agenda item

The CHAIRMAN drew attention to two draft resolutions on the reform of the Executive Board. The first, proposed by the delegations of Algeria, Cameroon, Colombia, Cuba, Egypt, Lebanon, Libyan Arab Jamahiriya, Malaysia, Morocco, Pakistan, Philippines, South Africa, Tunisia, United Arab Emirates and Zimbabwe, read as follows:

The Fifty-fourth World Health Assembly,
Guided by the Purposes and Principles of the Charter of the United Nations which stress on the sovereign equality of all Member States of the United Nations;
Reaffirming the principle of equitable participation of all Members of the Organization in its affairs;
Realizing its responsibilities, enshrined in Article 18 of the Constitution, to determine the policies of the Organization and to review and approve reports and activities of the Board;
Having considered Article 27 of the Constitution, which states that the Board shall adopt its own rules of procedure;
Recalling Article 28 of the Constitution that lays down the functions of the Board, which include, inter alia, to give effect to the decisions of the Health Assembly;
Convinced that increased participation of Member States not represented in the Board in its proceedings, especially in its working groups and drafting committees will contribute to improve the work of the Executive Board;
Stressing the need for improved participation of all Member States in the deliberations of the Board, on any matter of interest to them;
Convinced that such improved participation can be achieved through a review of the Rules of Procedure of the Board,

1. REQUESTS the Executive Board:
   (1) to ensure improved participation of all Member States in its proceedings including working groups and drafting committees;
   (2) to review, to that end, its Rules of Procedure in a transparent and open-ended intergovernmental process, according to the following guidelines:
      - the proceedings of the Board and its committees and working groups shall be open, transparent, interactive and participatory;
      - except in matters requiring closed session, all WHO Member States shall have the right to participate in working groups, committees, subworking groups and subcommittees or other such bodies established by the Board;
      - discussion of all agenda items in the Board and its committees or working groups shall be open to all WHO Member States;
- all WHO Member States shall have the right to speak on any item of their interest and submit proposals for consideration by the Board;

(3) to finalize the review process before the next World Health Assembly and present a report for approval of the Assembly;

2. URGES the Executive Board to consider other proposals and make recommendations for improving and enhancing the participation of all Member States in the Executive Board and its subsidiary bodies;

3. REQUESTS the Director General, within her mandate, to ensure that the observers to the Board have adequate arrangements for seating with country flags;

4. DECIDES to consider the issue under the same agenda item in the next Health Assembly.

The second draft resolution, proposed by the delegations of Australia, Austria, Belgium, Bolivia, Bulgaria, Canada, Chad, Croatia, Denmark, Finland, France, Germany, Hungary, Iceland, Ireland, Israel, Italy, Japan, Latvia, Lithuania, Luxembourg, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Russian Federation, Slovakia, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland and United States of America, read as follows:

The Fifty-fourth World Health Assembly,

Being guided by the Purposes and Principles of the Charter of the United Nations which establish the sovereign equality of all Member States of the United Nations;

Recalling the Constitution of the World Health Organization and the Rules of Procedure of the Executive Board;

Noting the views and concerns expressed by Member States on the methods of work of the Executive Board,

REQUESTS the Executive Board:

(1) to conduct a review of its working methods and those of its subsidiary bodies in order to ensure that they are effective and efficient, and that its proceedings are participatory, transparent and interactive;

(2) to establish an ad hoc open-ended working group to that end, that will make recommendations for improvement of the working methods;

(3) to inform the Fifty-fifth World Health Assembly on the progress of the review.

He proposed that a drafting group to include the sponsors of the two draft resolutions and any other delegations interested should convene immediately under the chairmanship of the delegate of Colombia with a view to formulating a compromise text for consideration by the Committee.

It was so agreed.

(For resumption of discussion, see section 5.)

Dr Dahl-Regis took the Chair.
4. **TECHNICAL AND HEALTH MATTERS:** Item 13 of the Agenda (continued from ninth meeting of Committee A, section 3)

**Tobacco control:** Item 13.5 of the Agenda

**Framework convention on tobacco control: report by the Intergovernmental Negotiating Body (Documents A54/13 and A54/13 Add.1)**

The CHAIRMAN drew attention to a draft resolution on transparency in the tobacco control process proposed by the delegation of Palau, and supported by the delegations of Bangladesh, Cook Islands, Fiji, Papua New Guinea, Samoa and Tonga, which read as follows:

The Fifty-fourth World Health Assembly,

Noting with great concern the findings of the Committee of Experts on Tobacco Industry Documents, namely, that the tobacco industry has operated for years with the expressed intention of subverting the role of governments and of WHO in implementing public health policies to combat the tobacco epidemic;

Understanding that public confidence would be enhanced by transparency of affiliation between delegates to the Health Assembly and the tobacco industry,

1. **URGES** Member States to recognize the importance of knowing of affiliations between the tobacco industry and members of their delegations;

2. **CALLS ON** WHO to continue to inform Member States on activities of the tobacco industry.

Dr JIMÉNEZ DE LA JARA (representative of the Executive Board) said that the Board had considered a progress report on the proposed framework convention on tobacco control and a report by the Board's Standing Committee on Nongovernmental Organizations. The Board had commended the reported progress made by the Intergovernmental Negotiating Body in developing the framework convention. The Negotiating Body had agreed that nongovernmental organizations could participate in its work in accordance with existing WHO rules and that the Board should be encouraged to explore ways of expediting the review of applications for official relations from organizations seeking to participate in the negotiation. In that connection, the Board had in turn agreed to adhere to the admission criteria set forth in the principles governing relations between WHO and nongovernmental organizations and to authorize its Chairman, together with the Chairman of the Standing Committee on Nongovernmental Organizations, to consider requests from organizations that wanted to participate in the work of the Negotiating Body on an ad hoc basis. Organizations that met the admission criteria and had relevant mandates would be provisionally admitted into official relations, which would then be confirmed or terminated at the subsequent January session of the Board, as stated in decision EB107(2). Unless otherwise decided by the Board, that arrangement would continue to apply until adoption of the framework convention on tobacco control. Terms of reference for that process would, however, be required in order to justify decisions on admission or exclusion.

Mr DÜRLER (Switzerland) said that the current pace of the negotiations relating to the framework convention might frustrate the ambitious goal of achieving a conclusion as scheduled, bearing in mind that significant parts of the proposed text had not yet been addressed and the question of the protocols remained open. He therefore advocated an increase in the frequency and/or duration of

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the sessions of the Intergovernmental Negotiating Body in 2002. Switzerland was committed to a strong framework convention which provided clear guidance to Member States in their efforts to curb the increasing use of tobacco. The success of the framework convention, representing as it did the first major international agreement in the field of public health, was crucial for the victims of tobacco smoke, as well as for WHO and its Member States.

Dr CHURNRURT AJ KARNCHANACHITRA (Thailand) said that her country had actively implemented tobacco-control interventions, particularly since 1992, as a result of which the smoking rate had been constantly declining. It also used income from tobacco excise tax to promote health activities. It firmly supported international cooperation in tobacco control; the framework convention and proposed related protocols should be used as a means of global regulation. Every country should have harmonized strategies for tobacco control, especially in regard to activities that had a cross-boundary effect. In Thailand, nongovernmental organizations played an important role in controlling tobacco use and she therefore supported their participation in the work of the Intergovernmental Negotiating Body.

Ms BENNETT (Australia) said that her country strongly supported the development of a framework convention on tobacco control in the interests of concerted international action to implement effective tobacco control measures. For the past year, it had been active in setting in motion a comprehensive strategy aimed at mobilizing support for the framework convention within Australia and the Western Pacific Region. It would continue to support the negotiation of a strong framework convention that set out clear commitments modelled on a comprehensive multifaceted approach to domestic tobacco control. In early 2001, an extended package of support for the Region had been developed in recognition of the need for awareness of the framework convention. It built on an Australian-funded agreement with the Regional Office for the Western Pacific that recognized Australia's commitment to share its capacity and experience in tobacco control with its neighbours. In consultation with the Regional Office and New Zealand, Australia had also designed a programme aimed at providing practical tools and access to relevant tobacco-control information in order to boost tobacco-control capacity and raise awareness of and promote action on the framework convention. Those activities built on its longstanding support for the Tobacco Free Initiative. She echoed the concerns raised by the delegate of Switzerland concerning the achievement of the set objectives within the given time-frame.

Ms DJAMALUDDIN (Indonesia) reaffirmed Indonesia's commitment to a comprehensive tobacco-control programme. While welcoming the forthcoming third session of the Intergovernmental Negotiating Body, she was nevertheless concerned that the goal of the negotiation appeared to be to produce a framework convention text, rather than to provide a meaningful instrument aimed at preventing the further spread of tobacco addiction. Negotiation of the framework convention should be accelerated, with less discussion of unnecessary details and more attention to achieving a consensus. She suggested the possibility of establishing a global fund aimed at helping developing countries to switch to alternative crops during the transition period. Noting that World No-Tobacco Day 2001 had taken passive smoking as its theme, she urged WHO to encourage the United Nations to implement a clean indoor air policy within its buildings.

Dr DALKILIÇ (Turkey) supported WHO's tobacco-control activities and expressed the hope that all countries would endeavour to implement the framework convention once it came into force in order to avert the impending disaster caused by uncontrolled tobacco promotion and thereby protect both current and future generations. Although Turkey had enacted legislation that prohibited smoking in public places, as well as the marketing and sale of tobacco to minors, it remained concerned by the promotion of tobacco through the media and the Internet. It was therefore important to target anti-smoking activities at children and adolescents.
Mr PAVELSONS (Latvia), speaking on behalf of Estonia, Latvia and Lithuania, said that the framework convention should provide a valuable tool that would set and govern the implementation of internationally accepted standards for tobacco control and also provide an impetus for legislative initiatives at the national level. The second session of the Intergovernmental Negotiating Body had been constructive, although the final balance of the text could not be judged until important outstanding matters, such as compensation and liability, had been settled. The final product should prove a major turning point in public health protection and should prevail over other related instruments. The principles of non-discrimination in international trade should not be used to limit the application of tobacco-control measures. In the light of recent developments in international law, however, it was likely in future dispute settlements that international economic law would be construed in the context of basic human rights, including the right to health.

With an ultimate view to prohibition, the Baltic States had taken a firm stand on tobacco advertising and the sale of tobacco products to young people. Where advertising was subject to constitutional restraints, there should be a gradual introduction of a total ban on all forms of advertising, marketing, promotion and sponsorship of tobacco products. Although special attention should be devoted to reducing the appeal of such products to young people, the final goal should be to ban tobacco advertising to all age groups. National legislation, as well as agreements and measures adopted at the governmental and nongovernmental levels, should also provide effective protection from tobacco smoke in the environment. That principle should be reaffirmed at the international level by the inclusion of such provision in the framework convention. Further the convention should specifically emphasize concerted regional cooperation as the most effective means of combating the smuggling and illicit sale of tobacco products, to which the Baltic States were particularly vulnerable in view of their geographical position as transit countries. He reiterated the willingness of the Baltic States to cooperate energetically for achievement of the goal of better tobacco control through a meaningful and effective framework convention.

Dr TSHERING (Bhutan) expressed support for the framework convention as an effective tool in combating the global forces working against tobacco control in their drive for profit at the cost of human lives. It would also provide a common ground for implementing tobacco-control activities and further unite Member States in their efforts to achieve that goal. At a meeting on the framework convention held in Jakarta before the second session of the Intergovernmental Negotiating Body, the Member States of the South-East Asia Region had confirmed their regional position and identified common approaches to achieving a practical and effective convention that could easily be implemented. Bhutan, much of which had already been declared tobacco-free, offered to host the next such meeting as a gesture of its support for the convention.

Dr POUTASI (New Zealand) strongly supported moves to reduce the number of people who smoked and who were exposed to second-hand smoke. In that connection the framework convention offered an unprecedented opportunity for countries to work together to reduce the public health consequences of tobacco smoking. She therefore endorsed a strong convention that included specific actions and policy commitments and extended national, regional and international control efforts, with particular emphasis on protection of the rights of indigenous people. As the development of protocols could be a lengthy process, bold tobacco-control efforts should form part of the framework convention itself. New Zealand was proud of its own comprehensive tobacco-control programme, which featured a broad range of initiatives, including subsidized nicotine-replacement therapy. It was currently considering legislation aimed at protecting the health of workers in hospitality venues by seeking to minimize their exposure to second-hand smoke, and to implement measures intended to restrict young people's access to tobacco. Strong tobacco control was vital to reducing the death and illness caused by tobacco smoking and bring the smoking epidemic under control. To that end, she looked forward to continued participation in the negotiations on the framework convention and to sharing her country's tobacco-control experiences with others who had yet to face the same hurdles.
Mr GUDMUNDSSON (Iceland) said that expectations of the Intergovernmental Negotiating Body were high. Tobacco was currently the only legal addictive substance that killed consumers when used as intended. Prevention was crucial and advertising campaigns targeted at young people by the tobacco companies should not be tolerated. A new bill under discussion by the Icelandic Parliament would further restrict the availability of tobacco in the country and essentially prohibit smoking in public places. He urged WHO to encourage the application of its own no-smoking rule in the Palais des Nations.

Dr STAMPS (Zimbabwe) shared the concern that progress on the convention was slow and suggested that more frequent or longer meetings might be required. He was pleased to note the degree of consensus in the African Region in relation to the negotiating process. In Zimbabwe, World No-Tobacco Day would be held at a girls' school, an appropriate choice of venue since young women were both prime targets for tobacco marketing and casual employees on tobacco-growing farms. Harare international airport had prohibited smoking, as had domestic airlines. Measures had been taken to discourage smuggling, including the introduction of a reward system for informers.

More transitional support was needed for poor agricultural communities in tobacco-producing countries especially in Africa. Low-income countries also needed further assistance in the development and enforcement of legislation to control tobacco use.

Mr FETISOV (Russian Federation), welcoming the progress to date, said that the framework convention should include effective, legally binding provisions without losing the character of a framework convention, so as to attract as many signatories as possible. It must be legally and politically viable. However, the provisions of the convention must not contradict existing legislation in Member States. Economic, ethical and cultural aspects in countries preparing to accede to the convention must be borne in mind. It might be possible to include more rigorous measures in optional protocols. That would also allow work on the draft convention to be completed within the allotted time. In addition to controlling tobacco, it was also important to promote healthy lifestyles.

Dr NOVOTNY (United States of America) said that, despite two well-organized and productive sessions of the Intergovernmental Negotiating Body, it was unlikely that the process could be completed on schedule. The negotiations would only be successfully completed through the member-driven process initiated by WHO, which was representative of the regions, used sound parliamentary practices and provided opportunities for input from Member States under the sound leadership of the Intergovernmental Negotiating Body and its officers. Regional input was critical to developing consensus on an effective convention.

He reaffirmed the support of his country for the framework convention process and looked forward to working with WHO to develop an instrument that promoted policies to prevent tobacco use among children, reduce illegal trade in tobacco and protect children and other vulnerable groups from passive exposure to smoking. Such policies would improve public health outcomes on a global scale. A strong global convention was an instrument that all Member States could embrace and sign.

Lastly, he endorsed the proposals that the United Nations should be urged to adopt a clean indoor air policy in its buildings.

Mr CHAKALISA (Botswana) urged continued progress in developing the framework convention. The ultimate aim should be to achieve a world free of tobacco. However, tobacco played an important role in the economies of some developing countries and adequate support would need to be provided to enable them to diversify. Such diversification would mitigate the effects of loss of tobacco revenues and ensure that previous gains made in health and social development were not lost.

All forms of tobacco advertising should be banned with a view to protecting vulnerable groups, such as youth, and creating non-smoking generations in the future. Regional cooperation would be vital in pursuing tobacco-control strategies and he urged Member States to cooperate at the regional and international levels in support of the framework convention.
Dr HETLAND (Norway), welcoming the progress made by the Intergovernmental Negotiating Body, endorsed the views expressed by previous speakers that the pace of the negotiation process should be increased. He confirmed the willingness of his country to work for a strong and substantive framework convention and believed that all people should have the chance to breathe smoke-free air as a human right. Norway had noted the progress made by the Scientific Advisory Committee on Tobacco Product Regulation and would continue to support its activities. Tobacco-product regulation should be further developed in a protocol to the framework convention.

Dr OTTO (Palau), introducing the draft resolution, pointed out that the morbidity and mortality rates resulting from tobacco use in all its forms far exceeded those from HIV/AIDS, alcohol abuse and injuries combined. The preambular section of the proposed draft resolution clearly indicated that the tobacco industry had been working hard to subvert the combined efforts to control the use of tobacco. He therefore called upon the Committee to support the draft resolution as a message to the tobacco industry that its activities would be closely monitored to ensure that it did not exert any influence on WHO’s work to control tobacco use. He expressed appreciation to the cosponsors of the draft resolution and reaffirmed his support for a strong framework convention and related protocols.

Dr TEMU (Papua New Guinea) said that he looked forward to the prudent finalization of the framework convention and associated protocols. Noting with concern, however, the information about tobacco-industry practices contained in document A54/14, he supported the draft resolution, which highlighted the need for transparency at every level throughout the entire negotiation process.

Mr ROKOVADA (Fiji), a cosponsor of the draft resolution, stated that a strong convention was vital to thwart successfully attempts by tobacco companies to undermine the efforts made by governments to combat the tobacco epidemic. His country had adopted a Tobacco Control Act which, among other measures, banned all forms of advertising of tobacco products and sponsorship of sports and social events by tobacco companies. He noted, with regret, the continued sponsorship of Formula I Grand Prix motor racing by tobacco companies in countries that professed to ban sponsorship of sports by the tobacco industry.

He expressed the conviction that public confidence required transparency concerning any affiliation between delegates to the Health Assembly and the tobacco industry.

Mr COSTI SANTAROSA (Brazil) fully supported a strong framework convention and related protocols on tobacco product regulation, advertising and smuggling. His Government’s Ministry of Health, which led the national strategy on tobacco control, had been implementing comprehensive regulations on tobacco products for the past two years. Moreover, legislation had been passed establishing a total ban on tobacco advertising and sponsorship, and the National Agency for Sanitary Control had recently established the maximum levels for tar, nicotine and carbon monoxide, and had also begun to monitor the tobacco-manufacturing process, including disclosure of the ingredients of cigarettes. However, certain problems persisted. One of the most important was smuggling, which was difficult to deal with because any solution depended on an international approach; it should be a priority issue for a protocol for the convention.

In view of the special features of each country and region and the different reactions from manufacturers in the various countries, WHO needed to strengthen its capacity to coordinate and provide technical and financial support, especially to developing countries, with a view to establishing a specific approach to the regulation of tobacco products.

He indicated that Brazil would be hosting a regional consultative meeting on the framework convention with a view to preparing a common position for Latin American and Caribbean countries for the next session of the Intergovernmental Negotiating Body. Nongovernmental organizations were important partners in tobacco control and should be involved in all national and international activities relating to the framework convention. He agreed with previous speakers that the pace of the negotiating process should be increased through the holding of more and longer meetings during 2002.
Mr CHOWDHURY (India) welcomed the progress made in the negotiation of the framework convention. To draw wide support, the convention should have a broad over-arching approach with no mandatory time-frame for the implementation of the various steps; that would enable governments to proceed according to the circumstances in their countries. Moreover, the convention should not set out commitments for governments that lay within their individual sovereign domain, in such fields as customs and excise duties, and penalties for breaches of the convention. It should recognize the huge effort required to redeploy persons currently employed in tobacco-related activities. A global fund would have to be established to assist developing countries in that regard. Finally, the detailed protocols should be taken up at a later stage, once the convention had been adopted. That would make it possible for signatories to introduce control measures gradually.

Dr EL-SHAFAI (Egypt), commending WHO's tobacco-control measures, indicated that Egypt had established a committee to combat tobacco use and promote tobacco-control activities, which worked in collaboration with relevant institutions, and with other legislative and regulatory bodies, in prohibiting tobacco publicity and smoking among persons under the age of 18 years. There were 20 medical centres in the country to encourage young persons to give up smoking. Tobacco control was a most important priority for the development of a healthy adult population, and measures to support the prohibition of the sale of tobacco products to young persons and the banning of smoking in public buildings and open areas, especially those frequented by children and young persons, were vital. Moreover, the warnings printed on cigarette packets should be clear and unambiguous. He called for support from nongovernmental organizations, particularly those working with women and children, for tobacco-control activities. He also emphasized the importance of expanding research on ways of encouraging people to give up all forms of tobacco smoking.

Mr MACPHEE (Canada) joined previous speakers in welcoming the progress made in the negotiations on the framework convention and the efforts being made by Member States to address critical areas such as advertising, packaging and labelling and the illicit trade in tobacco products. Canada looked forward to participating fully in the next round of negotiations. He also expressed appreciation of the contribution of nongovernmental organizations to the negotiations.

Canada's commitment to the convention stemmed from its firm belief that international action was needed to deal with the serious global health issue of tobacco use. A strong convention which supported a comprehensive international response to tobacco control would advance and protect the health of not only current but also future generations.

Mr LEE (Republic of Korea) indicated that his country was implementing various anti-smoking campaigns with the objective of significantly reducing smoking rates and would share experience on successful measures with other Member States. It would also participate actively in the development of the framework convention and in the international alliance for successful tobacco control. As one of the co-hosts of the next football World Cup finals, his country was considering designation of the event as tobacco-free, thereby increasing momentum in support of the anti-smoking campaign. He expressed the hope that Member States would support that initiative.

Dr PARASRAM (Trinidad and Tobago) commended the efforts of WHO in the field of tobacco control, the progress made by the Intergovernmental Negotiating Body, and action to ensure the transparency of the negotiating process. His country would continue to give priority to the reduction of tobacco use and the creation of a smoke-free environment. It would also support regional and global action and take whatever steps were appropriate. He looked forward to the finalization and adoption of the framework convention and the development of relevant protocols.

Ms ROVIROSA (Mexico) recognized the efforts that were being made by the Intergovernmental Negotiating Body to achieve the adoption of a framework convention on tobacco control. The process must be integrated and coordinated at the international level. It was also
indispensable that the framework convention addressed all the various aspects of the problem, such as public health and economic implications, including the consumption and production of tobacco and the development of commercial and enterprise policies.

The convention should adopt a balanced approach which took into consideration both active and passive smokers, as well as producers, and should include a list of indicators with a view to harmonizing criteria for measuring the health and economic impact of tobacco consumption. Mexico wanted the convention to be adopted within the envisaged schedule and thanked Brazil for organizing the consultation meeting on a common position for Latin American and Caribbean countries for the next session of the Negotiating Body.

Ms DJONEVA (Bulgaria) firmly supported the proposed framework convention as an exceptionally important international document in the field of public health. The negotiations on the convention provided an opportunity to focus the attention of all countries on a major health problem and one for which an effective solution could be achieved only through concerted efforts. The convention should set out basic conditions and principles, and the general rights and obligations of the parties, so as to facilitate its ratification by as many countries as possible. Specific commitments should be set out in additional protocols, which would enable the various states to accede to the protocols in accordance with their national interests and in line with concerted measures for the achievement of common goals.

She expressed appreciation of the role played by the Chair of the Intergovernmental Negotiating Body, in particular in drafting the Chair’s text. Bulgaria would participate actively in preparing the European regional contribution to the next round of negotiations.

Dr DLAMINI (Swaziland) reaffirmed the support of her country for the Tobacco Free Initiative and the framework convention. Swaziland was in the process of improving legislation to stop smoking in public places. Smoking-cessation campaigns would be needed to assist those who wanted to give up smoking. Countries that depended economically on tobacco production would need support in the development of alternative cash crops. The practices of dumping and smuggling tobacco into developing countries were targeted particularly at young persons. She called for a speedy finalization of the convention and supported the draft resolution before the Committee. She appealed for support for tobacco-control measures in Swaziland.

Dr MOSOTHO (Lesotho) welcomed the progress made in the framework convention negotiations, but shared the concern expressed by previous speakers that the time-frame was too short. Nevertheless, ongoing consultations had allowed Member States, including his own, to develop good basic rules for an acceptable level of control of tobacco smoking. Indeed, much progress had been made in Lesotho, especially by targeting youth as a catalyst for attaining long-term goals. He therefore called for a more rapid negotiation process, although care should be taken so as not to lose sight of the ground gained and the opportunities for promoting a sound and healthy lifestyle.

The importance attached to tobacco control by his Government was demonstrated by the manner in which World No-Tobacco Day 2001 would be celebrated, with the Head of Government articulating public policy on the issue and declaring all Government premises and vehicles smoke free. His country had adopted a multisectoral approach to the problem in view of the diverse nature of the impact of tobacco consumption on health and development.

Dr SADRIZADEH (Islamic Republic of Iran) expressed support for the recommendations of the committee of experts, as set out in document A54/14, and welcomed the enhanced capacity of WHO to respond to requests from countries for support, particularly in relation to legislation, surveillance and media advocacy. He supported the draft resolution.

Mr GRBEŠA (Croatia) expressed appreciation of the leadership in the framework convention negotiations, and supported a strong and effective convention. At the end of 1999, Croatia had adopted
tobacco-control legislation that encompassed most of the provisions envisaged in the framework convention, including the prohibition of the sale of tobacco products to persons under the age of 18. He agreed with previous speakers that the frequency of forthcoming negotiating sessions should be increased and he assured WHO of the support and collaboration of his country in the negotiating process.

Dr MAHJOUR (Morocco) emphasized the magnitude of tobacco addiction at national, regional and international levels and expressed the conviction that the framework convention was an important legal instrument that would lay the basis for establishing and adopting international measures for a significant reduction in tobacco consumption and to reduce its health and socioeconomic impact. Although much remained to be done, he paid tribute to the efforts made so far.

In September 2000, the Moroccan Ministry of Health had organized a multisectoral dialogue on the national strategy to combat tobacco addiction in the light of the framework convention with the participation of several ministerial departments, experts and representatives of civil society. The process had resulted in the establishment of a multidisciplinary group entrusted with formulating the policy, planning and coordinating all tobacco-control activities and reviewing anti-tobacco legislation with a view to developing overall regulations that were in accordance with the future framework convention and its protocols.

Dr FALL (Senegal) commended WHO's tobacco-control activities. Senegal had established an interministerial committee to combat tobacco use, which was supported by a coalition of parliamentarians and nongovernmental organizations. The country had also been selected for the implementation of a pilot project to protect young persons against tobacco use. He encouraged WHO to place emphasis on information, education and communication activities. As a result of such activities, the second largest city in Senegal had succeeded in less than 10 years in prohibiting the sale and consumption of tobacco. His country therefore unreservedly supported the development of a strong and effective framework convention. It endorsed the draft resolution and asked to be listed as a sponsor.

Dr TOUYÁ (Uruguay) emphasized the importance of achieving consensus at the subregional and regional levels with a view to contributing to the progress of the negotiations. Uruguay and the other Member States of MERCOSUR (Common Market of the Southern Cone), as well as the associated States, Bolivia and Chile, had commenced the coordination of their tobacco-control programmes. The framework convention should be a public health instrument that would address all links in the tobacco chain, from production to the final consumer. The convention, dealing with public health, should have priority over trade instruments. He supported the draft resolution.

Dr LEVENTHAL (Israel) emphasized the harm done by tobacco use. The Parliament of Israel had adopted new legislation that would place an increasingly broad ban on smoking in most public areas. However, as the tobacco industry was finding creative ways of winning over young persons and adolescents, he supported the draft resolution.

Dr DA COSTA E SILVA (Tobacco Free Initiative) thanked the delegates for their support and comments, in particular those of Bhutan and Brazil for offering to host regional meetings, which would be important in increasing awareness of the Member-driven process. She agreed that more frequent and longer meetings of the Intergovernmental Negotiating Body would make it possible to address the issues more fully.

The Committee noted the reports.
Other activities (Document A54/14)

Dr NOVOTNY (United States of America), referring to document A54/14, commended the summary of the findings of the committee of experts and applauded the global leadership shown by WHO, including the United Nations Ad Hoc Inter-Agency Task Force on Tobacco Control, which had facilitated the development of new partnerships to look at the economic and trade issues related to tobacco control and to support research on those issues. He appreciated the need for transparency in the tobacco-control process but proposed that, in order to make the draft resolution introduced earlier in the meeting acceptable to more Member States, paragraphs 1 and 2 should be replaced by the following:

URGES WHO and its Member States to be alert to any efforts by the tobacco industry to continue this practice and to assure the integrity of health policy development in any WHO meetings and in national governments.

Dr YUNES (Brazil) said that his country had been pursuing various approaches and activities in tobacco control and sought the support of WHO, the World Bank and IMF in formulating the economic aspects of national policies, in particular through studies on taxation, smuggling and agricultural diversification. WHO should establish a budget to support development of the framework convention and for other tobacco-control activities. He stressed the importance of the Scientific Advisory Committee on Tobacco Product Regulation and suggested that its work should be widely disseminated.

Mr DÜRLER (Switzerland) welcomed the recommendations of the committee of experts referred to in document A54/14, which had been chaired by Professor Zeltner of his country. Switzerland had already introduced measures to ensure that its delegates to WHO meetings disclosed any affiliations with the tobacco industry and urged other Member States to do likewise. Expressing support for the draft resolution, he requested WHO to consider measures to ensure the transparency of any possible affiliations between nongovernmental organizations in official relations with WHO and the tobacco industry, and to monitor activities of the latter aimed at impeding the negotiation of the framework convention. WHO should also facilitate the dissemination and exchange of information on unethical practices of tobacco companies in relation to Member States and other interested parties.

Mr CASTILLO SANTANA (Cuba) said that, although document A54/14 provided a good basis for the work of the Health Assembly, the draft resolution did not do justice to the recommendations of the committee of experts, bearing in mind also certain incidents related to industry that had affected WHO in the past. He therefore proposed that the first preambular paragraph should be amended to read:

Noting the findings of the Committee of Experts on Tobacco Industry Documents, namely that the practices of the tobacco industry, on occasion, have had a negative impact on WHO’s global tobacco-control policy.

Dr STAMPS (Zimbabwe) proposed that the draft resolution should be amended by expanding the second preambular paragraph to encompass delegates to other WHO meetings which would include those of the Intergovernmental Negotiating Body; by replacing “of affiliations” by “any affiliation” in paragraph 1; and by replacing “CALLS ON” by “MANDATES” in paragraph 2. He supported the draft resolution with those amendments.

Mr SHAMANOV (Russian Federation) supported the draft resolution in principle. As paragraph 1 was unclear and likely to give rise to legal queries, he endorsed the amendment proposed by the delegate of the United States of America.
Dr HETLAND (Norway), noting that the tobacco industry had affiliations with several nongovernmental organizations in official relations with WHO, inter alia, in the field of toxicology, also supported the draft resolution as amended by the United States of America. Ratification of the framework convention would enable open dialogue with the industry, and once the convention had entered into force, WHO would have a mandate for consultations with all stakeholders.

Mr KINGDON (Australia), stressing the importance of transparency, supported the draft resolution as amended by the delegate of the United States of America, which would encourage governments as well as international bodies to be alert to subversive activities by the tobacco industry.

Dr OTTO (Palau) endorsed the comments made by the delegate of Switzerland and the amendments proposed by the delegate of Zimbabwe. However, in a spirit of cooperation, his delegation would accept the amendment proposed by the delegate of the United States of America, and supported by Norway and Australia. Palau was also ready to accept the amendment proposed by Cuba.

Mrs HEIDET (International Cystic Fibrosis (Mucoviscidosis) Association), speaking at the invitation of the CHAIRMAN, said that her organization had encouraged its 56 member countries to organize local campaigns on passive smoking, the theme of World No-Tobacco Day 2001, which was particularly harmful to those affected by cystic fibrosis. That disorder affected up to 1 in 2000 newborns and at least 70 000 known sufferers worldwide. Numbers were increasing, owing to better diagnosis. Research had demonstrated that the condition of children suffering from the disorder could be further damaged by exposure to cigarette smoke before and after birth. With treatment most patients currently reached adulthood, although employment was limited to sedentary occupations and exposure to tobacco smoke at work or in public places was a continuing danger. Her organization had participated in many activities in the field of noncommunicable diseases and supported WHO in its efforts to reduce environmental exposure to tobacco smoke.

Mr OLUWAFEMI (Infact), speaking at the invitation of the CHAIRMAN, said that the Health Assembly should be a model of good governance by ensuring transparency regarding affiliations between its Members and the tobacco industry. Transparency was essential to make institutions more accountable to governments and to people and was an important first step towards preventing undue influence by bodies whose practices were harmful to human health. A recent survey by Infact in 31 countries had shown that over 70% had no laws requiring the tobacco corporations to disclose basic information about their lobbying activities or political contributions. The report of the WHO committee of experts and other studies, including research by Infact, indicated that corporations continued to interfere in public health policy at national and international levels, seeking to shape it to their advantage. He urged the Health Assembly to adopt the expert committee’s recommendation on ensuring the transparency of affiliations between delegates to the Health Assembly and tobacco companies, and between nongovernmental organizations and tobacco companies, both to safeguard the integrity of its decision-making and to increase public awareness of tobacco industry influence.

Dr KARAM (Secretary) reminded delegates of the amendments to the draft resolution that had been proposed by the delegates of Cuba, Zimbabwe and the United States of America. The proposal made by the delegate of Zimbabwe could be accommodated by amending the second preambular paragraph to read:

Understanding that public confidence would be enhanced by transparency of affiliation between delegates to the Health Assembly and other WHO meetings and the tobacco industry.

Dr STAMPS (Zimbabwe) recalled that he had also proposed amendments to paragraphs 1 and 2. He was unable to accept the amendment proposed by the delegate of Cuba to the first preambular paragraph because it did not identify the expressed intention of subverting the role of governments and
of WHO in implementing public health policies. He would prefer to retain the paragraph as originally proposed.

Mr CASTILLO SANTANA (Cuba) said that he had wanted to make it clear that the tobacco industry had not set out in all cases intentionally to subvert the role of government. At the sessions of the Intergovernmental Negotiating Body, Cuba had steadfastly endeavoured to promote a multisectoral approach. For that to succeed there must be a degree of coordination at national level between the tobacco industry, the health sector and other sectors concerned. Other countries had adopted a similar approach and it was therefore unfair to generalize. He would prefer to see a form of wording that safeguarded the existing levels of coordination in many countries between the tobacco industry and the health sector and had therefore sought to rephrase the first preambular paragraph in more general terms. He was, however, prepared to accept a compromise.

Mr KINGDON (Australia), while respecting the concerns expressed by the delegate of Cuba, said that the draft resolution must reflect the views of the committee of experts. Dr TOUYÁ (Uruguay) endorsed that view. The preambular paragraph reflected the actual situation and, as such, should stand.

Mr CASTILLO SANTANA (Cuba) said that, having made his views clear, in the interest of consensus he would abide by the decision of the Committee with regard to the first preambular paragraph.

Dr STAMPS (Zimbabwe) said that he could accept the amendments proposed by the delegate of the United States of America, as an addition to paragraphs 1 and 2, but not as a replacement for them. Dr NOVOTNY (United States of America) said that it was his understanding that the cosponsors had already accepted his proposed amendment and emphasized that his aim was to focus greater attention on conflicts of interest and on the issues raised by the committee of experts.

Dr STAMPS (Zimbabwe), saying that the amendment under discussion broadened the concept but weakened the thrust of the draft resolution, held to his view. He recalled that he had also proposed the substitution of “any affiliation” for “of affiliations” in paragraph 1, and “MANDATES” for “CALLS ON” in paragraph 2.

Mr DÜRLER (Switzerland) agreed with the previous speaker that the paragraph proposed by the delegate of the United States of America should be included in addition to the existing paragraphs 1 and 2, as amended by the delegate of Zimbabwe.

Mr SHAMANOV (Russian Federation) said that it was also his understanding that the amendment proposed by the delegate of the United States of America had been accepted. It offered a solution to the concerns he had already expressed regarding the clarity of the existing operative paragraphs.

Dr NOVOTNY (United States of America) said that the term “MANDATES” proposed by the delegate of Zimbabwe went beyond WHO’s role and might have budgetary implications. It would be inappropriate for WHO to be involved in investigating business activities. In that regard he disagreed with the recommendation of the committee of experts. The aim should be to raise the level of interest in the practices of the tobacco industry.

Dr HETLAND (Norway) endorsed the proposal to have three operative paragraphs, as amended.
At the suggestion of the CHAIRMAN, Dr STAMPS (Zimbabwe) agreed to withdraw his proposed amendment to paragraph 2, but he stressed his wish to see the retention of paragraphs 1 and 2.

Dr NOVOTNY (United States of America) requested delegates to consider carefully the implication of paragraphs 1 and 2. Was it appropriate to place any impediment in the selection of delegates by sovereign states, and was the activity called for in paragraph 2 appropriate for a public health agency? He again urged that the wording he had proposed should replace paragraphs 1 and 2.

Mr DÜRLER (Switzerland) said that there should be no objection to WHO continuing to do what it had done before. Moreover, in its current form, paragraph 1 was quite general and did not commit Member States to any specific action.

The CHAIRMAN suggested a brief suspension to allow informal consultation.

It was so agreed.

The meeting was suspended at 18:50 and resumed at 19:00.

Dr KARAM (Secretary) said that, in the course of informal consultations, Bangladesh had withdrawn from the list of cosponsors of the draft resolution, while Jamaica, Senegal and Switzerland had asked to be added to the list. The revised text of the draft resolution read as follows:

The Fifty-fourth World Health Assembly,

Noting with great concern the findings of the Committee of Experts on Tobacco Industry Documents, namely, that the tobacco industry has operated for years with the expressed intention of subverting the role of governments and of WHO in implementing public health policies to combat the tobacco epidemic;

1. **URGES** WHO and its Member States to be alert to any efforts by the tobacco industry to continue this practice and to assure the integrity of health policy development in any WHO meetings and in national governments;

2. **URGES** Member States to be aware of affiliations between the tobacco industry and members of their delegations;

3. **CALLS ON** WHO to continue to inform Member States on activities of the tobacco industry that have negative impact on tobacco-control efforts.

The draft resolution, as amended, was approved.

The meeting was suspended at 19:05 and resumed at 19:45, with Mr Gunnarsson in the Chair.

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2 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA54.18.
5. **EFFECTIVE FUNCTIONING OF THE GOVERNING BODIES IN WHO**: Supplementary agenda item (resumed from section 3)

The CHAIRMAN announced that the drafting group established earlier had not yet reached agreement on the text of a revised draft resolution. He therefore proposed adjourning the discussion.

*It was so agreed.*

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

*The meeting rose at 19:50.*
EIGHTH MEETING
Tuesday, 22 May 2001, at 9:30

Chairman: Mr D.A. GUNNARSSON (Iceland)

1. SECOND REPORT OF COMMITTEE B: (Document A54/52)

Dr KUNENE (Swaziland), Rapporteur, read out the draft second report of Committee B.

Ms BALOCH (Pakistan), referring to the draft resolution on assessments for the financial period 2002-2003, asked why the reference to the Financial Regulations in paragraph 1, which her delegation had said was very important, had been deleted and whether the Financial Regulations still applied in the absence of the reference.

The CHAIRMAN explained that it had been deleted as superfluous and that the Financial Regulations would still apply.

Dr STAMPS (Zimbabwe) asked for confirmation, in the interest of transparency and clarity, that the amounts in the two columns of the Annex to that draft resolution would be billed in two equal annual instalments, as provided for in Financial Regulation 6.1.

The CHAIRMAN confirmed that that was, indeed, the case.

Dr STAMPS (Zimbabwe) said it was also important for it to be made clear to those countries whose assessment for 2003 differed from that for 2002 in the Annex that the equal amounts being billed had been established in accordance with Financial Regulation 6.1 and that there had been no revision of their assessment.

The CHAIRMAN assured him that the fact would be clearly stated in the covering letters to Member States.

Ms BALOCH (Pakistan), referring to transparency in tobacco control process, said that, although she accepted the draft resolution that had been approved by the Committee in her delegation's absence on the previous day, she would like to place on record that, had it been present, her delegation would have requested that the term "... and the staff of WHO" be added after the phrase "members of their delegations" in paragraph 2.

Dr STAMPS (Zimbabwe) said the Pakistani delegation's fear could be allayed by the fact that all WHO staff were obliged to disclose any conflict of interest concerning their work for the Organization.

Mr TOPPING (Legal Counsel) confirmed that such a requirement had always existed in the Staff Rules, but said that the Director-General had recently amended those Rules to make that requirement more explicit. The amended text would be submitted to the Executive Board for confirmation on the following day.
Dr POUTASI (New Zealand) suggested that the word “health” in paragraph I(1) of the English text of the draft resolution on the International Decade of the World’s Indigenous People should be placed after the words “highest attainable standard of”.

It was so agreed.

With that amendment, the report was adopted.¹

2. EFFECTIVE FUNCTIONING OF THE GOVERNING BODIES IN WHO: Supplementary agenda item (Document A54/B/Conf.Paper No.6) (continued from seventh meeting, section 5)

The CHAIRMAN, after congratulating the Chairman of the drafting group which had produced a balanced proposal that was a compromise between the two views expressed, invited the Committee to consider the proposed draft resolution on reform of the Executive Board, which read:

The Fifty-fourth World Health Assembly,

Being guided by the Purposes and Principles of the Charter of the United Nations which recognized the sovereign equality of all Member States of the United Nations;

Affirming the need for equitable participation of Members of the Organization in its affairs;

Recalling the Constitution of the World Health Organization, in particular, Articles 18, 24, 27 and 28;

Noting the views and concerns expressed by Member States on the methods of work of the Executive Board and on the limited participation of Member States not represented in the Executive Board or its subsidiary bodies in the proceedings thereof;

Bearing in mind that improved participation of Member States not represented in the Board in its proceedings, especially in its working groups and drafting committees may contribute to improving the work of the Executive Board,

1. REQUESTS the Executive Board:
   (1) to conduct a review of its working methods and those of its subsidiary bodies in order to ensure that they are effective, efficient and transparent, and to ensure improved participation of Member States in its proceedings, including working groups and drafting committees;
   (2) to establish, for that purpose, an ad hoc open-ended intergovernmental working group that will make recommendations to the Executive Board for improvement of its working methods;
   (3) to inform the Fifty-fifth World Health Assembly on the progress of the review, including any recommendations for consideration by the Assembly;

2. REQUESTS the Director-General, within her mandate, to ensure that Member States participating in the proceedings of the Board, but not being members thereof, have adequate seating arrangements with name plates.

¹ See page 308.
The CHAIRMAN proposed that the word “recognized” in the first preambular paragraph should be replaced by “recognize”.

The draft resolution, as amended, was approved by acclamation.¹

3. THIRD REPORT OF COMMITTEE B (Document A54/53)

Dr Kunene (Swaziland), Rapporteur, read out the draft third report of Committee B.

The report was adopted.²

4. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 9:45.

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA54.22.
² See page 308.
PART II

SUMMARY RECORDS OF
THE MINISTERIAL ROUND TABLES
The CHAIRMAN, introducing document A54/DIV/4 and opening the round table, said that it should provide an opportunity for a lively exchange of views on mental health. The discussions would be supported by two facilitators, Professor G. Astbury (University of Melbourne, Australia) and Professor A. Kleinman (Harvard University, United States of America).

Professor KLEINMAN (Facilitator) stated that depression alone accounted for about 4% of the global burden of disease. When suicide was included, the cost of depression was raised by 40%. More than 400 million people worldwide suffered from mental health problems (one in five patients in primary health care and a family member in one in four families), and epidemiological studies estimated that between 10% and 15% of adult populations experienced mental or behavioural disorders during their lifetimes. Mental health disorders had high medical and social costs — representing 2.5% of gross domestic product in the United States of America — and contributed to a high proportion of suicides, currently estimated at over one million per year worldwide. Mental health problems were frequently interrelated, contributed to and resulted from poverty, and were often more prevalent in women. WHO's abuse trends linkage alerting system (ATLAS) project estimated that 43% of countries studied had no mental health policy, 23% had no legislation on mental health, 38% had no community care facilities for the mentally ill, and in 41% treatment for severe mental disorders was unavailable at the primary health care level. Few mental health projects had been expanded to the national level, even though many had shown evidence of cost-effectiveness. Despite the known cost benefits of treating depression, most surveys showed that less than 50% of depressed patients in primary care were either properly diagnosed or treated. Many mentally ill persons failed to seek treatment. There were also serious human rights violations associated with patients in mental hospitals who were among the most vulnerable and inadequately cared for of all patients, while in many societies the mentally ill were often the victims of stigma and discrimination.

The loss of disability-adjusted life years (DALYs) associated with mental health problems in fully established market economies was twice that in low-income countries, indicating that mental health problems increased with prosperity. What was needed to close the gap between knowledge and practical action was a more effective integration of mental health services in primary health care, taking into account local conditions, greater use of preventive measures, increased dedicated financial and human resources backed up by intersectoral support, greater availability of essential psychiatric drugs, and an education campaign to combat stigma.

Round-table participants might consider what could be done to increase awareness of the burden of mental health problems and the need to commit greater resources to their resolution; the level of responsibility of the public health sector in that area in the face of other health priorities and limited resources; and the key strategies being used and obstacles encountered in their countries in addressing mental health problems.

Dr LÓPEZ (Chile) stressed that close alliances between all those involved in treating and caring for people with mental illness, including their families, were needed in order to raise the profile of mental health and attract more resources. For the past 10 years, Chile had therefore been promoting the establishment of such groups at national and regional levels. The initiative had been accompanied...
by efforts to raise general awareness of the public health implications of mental health disorders and to improve the ability of local health services to respond to the problem. Results of national and international epidemiological research studies had enabled the scientific community and health professionals to develop better treatment and prevention strategies. As a result of its greater visibility, mental health was currently regarded as an important component in Chile's health reform programme.

The public sector had an important role to play in ensuring that psychiatric treatment was made available at the primary health care level to people with few resources. Indeed, the population should have access to the specialized services they required regardless of their ability to pay.

In addition to the type of mental health disorders prevalent in developing countries, Chile also had to contend with those associated with more developed countries, such as schizophrenia and bipolar disorders. Treating them was not easy and had needed the establishment of outpatient clinics and specialist units in general hospitals. Depression was a major cause for concern, particularly among women. A programme designed to detect and treat depression was being developed at the primary health care level and 40% of general medical practices currently provided access to a psychologist. In addition, the new generation of safer antidepressants was being made more widely available. Alcohol and drug dependence constituted another serious mental health problem which Chile was confronting through provision of treatment to those in need with support from non-profit organizations. Other major areas of concern, about which more information was urgently required, included the mental health of schoolchildren and indigenous people, and work-related mental health problems.

In 2000, Chile had launched a national mental health plan, and additional resources had been made available that would increase the proportion of the total health budget allocated to mental health by between 1% and 1.4% in the first year.

Dr KASI (Pakistan) related that recent studies in rural areas and urban slums in Pakistan had shown a high prevalence of neuropsychiatric disorders. Mental health had also been identified as a main priority area in the national health policy. The Lunacy Act of 1902 had recently been replaced by the National Mental Health Ordinance 2001 which provided a balanced framework for protecting the human rights of mentally ill people and their families. The national mental health programme had established pilot projects at local level to provide mental health care as a component of primary health care. The media and nongovernmental organizations were supporting efforts to promote public awareness and understanding of mental illness by tackling traditional myths and superstitions. Other public sectors, in particular the Department of Education, were actively involved in the mental health programme, and mental health education was being introduced in medical schools. Psychiatric nursing courses were also being offered by nursing schools. Mentally ill people and their families were eligible to receive grants, as well as social and disability pensions. Most health care services for the mentally ill were provided by the public sector, although the private sector was rapidly emerging as a new player in that area. As yet, no policy existed to regulate private sector providers and health insurance was not available, although the Government had recently submitted an ordinance on the regulation of private hospitals, including mental health institutions.

Dr FRENK MORA (Mexico) underlined the double burden of disease that was afflicting developing countries. They faced mental health problems linked to backwardness and poor hygiene, such as epilepsy and mental retardation, as well as new types of mental disorder more commonly associated with developed countries, such as depression and psychosis. Moreover, current epidemiological and demographic trends, such as population ageing, indicated that the burden of mental disease was set to increase in the future in all countries.

Mental health problems served to magnify existing deficiencies in the overall health care system in respect of quality of treatment and care, respect for the human rights of people with mental health disorders, and fairness in financing, including the lack of health insurance cover for the mentally ill. Consequently, mental health should be treated as a priority in efforts to reform health systems. An important first step in increasing awareness of the problems associated with mental disorders was to document the scope of the problem. In that respect, Mexico had carried out several surveys which, in
conjunction with WHO’s ATLAS project, should provide scientific evidence for treating mental health as a priority area.

The public sector had a vital, proactive governance role to play in articulating the importance of mental health, protecting the human rights of those suffering from mental disorders and combating the stigma attached to mental illness. In Mexico, priority had been given to devising new mental health programmes, in particular to tackle alcohol and drug dependence, depression, schizophrenia, dementia, psychological disorders in children, and epilepsy. New pilot projects were under way to introduce innovative approaches that included the integration of prevention and treatment of mental health disorders in general health care systems; early detection of learning disabilities and social rehabilitation of patients in half-way houses, sheltered workshops and residential accommodation to facilitate their gradual reintegration into the community.

He agreed with Dr López on the need to focus special attention on the mental health of indigenous people, taking into account their particular cultural circumstances.

Mr MUMBA (Zambia) observed that mental health problems continued to have a considerable negative impact on his country’s health status. While Zambia had done a great deal to upgrade the quality of mental health care in recent years, there had been a significant erosion of the human resource base, in particular, front-line mental health workers. Health infrastructures and equipment were in a deplorable state, and essential psychotropic drugs were only intermittently available. Zambia had established a post of mental health specialist, and some progress had been made. A mental health situation analysis had been undertaken; a draft bill had been submitted to the Ministry of Legal Affairs; mental health had been integrated into the essential health care package at community level, with the possibility of referrals; and mental health had been accorded its place among public health priorities.

Zambia’s participation in international forums and projects had led to the establishment of key links with a broad spectrum of mental health experts. As a member of the International Consortium for Mental Health Policy and Services of the Global Forum for Health Research, Zambia was pursuing ways of securing WHO support, and was participating in the WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse. At the local level, partnerships had been established with communities, giving them a central role in realizing improvements in mental health care. His Government was committed to developing a mental health policy, providing human resources for mental health, reviewing relevant legislation and upgrading health infrastructure and equipment. New international networks would also be developed that would benefit the local mental health programme. Zambia viewed the stigmatization and marginalization of people with mental health problems as an inappropriate legacy from the past. Mental health services were a crucial component of primary health care that would enable people to work productively and fruitfully. The inclusion of mental health in WHO’s public health agenda underscored the commitment of governments to the development and improvement of national mental health services in line with relevant resolutions adopted by the Health Assembly, the WHO Regional Committee for Africa, the United Nations General Assembly and UNDCP.

Professor ASTBURY (Facilitator) said that sustainable improvements in mental health and emotional well-being would require the reduction of current gender disparities in mental disorders. Socially determined differences between men and women affected the power and control of individuals over the socioeconomic determinants of their mental health, access to resources, personal status and opportunities, and treatment in society. They also influenced susceptibility and exposure to specific risks associated with mental health such as sexual violence. Depression accounted for the largest proportion of the burden associated with mental and neurological disorders and, despite wide variations in prevalence across countries, was consistently reported to be about twice as common in women. Women also predominated among those who experienced three or more concurrent disorders, including depression, anxiety, agoraphobia, panic disorder and post-traumatic stress disorder. One exception was alcohol dependence, in which men predominated. Psychiatric co-morbidity was a
repeated finding in studies on the mental health effects of violence by an intimate partner. Reducing
the number of women suffering from depression was a matter of urgency in order to decrease the
global burden of disease and disability caused by mental disorders.

Mental health policy must be based on a gender analysis and have a public health focus; gender-specific risk-factor reduction strategies should be established. The services available should be gender sensitive and there should be equitable access to those services. Effective strategies for risk-factor reduction in mental health could not be gender neutral if the risks themselves were gender specific. Many such risks arose from women's exposure to poverty and socioeconomic disadvantage. Women accounted for more than 70% of the world's poor and earned significantly less than men when in paid work. Low rank in the workplace and gender-specific roles further increased women's susceptibility to depression, by emphasizing passivity, submission and dependence. Emerging evidence indicated that globalization and economic reform had exacerbated income inequalities with the greatest impact on poor women. Those changes were associated with increases in rates of depression and even suicide. The mental health effects of economic reforms should therefore be monitored.

Exposure to gender-based violence posed another formidable risk to mental health, increasing rates of depression and post-traumatic stress disorder. Women were reluctant to report violence, compounding associated mental health problems. Given the marked reduction in depressive symptoms when women stopped experiencing violence and began to feel safe, access to safe, affordable housing was a powerful mental health treatment.

Mental disorders needed to be placed in a social context; mental health budgets would be depleted rapidly if funding focused solely on treatment and not on reducing exposure to mental health risks. Attention should be paid to reducing gender disparities in mental health, using a patient-centred approach. Underdiagnosed and poorly treated complex problems, especially the combination of depression, psychiatric co-morbidity and multi-somatization occurring within the context of difficult psychosocial and economic circumstances, required urgent resolution. Furthermore, gender-based barriers to mental health care, including cost, insurance cover and gender bias in treatment, should be removed. The inclusion of a focus on mental health in all programmes relating to child health was a priority since exposure to significant adversity in childhood strongly predicted multiple negative mental and physical health outcomes in adult life. Intersectoral collaboration and gender-sensitive policy-making in the areas of education, transport, housing and employment were important to ensure improvements in the multiple determinants of mental health.

She invited participants to consider several core questions: first, the extent to which their country's mental health policy was gender sensitive and identified and dealt with gender-specific risk factors necessary for prevention. Secondly, what needed to be done to enable primary health care providers to gain and use the skills necessary to identify gender-related violence and for the management and care of the ensuing health problems. Thirdly, how could the health sector improve intersectoral collaboration in order to remove gender bias and discrimination, and lastly, how could countries modify social structural factors such as child-care responsibilities, transport, costs and lack of health insurance that constrained women's access to mental health care.

Mr MORRI (San Marino) agreed that mental disorders should receive greater attention. Since 1955, patients in San Marino had enjoyed free, direct access to medical care, including care for mental and neurological disorders. As San Marino had no psychiatric hospitals, patients requiring admission were referred to institutions in other countries. In addition, relevant legislation was being reviewed to respond to new needs, including support to care providers.

San Marino had always attached importance to caring for patients with mental disorders through social and community-based services, and strategies had been improved to enhance quality of life. Rehabilitation was individually tailored, and included access to half-way houses for reintegration into the community, occupational rehabilitation workshops and special training contracts. Private companies could enjoy reductions in their social contributions if they employed certified disabled persons and were required by law to employ one disabled person for every 20 employees. Those and
other administrative and social measures were effective in preventing the stigmatization of persons with mental disorders.

Voluntary assistance contributed significantly to the services provided by the State, and some voluntary associations were actively promoting information on mental disorders, supporting rehabilitation, and encouraging the involvement of the mentally and physically disabled in sport.

Current commitments would need to be sustained, through, *inter alia*, investment in human resources and the implementation of preventive programmes targeted at all social groups, and the provision of effective and individually tailored care. It would also be essential to improve understanding between patients with mental disorders and doctors.

Dr JANDRISKA (Ecuador) drew attention to four issues associated with mental health problems in his country: the fact that Ecuador was located in a high-risk disaster area; the number of persons displaced as a result of the “Plan Colombia” strategy; the high levels of migration away from families in order to find work; and the level of political instability. It was important to analyse mental health in relation to society. To that end, his Ministry had set up a series of mobile units in poor areas from which wage earners were often forced to migrate and a psychologist had been attached to each unit to analyse the resulting community problems.

Since 1994, there had been greater awareness of mental health in Ecuador, and it was hoped that the draft legislation developed in that regard would enter into force as soon as possible. Ecuador faced a wide range of mental health disorders with prevalence of alcohol misuse particularly high in young people. A multifaceted approach was needed to ascertain the causes of substance misuse and violence, in particular violence directed at women. Ecuador and a neighbouring country planned to develop joint legislation on psychotropic substances.

Affirming the need to pay attention to indigenous populations, he said that his Government was taking steps to provide those in Ecuador with health care services of good quality based on local needs.

Professor EE Heok Kua (Singapore) emphasized the need to convey a positive message indicating that many people did recover from mental health problems. To that end, Singapore’s health authorities worked closely with nongovernmental organizations, held public forums every two months on common mental illnesses including depression and anxiety, and collaborated with the mass media to destigmatize mental illness and to ensure that correct information was provided.

It was important for governments to ascertain the extent of mental health illnesses in order to plan service. Following a national survey in Singapore, action had been taken in three areas: teachers and counsellors had been trained to recognize and manage mental health problems in schoolchildren; personnel and managerial staff had also been taught to recognize the common signs of mental illnesses in the workforce, as well as counselling techniques; and retired professionals had been trained to provide counselling support to the elderly. In all cases, if a problem could not be managed, the individual concerned was referred to a specialist.

He expressed the hope that mental health would remain a focus of attention for WHO, and that, in the future, the Organization would coordinate programmes and make sure of their effectiveness.

Mr ROLIGHED (Denmark) said that, in his country, all persons had free and equitable access to the health system irrespective of sex, age, social status and the problem from which they suffered. It was important to ensure that mentally ill patients were given appropriate treatment, and to that end the Danish medical authorities worked closely with research, education and quality assurance programmes.

Dr AMATHILA (Namibia), noting that the stigma of mental illness had been eclipsed in Namibia by that associated with HIV/AIDS, said that gender disparities had been actively addressed in her country and that no health service excluded women. As far as mental health was concerned, women in Namibia appeared to be stronger than men; however, the level of violence against women
was increasing. The health authorities had set up centres for women and children who had been abused, and in the previous year, an organization entitled “Men against violence against women” had been set up by men to provide counselling to abusive men.

Unemployment, poverty, alcoholism and HIV/AIDS were important factors in the rise in mental instability in Namibia, especially among young people. The refugees from neighbouring war-torn Angola also experienced mental health problems. It would therefore be important to create employment opportunities where possible, and to improve the country’s economy. HIV/AIDS had resulted in increased incidences of depression and suicide; counselling services were not always accessible to the young, and immediate, confidential support, which should also cover mental health issues, should be provided. Traditional healers were currently based at rural clinics to deal primarily with mental illness. Pensions for persons aged 60 years and over had helped to reduce depression among the elderly. However, the elderly were having to take care of an increasing number of AIDS orphans, and additional steps should be taken to support them in that regard.

Namibia currently had one psychiatrist, and needed additional investment in human resources and training to improve care for those with mental illness. Some 15% of the gross domestic product was devoted to health services, and it was important to ensure that due attention was given to mental health.

Mr MABOTE (Lesotho) said that, historically, mental health services in Lesotho had been marginalized, as was reflected in both legislation and budget allocations, with stigmatization and discrimination rife. Mental ill-health accounted for a significant proportion of DALYs lost, with the largest proportion of the burden due to epilepsy and depression, the latter being more common in women than in men. Substance abuse, especially of alcohol, was rising and his country recognized the need for vigilance in that area. For many years, mental health services had failed to pay sufficient attention to emerging gender-related issues and violence, but the Government was giving serious attention to gender-sensitive policies and a specific ministry was dealing with the question. Moreover, an association of women lawyers was playing a leading role in raising private and public awareness of gender issues in many areas. Mental health policy was being revised to incorporate contemporary gender-related issues and to encourage disclosures of violence and emotional abuse. In addition, public awareness campaigns, seminars and workshops were providing a strong foundation for policy formulation concerning effective prevention of gender-related mental health problems. Preventive measures included poverty-reduction strategies involving-income-generation projects. Training was needed to sensitize health care workers and others, such as the police, to the mental health consequences of gender-related violence, and to the need to provide tactful counselling and support.

The CHAIRMAN remarked that it was important for ministers of health to gain the attention of ministers of finance and to raise public awareness of mental health issues.

Professor OPALA (Poland) said that the Polish Ministry of Health and Social Welfare had approved a new mental health programme in 1994 with the aim of ensuring improved access to appropriate health care and support for those with mental disorders. The implementation of the programme and the mental health of the population were being monitored. A recent study of mental health had revealed that the number of people with a positive assessment of their lives had increased but feelings of happiness and satisfaction had declined. Higher mental well-being was associated with broader social support, increased income, participation in religious practices and marriage, whereas a lower sense of mental well-being affected in particular the elderly, the unemployed, those with a lower income and the lonely. The highest risk for mental disorder was found in persons over 65 years old, 51% of whom (88% in women) admitted to feeling sad and depressed. The Council for Mental Health Promotion had drawn attention to some of the risk factors for mental disorder and measures had been introduced to monitor and promote mental health, including the identification of risk groups, the introduction of educational programmes for families, the implementation of school curricula to develop skills in problem-solving and coping and the establishment of various forms of psychological
counselling and intervention for people in emotional crisis. Such measures would be included in the national mental health programme.

Mr EL KHYARI (Morocco) observed that lack of knowledge was hampering efforts to tackle mental health problems, many of which were influenced by complex social factors. Moreover, the financial and human resource costs of long-term treatment and support for those with mental disorders were beyond the reach of many developing countries. Many were experiencing economic transition and its consequences, such as the splitting of families and decreasing belief in traditional medicine, at the same time as undergoing as severe resource constraints. Mental health disorders required the involvement of several different ministries and many different aspects of civil society; they called for solutions that went beyond the conventional health care framework.

Mr NACUVA (Fiji) noted the need to consider mental health problems in the specific context of each particular country, taking into account changes such as the moves from colonial status to independence and from traditional societies to cash economies. In Fiji, the health budget was small and it was difficult to find the funds for mental health services. However, the sense of responsibility for caring for others was strong and it had therefore been possible to build on community involvement. The Ministry of Health had opted for a multisectoral approach involving all aspects of civil society in the promotion of mental health and the prevention of mental disorders. Fiji had one specialized psychiatric hospital. The emphasis on community-based services and vigorous clinical management had led to a dramatic decrease in the bed occupancy rate and length of stay despite an increase in the number of new cases. Relevant legislation was also being reviewed. It was vital to change social attitudes to mental health care and Fiji was addressing the problem in its own particular context and in spite of budgetary constraints.

Mr TAPSOBA (Burkina Faso) described the evolution of mental health care in his country, which included decentralizing the health system and incorporating mental health care into the responsibilities of district level structures. Lack of coordination had resulted in a lack of adequate supervision, insufficient epidemiological data, lack of enough properly trained staff, insufficient financial and material resources for mental health services, and inequitable access to medicines owing to the slow introduction of cheaper generic psychotropic drugs. A national mental health programme had been formulated to meet the main areas of concern and would be implemented, despite financing problems, as part of the national development plan which extended to 2010.

In regard to gender issues, he drew attention to a particular problem in Burkina Faso, that of a category of woman known as the "devourer of souls". These women, because they lived alone, were widows or had no resources, were often driven out of their villages although healthy in mind and body because they were alleged to be the cause of mysterious deaths. Eventually they either committed suicide, disappeared into the bush or suffered mental health problems. Only women - never men - were so accused. The public authorities and religious associations were aware of the problem but did not have enough resources to provide adequate support. He appealed for help from WHO.

Professor NYMADAWA (Mongolia) observed that, while mental disorders were increasing in all Member States, they were a particular problem for countries in transition. In the previous 10 years, Mongolia had undergone drastic socioeconomic changes in its efforts to build up a multiparty democracy and a market economy. That difficult task had rendered social problems more acute, resulting in increased prevalence of depression, alcoholism, accidents, suicide and crime, especially among the poor. According to a recent study, 51% of the adult population used alcohol and the suicide rate had risen five-fold between 1989 and 2000. The Government had introduced several measures to promote stabilization and provide social protection. Since 1990, cost-sharing mechanisms had been introduced into the previously universally free health service and a social health insurance scheme had been set up in 1994. However, the costs of treatment for chronic mental health conditions continued to
be met by the State in the same way as some other priority health services such as immunization programmes and pregnancy and childbirth care.

He expressed appreciation for WHO's support in coping with the mental health problems arising from economic transition. Mongolia faced a severe challenge from increasing mental health disorders, especially alcoholism and depression, and hoped to learn from the experience of other countries with different conditions and structures.

Dr TSHABALALA-MSIMANG (South Africa) said that one of her Government's objectives was to promote an integrated approach to health care. Health care was not regarded as being the responsibility of the Department of Health alone and it had been possible to increase social spending in recent years. A mental health bill, to be submitted to Parliament in the near future, would provide a framework for the delivery of care at all levels of the health system and would promote rights for those disabled by mental illness. South Africa was also finalizing a special training instrument to improve the skills of staff. An important challenge was the provision of appropriate services for people emotionally traumatized as a result of, for instance, rape, child abuse and family break-up. Prevention of mental disorders was crucial and often involved intersectoral collaboration. South Africa had initiated a programme aimed at the prevention of violence in schools and projects along the lines of the WHO parent-child bonding programme. The next step was to improve primary mental health care. One-stop centres had been established for abused women, and health workers were being trained to deal with basic problems, to counsel on victim empowerment, and to recognize the need for referral. Future activities should include expansion of the network of referral centres and attention to the needs of health workers who took care of people with mental disorders.

Recent research had indicated that high blood alcohol levels were associated with well over half of all non-natural deaths including homicides and traffic accidents. Greater emphasis should be given to reduction of demand and supply of alcohol; prevention in that area would have many human and financial advantages. The spread of HIV/AIDS among psychiatric patients was also a serious concern. A project aimed at developing comprehensive life skills in schools, which covered HIV/AIDS and substance abuse prevention, had been introduced under the WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse. Lastly, she drew attention to the need to develop appropriate community services and to shift budget resources accordingly.

Mr DIOP (Senegal), describing the experiences in his country, said that particular stress was being laid on raising public awareness of mental health matters. Through the national health education system, mental health experts were promoting a programme in the mass media, using all the Senegalese languages. In 2001, particular emphasis was being given to epilepsy, prevalence of which was 8% to 11%. An information programme was being developed to induce traditional practitioners to refer patients with mental disorders to specialized care services. So far, participation by the State in care for patients with mental diseases was still very low, although the Ministry of Health was currently developing a national programme in that regard. The strategies were aimed at reducing stigmatization and exclusion and encouraging family participation in caring for patients with mental health problems. Some patients were cared for in psychiatric villages, staffed by carers from the same region. Elsewhere specialized teams were being set up to visit patients in their own environment. An attempt was being made to integrate mental health care into the basic health care programme, which involved training health workers at all levels and improving prevention, screening and treatment. Traditional practitioners were also becoming increasingly involved in mental health care alongside professional health workers.

Mr MARUŠIČ (Slovenia) said that alcohol consumption and suicide each accounted for 30 deaths per year per 100 000 population in his country. The current national health programme contained little on the subject of mental health, so a national mental health programme and national legislation on alcohol and tobacco consumption were currently in preparation. Primary prevention had already been introduced into the work of general practitioners, who were required to put questions to
their patients concerning their mental well-being. Those with the highest risk factors were then involved in group therapy. A programme to encourage healthy schools and workplaces had also been launched. In order to reduce stigmatization, a patient advocacy act that stressed the need to protect the human rights of those with mental disorders was under discussion; its third and final reading was imminent.

Mr TAMRAKAR (Nepal) observed that further study was needed in order to determine whether certain behaviours and lifestyles might be conducive to mental illness, and to investigate the mitigating influence of spiritual aspects of individuals' lives, such as meditation. His country had adopted a national mental health policy. In the past, the size of the problem had not been recognized, owing to the stigma attached to mental disease, as well as to the shortage of trained personnel. A community-based pilot project was gradually being introduced, involving traditional healers and civil society as a whole in an awareness-raising campaign. However, it was difficult to allocate adequate resources in that area, and Nepal would welcome support from WHO to find funding for mental health projects and to provide drugs for a limited period.

Mrs AELVOET (Belgium) said that in her country, as in others, there had been an increasing demand for mental health treatment, despite a substantial economic upsurge, which indicated that wealth per se was no solution. Furthermore, stigmatization was still widespread; people with mental disorders were treated differently from those with physical illnesses and tended to be regarded as abnormal. During the past 25 years, there had been a trend towards encouraging patients to stay in their home environment, thereby enabling them to continue to work and function as usual. That had been achieved by the introduction of first-level care, home support services and home visits by doctors, in addition to outpatient and institutional care. In 2001, a 10% increase in the health budget had been agreed, constituting the largest increase for any government department. The concept had been accepted that chronically ill patients, including those with mental disorders, should receive financial and institutional support. A system had also been developed to place a ceiling on the amount each patient should pay in any one year, anything over and above that amount being covered by a reimbursement system, taking into account personal socioeconomic circumstances.

In connection with gender specificity, it had been established that women were more dependent on legal drugs, whereas men tended to be dependent on alcohol. For issues of national importance, it had been stipulated that at least one-third of the members of all national committees should be women, including those concerning health.

Mr PULAY (Hungary) said that awareness-raising campaigns had targeted various groups, the first being decision-makers, including the Minister of Health. With a view to a better allocation of resources, it was important to convince ministers of finance of the significance of mental health problems. For example, in Hungary, it had been decided that new antidepressant drugs should be made available at affordable prices, since the chronically mentally ill were among the poorest members of society. Hence national insurance now covered 90% of the costs for such drugs. A second target group consisted of the patients themselves. Although they were insured, lack of objective information and fear of stigmatization prevented them from coming forward for treatment. Other targets had included primary health care workers, who were crucial in combating gender discrimination, and detecting violence and mental illness in the family and schools. As the Director-General had stated in her address to the current Health Assembly, it was essential to act at the time to create a better future for the children of the world.

Dr KASI (Pakistan) said that the debate had shown that the prevalence of mental ill-health was high in all societies, particularly among women. Governments were obviously keen to adopt preventive as well as curative measures to eradicate mental health problems, to reduce stigmatization of people with mental disorders, and promote their social rehabilitation. However, efforts in
developing countries were hindered by lack of financial resources and technical capacity. He urged WHO and the developed countries to assist the developing countries in that regard. It was also essential to determine the scale of the problem and how it affected countries' societies and economies. The current discussion would contribute to that process and Pakistan looked to the international community for further support, while following a consistent policy.

An area not so far discussed was the collection of data on mental health problems in areas of conflict and occupation by foreign forces, in particular among refugee populations, as for example in Kashmir and Palestine. There was a danger that their concerns might be marginalized in the general debate.

Dr LEE (Republic of Korea) said that, until the mid-1990s, his Government's policy had been geared to long-term hospitalization of mentally ill patients. However, with the enactment of the Mental Health Act in 1995, there had been a trend towards a community-oriented approach, concentrating on early detection, early treatment, rehabilitation and integration in the community. Considerable improvements had been achieved. About one million persons were currently receiving treatment, representing 2.7% of the total population. A large-scale epidemiological study on mental illness was under way. Measures had been put in place to provide support for families, appropriate jobs for those able to work, and entitlements to disablement benefits. The Government was committed to combating social stigma related to mental illness through public campaigns and community-based projects. Mental Health Day 2001 had been celebrated with the design of a special emblem to draw attention to the importance of mental health and the organization of academic seminars and rallies for mentally ill patients.

Professor KLEINMAN (Facilitator) commented on the scope of activities to tackle mental health problems in the various countries, concluding that the most essential requirement was for demonstration projects that were systematically evaluated by outside teams. Such evaluations should be linked to a commitment to funding, with a view to expanding cost-effective interventions. It was the scaling-up of such activities that would bring about advances in the mental health field. No group of patients was more systematically abused, inadequately cared for and generally discriminated against than those with mental disorders. It was therefore heartening to hear that efforts were being made to change that situation.

Professor ASTBURY (Facilitator) remarked on the striking similarities in the different mental health programmes around the world, particularly in connection with the increasing problems due to economic change and transition. The widespread lack of hope about the future showed itself in mental health problems such as alcoholism and suicide. Basic requirements such as employment, housing and adequate income needed to be recognized as mental health issues.

The CHAIRMAN, summarizing the debate, observed that mental illness constituted a problem shared by all countries and that many individuals would experience a mental disorder at some stage during their lives. Time and again, speakers had emphasized the importance of traditional medicine and values in tackling mental illness. The decentralization of treatment evident in Africa was particularly interesting. It had become clear that the rate of technological change, changing economies, and globalization were having an impact on the mental health of populations in all societies. Furthermore the economic burden of mental ill-health could not be overemphasized. However, even in developed countries with adequate services, stigmatization was preventing people from coming forward for treatment.

The meeting rose at 12:10.
The CHAIRMAN, opening the round table, said that the objective of the discussion was to raise awareness of the need to place mental health firmly on national and international agendas and to generate the necessary political will to address the issue. Two facilitators would support the discussions: Dr S. Kaaya (Muhimbili University, United Republic of Tanzania) and Dr J. López Ibor (Complutense University, Madrid, Spain).

Dr KAAYA (Facilitator) reviewed the epidemiological situation of mental disorders globally. While there had been dramatic improvements in physical health and reductions in mortality rates in most countries of the world over recent decades, the same could not be said for mental, behavioural and social health problems, which were increasing. Moreover, the future would bring further increases as a result of the increased life expectancy of those affected by mental disorders and the larger number of persons entering the ages of risk, particularly in developing countries. That was an alarming prospect for human development if action was not taken.

The picture was compounded by the undefined economic and social burden for families, communities and countries of mental problems. Those indirect costs, such as the impact of mental disorders on families and care providers, the lost employment and productivity, crime and public safety, and premature deaths from accidents and suicide, often outweighed the direct costs. Lastly, there was a hidden burden associated with stigma and violations of the human rights and freedoms of those affected by mental disorders. Such stigmas increased the toll of illness for those affected and their families through general alienation from society, and lost opportunities for education, employment and a normal social life. Stigmatization was also responsible for people's reluctance to seek timely care.

Persons living in extremely difficult life circumstances were at particular risk; and she recalled the complex and circular relationship between poverty and mental disorders. Poverty was associated with specific risk factors for brain disorders such as poor nutrition, unhygienic living conditions, inadequate access to health care, lack of education and employment opportunities, and debt. Mental disorders also adversely affected economic circumstances as a result of the cost of care and the limits placed on educational opportunities and effective functioning in the home, the workplace and school.

Poverty was more common and more severe for women worldwide, and women were twice as likely to be affected by depression and anxiety disorders as men. The reasons included women's traditional low status, which exposed them to stresses while at the same time rendering them unable to change their stressful environment. Domestic violence and sexual violence had psychological consequences, of which depressive and anxiety disorders were the most common.

Despite that not very optimistic picture there was hope: research evidence had suggested that most mental disorders could be managed or treated and, in some cases, they could be prevented. Scientific advances in the treatment of mental disorders with medicine and through psychosocial intervention meant that most individuals and families could be helped. In addition to effective treatment and rehabilitation, strategies were available for the prevention of some disorders. She noted the large gap that separated the availability of effective mental health interventions from their widespread implementation. Although at least 70% of WHO Member States had updated lists of essential drugs, including those for mental health care, one-third of the world's population had no access to them. In rural areas of developing countries, antidepressant, anticonvulsant and antipsychotic drugs were rarely available.

Although contributing strongly to the overall disease burden, mental health accounted for less than 1% of total health expenditure in most countries. Furthermore, most of those scarce resources were used for long-term institutional care for the mentally ill rather than for community-based
approaches, which had been shown to give better outcomes. Owing to the inadequacy of services and the stigma attached to individuals with mental and behavioural disorders, less than half those who needed them actually made use of mental health services.

Since it was known that general health personnel were capable of managing many mental and behavioural disorders and that severe mental illness could be managed outside the hospital, the training of primary health care workers to deal with those problems could avoid wastage of effort and resources, and increase treatment rates significantly. Currently, 50% of patients with mental disorders who consulted primary care physicians were incorrectly diagnosed as suffering from physical illnesses. Improvement in training primary health care providers to diagnose and manage mental disorders was a common priority for both developing and developed countries. Integrating services into primary care with effective community linkages to provide support would best serve the many people affected by mental and neurological disorders.

The benefits of mental health interventions included reductions in mortality, for example from suicide, reductions in disability, and improvements in quality of life for persons affected and their families. Significant economic benefits could be derived through, for example, enhancing the productivity of the mentally ill and their care givers. At the global level, the benefits would be substantial, since mental disorders accounted for about 160 million lost years of healthy life, 30% of which could easily be averted through using existing interventions. The disability associated with depressive disorders in a community, for example, could be reduced by half with adequate treatment.

Lastly, she drew attention to the variety of successful and innovative approaches being used to deal with mental health issues, even in low-income countries, ranging from initiatives to train village doctors, children and mothers, to the setting up of rehabilitation villages and of cooperatives that would employ persons with mental illness. There was a great deal that countries could learn from each other, and she hoped that the discussions would provide an opportunity for such fruitful exchanges.

The CHAIRMAN observed that the growing incidence of mental disorders, which were currently posing major health and development problems worldwide, was aggravated by limited and poorly-oriented resources. On the other hand, scientific research suggested that there were certain psychosocial determinants of mental health that could be tackled, and initiatives to that end were being taken in both developed and developing countries.

He invited participants to respond to three questions. First, what could be done to increase awareness, commitment and resources to address the global mental health problem? Secondly, what was the level of responsibility of the public sector for addressing mental health issues and for maintaining the highest possible standards for mental health in the face of other health priorities and limited resources? Thirdly, what were the key mental health issues being addressed in countries, and what were the strategies being used? What were the main technical and policy obstacles that had to be overcome in order to improve mental health programmes and service provision?

Mr ABDULLAH (Maldives) welcomed WHO's initiative to place mental health on the global agenda. Awareness-raising on behalf of the complex and forgotten issue of mental illness could be just as successful as that on behalf of HIV/AIDS. WHO should vigorously persuade Member States to dedicate a significant part of their national health budgets to improving treatment and facilities for the mentally ill, thereby enabling a large number of people to return as productive contributors to the mainstream of society. He called upon his fellow ministers to attach greater importance to mental health and to step up their contributions to it.

Professor SPYRAKI (Greece) said that the mental health system in Greece had significantly changed in the past two decades, including the introduction of a modernizing legislative framework. With assistance from WHO and with financial support from the European Union, Greece had reformed its system of mental health care, thereby gradually bringing about significant qualitative and quantitative changes. Legislation passed in 1999 had given priority to primary care, outpatient care, de-institutionalization, pyschosocial rehabilitation, community care and the provision of information.
to the community; mental health services were to be decentralized and divided into sectors; social enterprises were being set up for persons with mental health disorders, and a committee had been established for the protection of their rights.

Within the framework of psychiatric reform, an action programme to develop mental health services throughout the country had been launched in 1997, which would be reviewed and updated every five years. The recent creation of a large number of permanent government posts related to the programme, at a time of relative economic austerity, had been a measure of the priority assigned to the mental health care system by the Government. In the current year, a committee of persons working in the media had been set up for the purpose of increasing awareness of mental health issues through television, radio and other means.

Mr T0NNE (Norway) said that as a result of a study conducted a few years earlier, which had led to some shocking conclusions about the state of the mental health care system in Norway, his Government was working on a long-term plan to bring the system up to acceptable standards. In reply to the third question put by the Chairman, he said that openness and inclusion were two of the key issues being addressed. The history of mental health care in Norway, as in many other countries, had been one of non-information, lack of openness, closed institutions, stigmatization, exclusion, shame and fear. The reform of that situation had been a long process which had required changes in culture, attitude and behaviour amounting to a complete re-education of society. The second key issue, inclusion of those afflicted and affected, was closely connected to the first, because it could not be attained without the active participation of patients and their families. That implied participation in the development of the mental health care system and treatment offered, participation in the design and performance of information and education programmes, and, perhaps most importantly, individual participation in self-help and self-treatment.

Research in Norway indicated that 20% of the population suffered from mental illness at least once during their lifetime, and that mental illness was a growing factor in causing school drop-outs, unemployment and absenteeism. In the debate on mental health some difficult and controversial questions had arisen, for example whether a general recognition of mental health problems as illness might not entail the risk of lowering the threshold of illnesses requiring treatment, thereby reducing the capacity of individuals to cope with their own problems.

Mr THOMPSON (United States of America), responding to the second question put by the Chairman, said that it was the responsibility of governments to disseminate information on mental health as widely as possible in order to combat the suspicion and scepticism that surrounded the subject. In all countries mental illness was among the five leading factors contributing to low productivity, absenteeism and suicide. In the United States, one-seventh of gross national product was spent on mental and physical health combined. More than US$ 1000 million was being spent on research into mental health, as a result of which great progress was being made in the United States.

Two of the most difficult problems in the field were suicides among young people and discrimination against women. More needed to be done to reach out to young people and to try, through the education system, to reduce the number of suicides and eventually to prevent them. There was no doubt that mental illness was more prevalent among women than men, a difference that should be reflected in research and in expenditure on services. His Government intended to give mental illness a higher priority than in the past, and to ensure that it was treated on a par with physical illness.

Dr ZELENKEVICH (Belarus), said that it was time to bring the problem of mental illness out into the open. One of the principal challenges was how to ensure that such illness was allocated its proper share of the scarce resources available, and to that end, it was important to include mental health in all health plans and policies and to involve general practitioners. The change-over from institutionalized forms of care to care in the community, as well as the increase in the number of specialists in mental health being trained in medical schools, would contribute to a more efficient use of resources. Greater efficiencies could also be achieved by mobilizing other sectors to assist the
health sector and by pooling resources. Nongovernmental organizations also had an important contribution to make.

Dr YUNES (Brazil) said that mental health was one of his Government's main priorities. Historically, it had been given a low priority despite the fact that mental disorders represented a heavy burden on the quality of life of patients and their families, as well as on the economy. In Brazil, as in many other countries, hospital-based care was still predominant, swallowing up most of the financial, technical and human resources available and limiting access to treatment. There was a need for strategies to enhance primary and community-based care.

A reform had been launched in the early 1990s aiming to decentralize the mental health care system and to redistribute resources from hospitals to community-based services; to disseminate information on the effectiveness of new models of treatment on patient rights and on the importance of combating stigma and discrimination; and to design and implement broad-based programmes for the social reintegration of long-term patients. The obstacles to the implementation of community-based mental health services in Brazil were the lack of trained health professionals, including general practitioners who could act as psychiatrists in remote areas, and the insufficient availability of drugs. His Government had introduced a programme to finance basic kits of psychiatric drugs for distribution, free of charge, at outpatient clinics, but since outpatient services were still insufficient the drugs were not yet reaching all those who needed them. It had also addressed stigmatization and human rights problems by conducting regular inspections of psychiatric hospitals. Legislation had been adopted to protect the rights of mental patients and to promote their social integration, and services had been introduced to support women living in violent domestic environments.

Dr KIYONGA (Uganda), noting the trust placed in traditional healers by the general population in his country, solicited views on the role that traditional medicine could play in mental health care. His country gave a high priority to the treatment of mental illness, as the HIV/AIDS pandemic and protracted civil strife had increased the incidence of such illnesses. Uganda, in common with other sub-Saharan countries, suffered from high rates of unemployment and poverty. The public sector was therefore seen as the key to tackling mental health problems and to raising public awareness so as to reduce stigmatization and to encourage the mentally ill to seek help. A loan recently granted by the African Development Bank would be used to reform national institutions responsible for health care delivery and to integrate the delivery of mental health and general health care. The training of health workers was currently being reviewed, in order to facilitate recognition at primary health care level of conditions likely to affect mental health and to avoid over-specialization.

Ms PHUMAPHI (Botswana) said that steps similar to those described by other speakers had been taken by Botswana in relation to patient integration, the setting up of community hospitals, and campaigns to reduce the stigma associated with mental illness. Two issues were of particular importance. First, it was essential to recognize that mental illness was a human problem as well as a medical problem, and to develop programmes aimed at particular social and economic groups. The power of peer groups could be harnessed to promote mental well-being. Secondly, her country attached importance to early intervention, which was a critical element in implementing mental health policies. She agreed that there was a need for research into mental illness and into the links between mental and physical health.

Mr AL-MADF AA (United Arab Emirates), concurred with previous speakers on the importance of eliminating discrimination and stigmatization in regard to the mentally ill. His country took account of the psychiatric causes of certain illnesses, and was making efforts to raise awareness of mental health issues among students in universities and training institutes. The need for interaction between various ministries was recognized, and the ministries of health and education in his country were working together to combat psychological disorders among schoolchildren. He emphasized the
importance of awareness-building, of the role of the family, of research, and of the use of the media in order to target areas for mental health action more successfully.

Dr AL KHRABSEH (Jordan) explained that his country faced two obstacles to the improvement of mental health care provision: lack of resources and a shortage of specialized workers in the mental health sector. Those two barriers were the result of armed conflict, human rights violations and other injustices.

He emphasized the importance of integrating mental health and general health programmes, and of making treatment affordable in order to care for the poor properly.

Professor MAMBA (Democratic Republic of the Congo) said that mental health problems in his country had been neglected because of the prevalence of major factors affecting physical health, notably infectious and parasitic diseases. Such neglect also stemmed from the African belief that more emphasis should be given to concrete than to abstract health problems. The war that his country was experiencing, which had displaced and killed many people and split up families, had resulted in various kinds of depression and stress caused by psychological trauma. Another major problem was the abuse of psychoactive substances, particularly cannabis.

Faced with a lack of mental health institutions and specialized human resources, his Government had decided to integrate mental health into primary health care, although such integration raised the problem of adequate training. The community-based health care system reduced the risk of patient rejection or stigmatization, but treatment often required the prescription of psychotropic drugs, whose high cost placed them beyond the reach of most patients. In that respect, he appealed for a North-South partnership so that his country's requirements for such drugs could be met.

Dr PRETELL ZARATE (Peru) said that developing countries, with their many priorities and scant resources, needed more information on mental health in order to raise awareness of the problem. The first step should be to carry out national epidemiological studies. He appealed to WHO to support countries in carrying out surveys on mental health at country level, in order to provide more accurate data on the prevalence and epidemiological profile of mental disease. Such surveys would permit an assessment of requirements in terms of human, professional, and family resources, and of mental health care provision. They would also support the development of appropriate models for developing countries to deal with mental health problems. He applauded the pragmatic efforts of many countries in providing psychiatric training for health care workers, but he wondered what results had been obtained from such training in terms of quality of care, prevention, diagnosis and referral to other levels. Secondly, he enquired what experience had been gained in mobilizing families and communities, particularly in rural areas, to avoid isolation, discrimination and stigmatization in respect of the mentally ill. Lack of resources and failure to prioritize mental health were problems shared by all developing countries, and it was therefore crucial to conduct a global survey on mental health.

Dr HAMUKWAYA (Angola) described how the mental health situation in her country had been aggravated by internal conflict and its consequences. Political, social and economic stability and prosperity were essential to bring about improvements. She emphasized the importance of promoting healthy lifestyles and adopting psychosocial rehabilitation measures as part of a national policy to improve the mental and physical health of the Angolan people. She also reaffirmed her country's intention to fight marginalization and social exclusion by associating its efforts with initiatives taken by WHO to promote mental health.

Dr AL-MUNIBARI (Yemen) agreed with earlier speakers that warfare and violence were among the major causes of mental illness. He also pointed out that smoking had a deleterious effect on mental health, and emphasized the importance of sporting activities in overcoming mental health problems. It was essential that the subject of mental health should remain on the agenda of future round tables.
Mr MATNOR (Brunei Darussalam) noted that WHO had not paid mental health the same attention as it had to other issues, and therefore needed to organize activities to promote awareness. In many countries, developments in the approach to mental health were guided by the outcome of discussions on the issue at international and regional forums. In his country, closed mental clinics within hospitals had been replaced in 1982 by a single specialist hospital providing outpatient care and counselling, and steps had been taken to decentralize primary health care so that it could be provided at community level. Brunei was able to provide free medical care and drugs because of its small population and land area.

Mr SENEVIRATNE (Sri Lanka) said that, although his country had achieved high levels of health with a relatively small financial investment, developments in mental health had lagged behind other aspects. Sri Lanka was facing high suicide rates and psychosocial disabilities related to stress, in connection with the socioeconomic effects of the war in the northern and eastern areas of the country. Lack of awareness of mental disorders, social stigma and the low priority attached to mental health continued to obstruct the development of mental health services. A series of measures had been taken in recent years to develop mental health services and to decentralize mental health care. The greatest problems faced by Sri Lanka were the lack of qualified psychiatrists, which should be alleviated by the training of medical officers, and the high rate of suicide among the young, which might be addressed through research conducted in cooperation with other countries.

Professor RATSIMBAZAFIMAHEFA (Madagascar) observed that mental health was an integral part of WHO’s definition of health, although it had long been overlooked in the developing countries because of the priority given to control of communicable diseases. At Madagascar’s present stage of epidemiological transition, the number of mental disorders and disabilities, court cases arising from mental health problems, the increasing number of suicides and of patients who remained hidden away, unable to face the difficulties of adapting to life in society, all served to highlight mental health as a top priority.

The celebration of World Health Day 2001 had widened the country’s understanding of the issue by seeking to redefine mental health and its implications for quality of life. It had also underlined that mental health was a means and an indicator of economic, social and cultural development so that failings in mental health led to poverty at every level. Thus her country had attached particular importance to the management of mental illness, which was handled chiefly by the public health system. Severe cases could be referred to provincial psychiatric centres, but otherwise mental health was part of primary health care. However, deficiencies both in number and quality of personnel had led to the appointment of a mental health coordinator to review the national mental health policy. That policy would include prevention and treatment of mental illness with social reintegration, and would especially emphasize the development of human resources with training for mental health nurses and psychiatrists. Doctors working in primary health care had training guides on mental health. The lack of international solidarity on mental health issues was to be deplored. She asked WHO to seek ways of developing partnerships to give fresh impetus to that new world priority.

Mrs DREIFUSS (Switzerland), responding to the Chairman’s second and third questions, suggested that the prime responsibility of the public sector was to ensure that everyone had access to care. In Switzerland, that meant that mental health was covered by health insurance on an equal footing with physical health. However, access to mental health care was hampered by the public’s poor level of knowledge of mental disorders. A second responsibility of the public sector was therefore to promote understanding of how mental disorders evolved in order to allow early intervention. Whereas certain issues such as drug dependence, because of their effect on public order, were well known and tackled, such disorders as depression quietly took hold before treatment could be delivered and before the community or the family became aware of their existence.
It was also the State's responsibility to develop and to ensure good quality mental health care, to conduct epidemiological studies, research and training, and to safeguard the human rights of patients with mental illnesses as persons fully integrated into society.

The approach to mental health problems should target different segments of society. Young people's problems, as manifested in drug abuse, suicides and depression, differed from the problems of the very old, characterized by serious depressions, and the problems of work-related stress and the workplace in general. Those approaches needed to be adjusted to take account of differences between men and women. Switzerland had had to develop specific responses to the problems of migrants and displacement. Caring for refugees and the particular traumas they brought with them required a different perspective on diagnosis. In summary, she stressed the need for widespread information, but also a targeted approach according to population groups, in order to promote understanding of mental health.

Mr HLAVAČKA (Slovakia) said that because mental health care was dominated by medical specialists the related strategies did not involve other professionals, such as social carers, patients and families. The role of the family was crucial, not only in terms of diagnosis (as the family was often the first to identify the problem), but also in enhancing access. The family could bring the patient for treatment and assist in reintegration. Thought should be given to a social environment that optimized the ability of the family to care for the patient. Often, the problem was not one of education or understanding, but of the economic ability to care.

Like other countries, Slovakia had formulated a mental health strategy. The difficulties lay in monitoring implementation and in establishing indicators of performance. Evaluation of treatments tended to be based on costs, the number of drugs used and the number of treatment centres available. However, there were few indicators to measure responsiveness of care. The views of the care givers, the families and the individual patients should be sought on how to improve the service. There was also a place for the type of benchmarking that WHO was carrying out. Finally, as to the role of WHO and other international organizations, the causes of mental illness, such as poverty and stress, must also be tackled.

Dr RWABUHIHI (Rwanda) noticed that the date for World Health Day, that year devoted to mental health, had been 7 April. However, that day was one of mourning in Rwanda to commemorate the tragedy of 1994, where in the space of only 100 days one million Rwandans had been killed by other Rwandans. The significance of that date would prevent Rwanda from celebrating World Health Day for many years to come.

Mental health programmes in Rwanda were being decentralized in order to help to cope with the healing of an entire society. It was not a question of healing a few groups on the margins but of instituting a mental health programme for the whole population. The need was more readily understood when set against the backdrop of the more-than 120 000 persons still in prison on suspicion of having participated in the massacre of their compatriots. One survey of 3000 children in 12 provinces had revealed that more than 90% had been in danger of being killed and more than 95% believed that they were dead, even though they were living. Those factors gave an indication of the enormity of the task being faced with very few resources.

Rwanda had chosen a participatory form of justice, in which people who had witnessed the massacres for three months would be able to tell the truth about what had happened. That was the reason to ask everyone to participate, including the traditional health systems, the district hospitals and the health centres, in order to seek the truth and assist in the healing process. The traditional healers were needed because there was a desperate shortage of so-called modern medical personnel. There were fewer than 200 doctors in Rwanda as compared with more than 10 000 traditional healers.

He thanked all those who had helped Rwanda, especially in training. He expressed his particular appreciation to Switzerland for its cooperation in training doctors and mental health specialists.
Dr JALLOH (Sierra Leone) welcomed the decision to focus on mental health for World Health Day 2001 and to include the subject on the agenda of the current Health Assembly.

The Ministers of Health of Uganda and the Democratic Republic of the Congo had raised the issue of civil strife as a factor in mental health problems. It was important for countries that had undergone war to share their experience of the relationship between war and mental health. On 6 January 1999, rebels had invaded his country's capital, Freetown, and had carried out widespread and barbaric attacks on the civilian population, including arbitrary executions, abductions, single and gang rapes, amputations, arson and looting. At least 10,000 people were alleged to have died and at present some 150,000 were displaced from their homes.

While most medical personnel acknowledged that gross atrocities had been committed, they knew little or nothing about post-traumatic stress disorder, which was difficult to define both conceptually and operationally. It was a unique diagnosis, in that an exposure or criterion stressor was an integral part of the disease. The criterion stressor required that a person had experienced an event that was outside the range of usual human experience. Although specific criterion stressors might be difficult to define, participation in war was generally deemed to be such an experience.

The concept of post-traumatic stress disorder should be considered with care, as not all disorders arising after traumatic events fell into that category. To overcome mass traumatization, as in the case of Sierra Leone, the healing capacity of family/community systems should support people in coping with severe stress and with more severe mental health problems. The number of traumatic experiences and their duration were important risk factors in the development of post-traumatic stress disorder. Sufferers from traumatic stress often had physical complaints, the so-called psychosomatic stress symptoms, although they were often misdiagnosed by medical practitioners who were not psychiatrists. It was important to consider not only conventional forms of depression and schizophrenia, but also the stress disorders that arose as a result of war.

Dr BOUPHA (Lao People's Democratic Republic) congratulated WHO for highlighting mental health and bringing that important topic to the attention of Member States.

Among its strategies for addressing mental health, her country had promoted a series of activities using video productions and school contests within a community-based approach, as part of a deliberate strategy to tackle mental health issues.

She stressed that mental health factors relating to women had generally been overlooked. There were some 75 million unwanted pregnancies in the world each year. Unwanted pregnancies could have tragic consequences for the women, their families and society as a whole. The issue was one of empowerment: women should be allowed to decide when and whether they wanted to become pregnant. A great deal of distress and depression could thus be avoided. She urged WHO and the authorities in each country responsible for mental health programmes to take into consideration the problems related to women's health.

Dr LEVENTHAL (Israel) said that the future of mental health lay not in hospitals, but in the community; it was the concern of society as a whole, not just of mental health professionals.

Israel had taken the opportunity provided by World Health Day 2001 to extend the event to a week of awareness-raising on mental health. He thanked WHO for providing excellent supporting material.

Mental health affected the whole community since virtually everyone experienced some form of mental health disorder at some point in their lives, although mostly to a very minor degree. The problems associated with mental ill-health were part of living in a modern society. Prevention of those problems and mental health promotion were important at all levels. He regretted the shortage of material available for preventive activities and asked WHO to provide leadership in that field; such material would have the added advantage of ensuring that the public was well informed.

In conclusion, he commended the admission of a former prime minister of Norway that he too had suffered from depression, thus highlighting the fact that such issues affected privileged as well as disadvantaged members of society.
The CHAIRMAN remarked that speakers evidently considered that mental health care was achievable and that community-based services appeared to be preferred. Some countries were ready to promote the necessary changes, and WHO had been asked to play a role in that. Community awareness was an appropriate strategy, and mutual help should be part of rural health care.

Speakers had emphasized that users were active players in the mental health field and that physical and mental health should be treated equally in health schemes. The question of discrimination against women must be borne in mind. Basic kits of essential drugs were needed. The human rights of mental patients should be closely monitored through appropriate mechanisms. Mental health programmes should include the clergy, trade and industry, politicians, faith healers and other members of society. With regard to the request by the Minister of Health of Peru for WHO to support epidemiological studies at country level, he noted that WHO was already conducting such a study.

All countries had agreed that awareness-raising was of prime importance, and the need for a multisectoral approach had been stressed. Programmes should include support for families, which played an important role and should also target the victims of violence.

Responding to a query from Mr AL-MADFAA (United Arab Emirates), the CHAIRMAN agreed that, although it had not been specifically mentioned, the private sector had a role to play in mental health.

Dr KAAYA (Facilitator), responding to the Minister of Health of Uganda, said that the role of alternative health systems, including traditional healers, should be considered, particularly in sub-Saharan Africa. Evidence from small-scale surveys of the pathways to care for people with mental illnesses indicated that about one-third of those seeing general practitioners had already consulted a traditional healer. Work in some areas suggested that collaborative links between mental health service provision and traditional healers could decrease the time lag before services were accessed, and it was accepted that early treatment of mental disorders produced better outcomes. However, little research had been done on the psychosocial and medicinal interventions used by traditional healers; that might limit the extent to which they could work with conventional medicine. She concluded that there was a need for more information to determine the types of services and levels of care where traditional and allopathic services could best work together, for patients' benefit.

The CHAIRMAN invited Dr López Ibáñez to introduce the round table's second topic, stigmatization and human rights violations.

Dr LÓPEZ IBÁÑEZ (Facilitator) focused on three points: (1) stigmatization was not only a human rights problem, but also a health problem; (2) stigmatization was everywhere, both in society at large and within the health care sector; and (3) it was possible to combat it effectively.

Stigmatization occurred through differentiation: it might derive from the identification of a particular physical characteristic; it could have a social connotation, such as gender, race or religion; or it could be psychological. Differentiation devalued the bearer and, often, the relatives and significant others of that person. Stigmatization led to discrimination and to attitudinal barriers. The consequences were social isolation, segregation and reduced self-esteem. Patients with mental diseases suffered the stigma associated with violence; they were seen as unpredictable and dangerous and were portrayed as violent in popular media, including the cinema. However, violence was not part of the patient, it was part of the illness: when the illness was correctly diagnosed and treated, the violence disappeared. Mental illness also carried with it the stigma of abuse: such patients were perceived to have a moral weakness, and to be able to get better, if they so chose. There was a perceived moral hazard that implied abuse of insurance systems. Sufferers were not seen as "real" patients, and that stigma extended to mental health professionals, so that mental health care was segregated from general health care.

The stigma of mental illness was a health problem because it delayed or prevented patients from receiving treatment when it was known, for example, that the fate of a patient with schizophrenia depended on diagnosis and treatment in the first six months. The stigma reduced compliance: the first
reason for relapse into depression was that the patient stopped medication when he or she felt better, spurred on by comments regarding the fear of addiction or to the effect that the patient was strong psychologically. Moreover, such a stigma increased the use of medical services, since most readmissions and emergency care of patients with chronic mental diseases were due to the interruption of treatment. It reduced opportunities for rehabilitation, increased tensions in families and increased the risk of alcohol and drug dependence.

On a global scale, the stigma reduced investment, resources and the people in research, teaching and health care. It was prevalent everywhere. Between one-third and one-half of the population had a strong prejudice against mental illness, while the remainder ignored the disease. The stigma increased as the social distance to the patient narrowed. It was high among relatives because of the burden of the disease. It was also high in health-care settings and among many mental health staff. There was a lack of parity between mental health care and other health care. Stigmatization worsened the outcome of many physical diseases: for instance, up to 50% of patients with myocardial infarction, patients admitted with cancer or those who had had a stroke, also had depression. That rate was even higher in patients with no clear diagnosis. That led to the abuse of patients’ human rights.

Stigma could be fought effectively through three measures. The first was to provide information to increase awareness. However, that was not sufficient by itself; increased information had also been shown to increase the stigma in some cases. Secondly, education had to be increased and public attitudes improved, both towards those who suffered and their relatives. Thirdly, action had to be taken to eliminate discrimination in laws and in social customs.

A strategy to end stigmatization was also required. The first element in that strategy was cooperation. For example, the World Psychiatric Association, of which he was President, had developed a programme on stigma that was being applied in 22 countries. The programme had been successful because it had involved all sections of society: patients, relatives, mental health professionals, representatives from administrations from both the health care sector and social affairs and education, mass media, and society at large. A core part of the strategy was the empowerment of people so that they could fight the stigma.

Change was possible. Scientific data from developed countries showed that 20 years ago depression had been seen as a moral weakness, whereas currently it was seen as a normal disease. In the past, 70% of depressed patients had come to psychiatrists on their own or through the recommendation of a friend, whereas at present nearly all came as the result of a referral by a general practitioner, another specialist or an emergency unit. Communication between general practitioners and specialists had improved. Over 50% of psychiatrists reported that the referral notes from primary care practitioners were of a higher quality.

There had also been changes in the stigma attached to schizophrenia. In the countries where it operated, the World Psychiatric Association’s stigma programme had succeeded in changing the way the disease was portrayed in the media. There were new rehabilitation strategies, new drugs with fewer side-effects, and new diagnostic technologies. Administrations were more helpful, and patients and relatives were more committed to combating the disease and obtaining more resources, better treatment and less stigma in society at large.

The CHAIRMAN launched the discussion by raising four questions. First, what measures had each country put (or did it plan to put) in place to fight discrimination and stigmatization of mentally ill people and their families? Secondly, what was the level of responsibility and the role of the public health sector in tackling such stigmatization and discrimination? Thirdly, how could other sectors contribute to stopping the denial, through discrimination, to mentally ill people of equitable access to services and consideration? Fourthly, given that mental health legislation required a balance between the right to individual liberty, the right to treatment and the legitimate expectation of community safety, what were the critical issues in formulating, implementing and enforcing balanced legislation?

Mr MATNOR (Brunei Darussalam) said that one of his country’s approaches to the problem of stigmatization of mental illness had been to change certain names. For example, the term “ward S”
commonly associated with mental problems, and hence “bad” people, had been replaced by “psychiatric ward”, and the new hospital had comfortable rooms instead of the cages and bars formerly used to hold mentally ill patients. The Lunatic Law had been renamed the Psychiatric Act. The word “mental” was no longer used; the terms “stress” or “light depression” were more acceptable to young people and made them more willing to come forward for treatment. Because those identified as having mental problems often lost their jobs, the Government provided allowances to encourage them to undergo treatment. Brunei’s main problem was how to encourage the formation of a nongovernmental organization to care for the mentally ill. The stigma attached to mental disease was apparently still too high for that to come about.

Dr PRETELL ZARATE (Peru) said that a significant cause of stigmatization and segregation was the pessimistic view of mental health patients as lost causes or as a source of great expense to the State. It would therefore be very useful to wage a major educational campaign showing the scientific progress made with regard to the causes of many of those problems and the existence of new and more effective methods of treatment and rehabilitation. For example, the World Summit for Children’s global campaign to iodize salt was an effective, cheap and easy means of preventing damage to the brain and mental disease.

Ms PHUMAPHI (Botswana) said that, in Botswana, stigmatization corresponded to fear of those with mental illnesses. That was perhaps because their loss of control of their lives was associated in the minds of others with disruption to their lives. The response to the four questions raised by their Chairman could be summed up in three words: information, education, communication. Botswana had medical-aid societies that did not provide adequate care for the mentally ill because of stigma; there was a high unemployment rate among the mentally ill because employers did not want to hire them; and insurance payments had been denied to the families of mentally ill patients who had committed suicide.

Consideration also had to be given to the plight of those who already had special needs in addition to suffering from the stigma of mental ill-health, for example, children in difficult circumstances, women, refugees and migrants, the elderly, conflict survivors, prisoners, and young people engaged in substance abuse. Those groups’ needs should be accommodated in appropriate legislation. It was also vital that patients be properly managed; to do so entailed removing stigma among health care workers. Consideration should be given to ways of countering the results of stigmatization by legislative means, such as regulations governing patient management that would help to eliminate stigmatization among health care workers.

Dr LEVENTHAL (Israel) considered that the present round table and the World Health Day campaign were part of the fight against stigmatization. Society could only fight stigmatization if the health sector played a leading role. The health sector should be reoriented to incorporate consideration of mental health issues in physical health. It had to set a good example. However, the fight against stigmatization concerned not just the health system but also the education and welfare systems; all should contribute.

In answer to the Chairman’s fourth question, violence had in the past been associated with mental illness because mental health institutions had once been considered prisons. To avoid that, patients should be given access to health services before their illness reached the point where they required institutionalization. In Israel’s experience, only the courts could strike the balance between respect for human rights and enforced admission to a mental health institution. Since Israel had adopted the policy of using the courts, more people were reflecting on the question. Health professionals were in effect asking society as a whole to share in taking such decisions, which resulted in a better balance.

Dr KIYONGA (Uganda) had seen evidence in his country that stigmatization could be overcome. When he had been a medical student in the late 1970s, no student would have dared to
admit to being near a mental hospital, yet when a psychiatric clinic had recently been closed in town and mental health patients had been asked on radio to go to an out-of-town hospital for treatment, the reaction had been good. Furthermore, people were contacting physicians about mental illness. In two further major developments, former sufferers from schizophrenia had formed an advocacy group to eliminate stigmatization of the disease, and the parents of epileptic children had created an association to seek care for their children and to promote the message that epilepsy was a manageable condition. In order to give people confidence, the health sector had to demonstrate that treatment worked and that people got better. Sufficient confidence had to be generated in the population that people could be treated before legislation was adopted. Such legislation should be timed to coincide with an improvement in care and not be rushed through.

Lastly, was there any evidence that the extended family structure prevailing in most African States offered an advantage in mental health care? Could it be shown, all other things being equal, that countries with an extended family structure stood a better chance of dealing with mental illness than developed countries that did not have such a structure?

Mr MIŠANOVIĆ (Bosnia and Herzegovina) said that stigmatization was an important issue in Bosnia and Herzegovina. The stigma arose from the subconscious fear that anyone could fall victim, permanently or temporarily, to mental ill-health. Bosnia and Herzegovina was a post-traumatic society in transition. Half the population suffered from war or stress-related psychiatric disorders; the other half had dealt with the problem by referring to the sufferers as "broken" people, partly out of fear that psychological trauma could be passed on to the next generation. It was difficult to fight stigmatization in post-traumatic societies because stigma was used to deny people's rights. Bosnia and Herzegovina needed a very different procedure for eradicating the problem of stigmatization. It needed extremely clear recommendations not only on how to eliminate stigma, but also on how to promote mental health and prevent mental disorders.

Mr TØNNE (Norway) said that the broad answer to the Chairman's four questions was that information, in the sense of education of society as a whole, was the best remedy. All efforts to fight stigma had actively to involve everyone who suffered from mental health problems and stigmatization.

With regard to the comments made by the delegate of Israel, it was important to distinguish between mental illness and the mental problems that arose in normal society. Care had to be taken that efforts to promote mental health did not produce stigma by turning normal problems into illnesses and disorders. Thresholds should not be lowered; rather, work should continue on education and information.

Mr ABDULLAH (Maldives) said that the biggest stumbling block in the fight against mental ill-health was the stigma attached to it. He endorsed the view that information, education and communication provided a way forward. He was gravely concerned by the breakdown of family values and strongly believed that spending more time with family and children would help to solve the problems. Research had proved that time spent with one's family removed fear and prevented the development of mental afflictions. People were being killed by the hectic lives they led, which gave rise to social problems for their families, including mental illness. The health sector could not tackle the growing problems on its own. An integrated approach was required, involving the education sector, the community and nongovernmental organizations.

Professor SPYRAKI (Greece) said that fighting stigmatization was important not only to overcome mental illness but also to improve society. In response to the Chairman's first question, about the measures put in place to fight stigma, he said that Greece had offered services for the mentally ill in psychiatric units in general hospitals and mental health centres; that had changed perceptions for both the patient and the relatives. Secondly, campaigns were important to teach children tolerance at an early age. Children had to realize that while mental illness had biological and
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... genetic determinants, social disparities were also crucial factors. Everyone should ask themselves to what extent they were responsible for the mental illness of others and what they could do to help.

Dr MODESTE-CURWEN (Grenada) said that her country had tried to fight stigmatization by shifting the emphasis from institutionalization of patients to the start of treatment in the community. However, because many of the mentally ill had never had a job or were unable to hold one, they returned to the institution shortly after being sent out to the community. Grenada had therefore started on a policy of industrial therapy to develop or teach skills, essentially in agriculture. She had recently toured an agricultural area in the presence of media representatives so that they would show mental health patients as productive rather than nonproductive or destructive persons. A multisectoral organization (involving health sector representatives and the community) was helping those with mental disorders by organizing activities such as sports meetings in which healthy members of the community participated alongside the patients. Recently, a long-term institutionalized patient had been helped to launch a book of poetry. The media had been extremely supportive throughout in promoting understanding of the productivity of the mentally ill.

The CHAIRMAN, summing up, said that stigmatization was increased by poor conditions in mental institutions and by pessimism about the outcome of mental disorders. Information, education and communication were required to fight stigma, and anti-stigma campaigns should involve the patients and their families; in that regard, the education of the community was a high priority. Appropriate legislation was needed to protect the rights of the mentally ill, since they suffered discrimination. With the use of proper strategies, stigma could be defeated; mental health literacy should start early, at school. Finally, providing care in general hospitals and in the community reduced discrimination since such settings did not carry the stigma of old-fashioned mental hospitals.

Dr RWABUHIHI (Rwanda), referring to the Ugandan Minister's comments, added that mental health institutions should not remain in isolation but should be located in city centres. Rwanda had recently opened a centre for psychological and social consultations in the middle of town, next to the main bus station, and had been surprised to find how many people it had attracted. It might help to make that approach more widespread.

Mr ABDULLAH (Maldives) asked for the role of families and the community to be included in considerations.

Dr LÓPEZ IBOR (Facilitator) addressed the issue of the magnitude of disease and the threshold of diagnosis raised by the Health Minister of Norway. The mental health field had previously been characterized by different schools of thought. That had changed, and WHO had played a leadership role in bringing about that change. He called attention to the importance of the chapter on mental disease in the Tenth Revision of the International Classification of Diseases (ICD-10), which was no ordinary chapter. It had been developed by a large group of researchers and had undergone many field trials. It was, without doubt, the largest international research project ever conducted. The outcome was that the reliability of diagnosis of psychiatric illness was higher than in many other specialties. Another system of classification existed; DSM-IV, the American Psychiatric Association's classification, was used in the United States of America and other countries. The differences between the two were, however, minimal: for research, DSM-IV was perhaps more accepted by the scientific community, but for everyday practice ICD-10 was probably more user-friendly. He encouraged all countries to use ICD-10 in mental health care; furthermore there was a version for primary health care.

The issue of threshold of diagnosis could be resolved by using the common language of diagnosis proposed in ICD-10, which defined diseases by the presence of specific symptoms and degrees of suffering. In his view, ICD-10 should be complemented by WHO's International
Classification of Impairments, Disabilities and Handicaps (ICIDH),\(^1\) which considered illness and health in a new light and was essential for the question of threshold.

The health sector had admittedly never been very interested in that classification, which was used in most countries more by the social than the health services. It was hard to teach clinicians about the degree and specificity of diseases, handicaps and disabilities. ICD-10 and ICIDH were accompanied by an array of diagnostic tools; the methods were available and they should be applied.

The CHAIRMAN said that all the participants had declared their political commitment to mental health, had clearly stated that mental health must be put on the national and international agenda, and had stressed the importance of awareness campaigns involving information, education and communication activities to inform all people worldwide about the mental health situation. He therefore considered it unnecessary to obtain any further commitments from the participants.

The meeting rose at 12:10.

\(^1\) For endorsement of the second edition of ICIDH, with the title International Classification of Functioning, Disability and Health (ICF), see resolution WHA54.21 (document WHA54/2001/REC/1).
armed conflict and natural disasters, as well as to social, political and economic change, had been recognized.

Effective pharmacological, psychological and psychosocial interventions were available to treat mental disorders. Psychosocial treatment strategies, including family care and community mental health programmes, had been successful in reducing the burden of mental illness on the family, reducing stigmatization and providing alternatives for improved and accessible health care, thus avoiding long-term hospitalization. Such programmes could be integrated into general health care, after training of existing general and primary health workers to detect and manage the most important mental disorders.

Despite the evidence, however, mental health programmes were accorded low priority worldwide, leading to inadequate development of services and a serious shortage of human resources. New concepts would have to be adopted, with a shift from clinical medicine to a public health model of prevention. Mental health care should be conceived not only as preventing illness but also as promoting well-being. She looked forward to discussion of the policies and programmes in participants' countries that were aimed at giving mental health the emphasis that it deserved.

Dr THAKUR (India) said that mental health disorders had been treated in India by yoga since ancient times. India had launched a mental health programme in 1982. The integration of mental health in the public health programme had aroused criticism at first, but was currently recognized as having been correct. Efforts were being made to improve services in mental hospitals in order to make them more patient-friendly. While he agreed that problems such as natural disasters and wars caused mental disorders, there were also area-specific problems. For instance, men from Kerala often worked in neighbouring countries, and their absence led to family problems, even suicide, while in poorer states such as Bihar the suicide rate was much lower.

With the development of genomic research, it would be possible to investigate whether some mental disorders were of genetic origin. The round table might identify the need for such a study, as gene therapy could then be used in treatment.

Mental disorders should not be considered as diseases but as part of life. It was his day-to-day experience in medical practice that many persons suffered from slight depression. Addressing their mental health would help them to function better. Efforts should be made to combat the stigma attached to mental deterioration.

Dr KOUCHNER (France) said that mental health was a concept with wider social ramifications than traditional psychiatry. Although the drugs developed over the past 20-30 years had allowed some progress in the treatment of mental disorders, they had also camouflaged the difficulties. People with mental health problems were always stigmatized. Furthermore, psychiatrists, psychologists and social workers did not agree on their practices or general objectives. The general medical community and psychiatrists disagreed about the extent of the mental health sector. Was social work a marginal component of the sector or was it fully integrated? Psychiatrists were unwilling to become involved in what they considered to be social problems, such as depression and suicides among young people. There was poor follow-up on the part of hospital emergency services and society in general of young people who attempted suicide. It was known that one in two succeeded on a second attempt and that half of those who had committed suicide had consulted a general practitioner the week previously. General practitioners did not have the training to deal with such problems.

There was insufficient communication between psychiatrists and social workers in developed countries. In France, the problem of drug addiction had initially been viewed as a psychiatric illness, whereas it was currently considered a social problem. It appeared that 30% of prisoners suffered from mental illness, and 20% had been imprisoned for that reason. Was their mental health dealt with adequately? Were domestic violence and alcohol abuse psychiatric problems? Those problems remained unsolved because of a lack of understanding between social workers, general practitioners and psychiatrists.
Efforts had been made to close down psychiatric hospitals and provide care in small community structures in general hospitals, close to the patients' families and to patients' associations. However, some psychiatrists complained that they were swamped by social problems and that closure of the large psychiatric hospitals meant that no beds were available for patients with severe psychiatric conditions such as schizophrenia or manic depression.

Dr STAMPS (Zimbabwe) said that, after achieving independence, his country had totally recast its Mental Health Act, so that it was currently dedicated to the needs of the patient rather than to the needs of society for protection. The Government had formulated its policy on mental illness, on the basis that psychiatric events were never due to a deliberate act on the part of the patient, so that all treatment, including the provision of drugs, was free. There was, however, a severe staffing problem. Nurses were being trained but, on qualifying, often went to more attractive posts abroad. The lack of trained staff meant that passive disorders were diagnosed long after the first symptoms appeared.

He drew attention to the increasing use of drugs in treating mental disorders, including the administration of stimulants and sedatives to children aged between two and four years. The use of psychedelic substances to ensnare youth, for the purpose of commercial gain, was a matter of great concern. Although the worst problem was that of alcohol, dangerous drugs were readily available to young patrons of night clubs. The involvement of community leaders had been very effective in confronting such trends. He appealed to all to work together to bring about a more spiritual approach to living, in order to reduce temporary or permanent mental disability.

Dr GAMKRELIDZE (Georgia) said that the significant social, political and economic changes that had occurred in Georgia at the beginning of the 1990s had had a negative effect on the country's medical care system and particularly on psychiatric care. Owing to major shortages of psychotropic medicines and a drastic deterioration of the conditions in hospitals, patients had left, and the mortality rate in the institutions had increased. In March 1995, the Georgian Parliament had passed a law on psychiatric care which had become the legal basis for the State programme. Hospital and outpatient care was provided by a network of hospitals, regional clinics, psycho-neurological clinics and consulting units. The State covered the treatment costs of about 30 000 patients registered as suffering from schizophrenia, affective disorders, organic and symptomatic psychoses, post-traumatic psychoses and other psychotropic disorders. However, more than 70 000 patients registered in psychiatric institutions outside the public programme required professional psychiatric care. The budget of the programme was greatly in deficit. In order to function optimally, it would require US$ 4.5 million, whereas the actual allocation was about US$ 1.5 million.

Nevertheless, the Government had managed to extend its programme. Regional psychiatric clinics had been opened, and a programme of psychosocial rehabilitation for children and young people had begun functioning in 2000. A service for urgent psychiatric care was planned for 2002. In 2000, a national health policy had been developed in the Ministry of Health, in cooperation with the Regional Office for Europe and the Georgian Society of Psychiatrists, with a strategic plan for implementation during the coming decade. The main strategic goals for development and reform of the psychiatric care system were: (1) extension of the public programme of psychiatric care and a gradual increase in free medical care; (2) creation of a system of social rehabilitation and social assistance to patients with mental disorders; (3) creation of a system of psychiatric care for children and young people; (4) a reduction of the suicide rate in the general population; and (5) reduction of the incidence of psychiatric diseases due to social stress. The plan envisaged the creation of five centres for the psychosocial rehabilitation of patients by the year 2009, in addition to the centre functioning in the capital; nine psychosocial assistance units had been opened in various regions of the country. The prolonged economic crisis did not permit full, regular financing of the State mental health care programme and made it difficult to ensure optimal functioning of the system of psychiatric care in his country.
Dr FARHADI (Islamic Republic of Iran) observed that the problem of the increasing gap between physical and mental health services was particularly acute in developing countries, owing largely to lack of awareness, low political commitment, an acute shortage of trained professionals, weak intersectoral collaboration and the absence of community services. All too often, mental health services were neither affordable nor accessible. The only way forward was to integrate mental health services into general and primary health care systems, thus ensuring the provision of the most basic level of services for the seriously ill.

Iran had taken that initiative following a pilot project in 1987, aimed at promoting awareness of mental health issues and making essential mental health care available to all. Following wide-ranging training programmes for medical personnel and community workers and the establishment of a large number of rural and urban mental health centres, mental health care was currently available to 6% of the rural population and 12% of the urban population. In addition, innovative programmes had been developed, such as an urban mental health programme, the integration of a preventive programme for substance abuse disorders, within the primary health care system, a school programme and integration of mental health into the “Healthy Cities” project.

With a view to expanding mental health services in 2001 and beyond, Iran’s national mental health programme was being revised, a new mental health act was in preparation, and efforts were being made to increase inpatient and outpatient mental health facilities and counselling services.

Mr BOQUINHAS (Portugal) said that his Government had approved a national mental health plan in 1996 and in the past five years had ratified a new mental health act and organized new mental health services around hospital and community care. Intersectoral cooperation was being promoted. Other legislation, concerning collaboration between the health sector, social services and nongovernmental organizations in the development of psychosocial rehabilitation programmes, had also been approved. For example, the national council for mental health and a number of regional councils had been established, and a hospital referral network put in place. The integration of mental health services into the national health service ensured their greater accessibility and adequacy. Inpatient treatment was being provided in general hospitals. Local services had been developed to replace psychiatric hospitals, and new psychiatric services were being funded at the community level, including services for children. Drugs for the treatment of severe mental illness were partly subsidized.

There was nevertheless a marked lack of progress in some areas. Stigmatization persisted, little attention was paid to preventive programmes and there were no community-based facilities to bridge the gap between hospital and home care. Epidemiological data on psychiatric morbidity and mortality and use of the available facilities were lacking. There was a particular need for monitoring and assessment of the national mental health policy, its implementation and the quality of care. Efforts were being made to promote mental health by investing in community-based facilities for long-term patients, developing a national plan to create other facilities such as day care and continuity of care on medium-term and long-term bases. Epidemiological and economic studies were being planned at local and national levels, and an ongoing monitoring and assessment programme had been established to ensure quality of service.

Mr KET SEIN (Myanmar) described how the launch of his Government’s mental health programme in 1998 had started to break down the misconceptions previously attached to mental health disorders. Awareness had been enhanced by the activities of health education teams and projects. Community participation in activities designed to provide moral support for sufferers had also been important in improving acceptance by the community and in encouraging community-based care. The engagement of well-known artists and cartoonists to open and promote exhibitions of paintings and drawings by people with mental disorders had contributed greatly to the change in people’s perception of mental illness and to minimizing discrimination.

The community-based approach to mental disorders covered the training of basic health care workers. New care guidelines had been issued, and the supply of basic psychotropic drugs had improved. Nongovernmental organizations were encouraged to promote mental health activities,
including the prevention of substance abuse among young people. Health education activities had been introduced in schools and in the community. A maternal and child welfare association had started to promote health and well-being, including programmes for education and income generation. National committees for women's affairs had sponsored the establishment of counselling centres for victims of violence.

At the national level, a concerted effort was being made as a result of the mental health theme for World Health Day 2001 to secure adequate supplies of affordable, good quality psychotropic drugs. Meditation, which was already part of Myanmar's culture, continued to be encouraged for the harmonious mental state that it promoted.

Dr BORST-EILERS (Netherlands) said that her country had also seen a growing demand over the past 10 years for help for mental disorders, due to the increasing incidence of such problems and to the fact that help was being sought at an earlier stage, largely as a result of de-stigmatization. The change had undoubtedly been promoted by well-known personalities who had openly admitted to suffering from certain disorders. The availability of effective treatment for mental health problems such as anxiety and depression in primary health care centres, by family doctors, psychiatric nurses, social workers or primary care psychologists, was also responsible for the growing demand.

Like France, the Netherlands had also begun to shift from institutional to community care, where patients received support and various kinds of ambulatory treatment. In order for the shift to be successful, budget cuts were inadvisable, as community care was not necessarily cheaper than institutional care in view of the personal support required. It was also important not to push the concept further than the community could tolerate. Some vulnerable patients with chronic psychotic conditions and those who posed a threat to others needed the protected environment of an institution and should not be exposed to life in a community. One of the most important aspects of community care was the building up of broad public support by making it clear to the local community that professional help was readily available in the event of a disturbance. Community care had been introduced into a number of cities in the Netherlands with great success.

Ms HUTT (United Kingdom of Great Britain and Northern Ireland) said that the National Assembly for Wales was aware that all the policy areas for which it was responsible, namely health and social services, housing, environment, economic development and education, were relevant to the improvement of health and well-being and to tackling mental health problems. It had also become clear to the Assembly in the two years of its existence that a national strategy for mental health was essential, with priority funding. Such a strategy would provide for local delivery and local management of services through primary care and community health development.

Every effort was being made in Wales to ensure that people who had used mental health services or were suffering from mental health problems were involved in policy development, both in their local communities and in the National Assembly.

In developing community services, it was essential to have plans and funds in place before closing existing institutions. It was equally important, with one in four people likely to experience mental distress at some time, either in their families or in their communities, to ensure that the community was able to address their needs.

Professor PHAM MANH HUNG (Viet Nam) informed the meeting that, like many developing countries, Viet Nam had seen an increase in the incidence of mental and brain disorders. The Government was dedicated to poverty reduction and had made considerable progress in the past five years. Priority had been given to programmes with a strong commitment to the provision of equitable health care services for the poor, including priority allocation of expenditure for health in poor areas. Health workers in the mental health field were encouraged by additional allowances equivalent to 20% of their salaries, a seven-hour working day and early retirement.

Improvements had also been made in hospital care, and the number of mental health departments in cities and provinces had been increased, as had the number of psychiatrists. More
recently, mental health care had been integrated into the general health service, with emphasis on community-based services. Most districts currently had a mental health consultancy, responsible for the care and follow-up of patients.

Community awareness of mental health problems had increased. Nevertheless, and despite the considerable progress made in providing mental health care, poor people continued to suffer. Limited government expenditure on health and the lack of well-trained psychiatrists on the one hand, and poverty, social discrimination and prejudice, a lack of information and superstition on the other, were major obstacles to the provision of mental health care and information on preventive treatment.

To counteract that situation, the Government had approved a five-year plan for development of the health sector with the aims, inter alia, of expanding health care centres to a further 50 communes, expanding community-based mental health services to other provinces, providing community-based management and improving cure and rehabilitation rates. A notable result was that 50% of the country’s community health centres had at least one medical doctor.

Mr ROCK (Canada), welcoming the exchange of views on common problems, said that his country’s experience was similar to that described by previous speakers. The Canadian Government had recognized the importance of integrating mental health into primary health care systems and had recently funded a pilot project to make mental health services available within the community. As almost 20% of primary health care patients presented with mental health problems, it had been considered important to ensure that the training of health professionals included the identification, recognition and treatment of such problems. The importance of early intervention in children to prevent more complex difficulties later on could not be overemphasized. Disease prevention was given high priority in Canada, and the development of a national approach towards early childhood development was encouraged. Thus, a “children’s agenda” had been created, covering prenatal nutrition for young mothers, programmes focusing on the crucial years of brain development between birth and the age of three years, early identification of signs of emotional maladjustment, and emphasis on the prevention of foetal alcohol syndrome and defects that limited personal development and led to social cost and disruption in later life.

Many of Canada’s communities, especially those of indigenous peoples, were rural and remote and experienced harsh winter weather. Increasing and successful use had been made there of modern information and communication techniques, such as telemedicine, teleradiology and telepsychiatry. Rather than being a barrier to the personal relationship between therapist and patient, the televised connection appeared to facilitate full participation in the consultation.

A new approach to the organization, coordination and financing of health research, including mental health, had been adopted with the creation of virtual mental health research institutes consisting of networks of researchers. One such institute was devoted to mental health and involved researchers in clinical and biomedical fields, the provision of services, and population health and health determinants. By bringing those four perspectives together and substantially increasing the level of financing, Canada's research enterprise was more effective and better use was made of its research funds. Investment in mental health was being increased to reflect more appropriately the importance attached to that area in the health system. Canada would be hosting the World Assembly for Mental Health in July 2001, bringing together people from around the world with valuable perspectives and insights into the ways in which national health systems could better organize, coordinate and deliver services for mental health, and he encouraged the involvement of all Ministers present.

Dr PENG Yu (China) described how the transition to a market economy in China had been accompanied by an upsurge in mental health problems; for instance, mental disorders were the single most important factor in university student drop-out rates. While recognizing the need to adapt its policies and activities to reflect the new health situation, the Government had insufficient numbers of health professionals with adequate training in the diagnosis and treatment of mental disease. Although China had sufficient supplies of domestic and imported psychotropic medicines, limited funds in remote areas restricted the access of farmers and agricultural workers to the drugs they needed. The
Government was focusing its efforts on providing basic and community-based training, delivered, in the case of remote areas, through the use of telecommunications.

In the 1990s, China had launched a programme aimed at assuring the rehabilitation of some 200 million persons and providing training in mental health for primary health care physicians. Its current goal was to reach as many as 400 million people nationwide, drawing on the help of WHO, among others, in order to launch pilot projects and honour its commitment to promoting mental health.

Dr DOTRES MARTÍNEZ (Cuba) stressed the importance of providing adequate care to all patients with mental disorders and of considering mental health from the point of view of both health services and such social factors as poverty, inequity, violence and other risk factors.

In Cuba, where health care was universally provided free of charge, priority was given to mental health. The trends since 1995 had been towards community-based care mediated through training and education of families to enable them to live with sufferers. Thus, 137 municipalities had established community mental health centres. Work was under way to restructure psychiatric hospitals and redefine their mission and functions both from the viewpoint of increasing primary health care coverage and of focusing attention on mental health.

Improvements had been made in information systems and in the identification of indicators to evaluate the impact of mental health measures. The identification of risk factors played a fundamental role in community-based care of patients with mental disorders and should be addressed as part of a preventive strategy that included family members and the community. In Cuba, the shift towards mental health had been carried out by training doctors, nurses and specialists at all levels. The country had many psychiatrists providing care to adults and children, while mental health concepts had been incorporated into training of primary health care physicians and family health specialists.

The participation of communities and of community organizations in providing services and rehabilitation to patients was vital for the management of risk factors, and ensuring that the goals set could be achieved in a sustainable manner.

Legislation was important: public health law, the family code and even the criminal code should include provisions to protect psychiatric patients and all disabled persons. Those persons should be guaranteed social benefits, opportunities to participate in society and to gain access to employment and education, and thus to avail themselves of an integrated system of care. In that regard, one of Cuba's greatest difficulties was that the economic embargo imposed on it by the United States of America restricted access by patients to the psychotropic drugs they needed. In spite of the difficulties, Cuba remained committed to community participation and health education as the best means of reducing the incidence of mental disorders.

Dr LEFF (Facilitator) noted that many countries had begun to decentralize psychiatric services, shifting mental health care from hospitals to communities by integrating it into primary health care. The challenge facing all countries was the same: how to provide a well-coordinated, comprehensive system of mental health care. The fact that vast numbers of people had no access to psychiatric care made it incumbent upon governments to elaborate policies, and enact or update existing legislation, with a view to ensuring that the move towards community-based care was placed high on the health and financial agendas.

Psychiatric problems could present at any phase of a person's life and no one was exempt. Children could be affected as a result of physical or sexual abuse or poor parenting, while adolescents might be victims of substance abuse. The incidence of depression was particularly significant among adults, while suicide, depression and dementia were most prevalent among older persons. Schizophrenia led to lifelong disability. Mental illness was no respecter of borders. In spite of significant progress in treatment of many illnesses, the main problem, even in developed countries, was gaining access to such therapies. Shortages of financial resources, inadequate infrastructure for distribution, and lack of trained staff were often to blame. Governments should recognize that many patients needed to take drugs for long periods and that, in order to improve access to psychosocial treatment, staff needed not only training, but also support, supervision and the time to deploy the skills
they had acquired. Innovative schemes such as those offering help to mothers suffering from postnatal depression, placing child counsellors in schools to detect and treat psychiatric disorders, training paramedics to administer psychotropic drugs, or involving families living with schizophrenia sufferers in training other families, should be encouraged and developed.

While the concept of community-based care had gained currency as an effective means, *inter alia*, of combating the stigmatization of mental illness, little had been done to integrate care at the primary health care level, although WHO had recommended that approach for many years. The emergence of consumer associations had added a powerful voice to the debate. Government departments should collaborate at the highest levels to assure the supply of the basic needs of patients for food, shelter and dignity, and to procure the resources required.

Mr KONDO (Japan)\(^1\) said that the competition inherent in a free-market economy had resulted in rising incidences of stress, distress and mental disorders in his country, underlining the importance of placing mental health high on the agenda. He welcomed the decision to devote World Health Day 2001 to that problem.

Until recently, Japan had placed considerable emphasis on the hospitalization of psychiatric patients. The results were too many long-term patients and the raising of several human rights concerns. Currently, efforts were being made to ensure that patients acquired greater autonomy as part of their reintegration into society. The Ministry of Health, Labour and Welfare focused on community-based care, and adequate support mechanisms were being set up, including employment opportunities for patients with mental disorders. Suicide was a significant social problem in Japan, often caused by financial difficulties. Adequate services to improve the social environment should be provided at the regional and workplace levels to prevent such difficulties. It would also be important to conduct research into the causes of depression.

As in other countries, stigmatization of patients with mental disorders was a major problem. Measures were being taken to eliminate prejudice and achieve social integration of sufferers through education and information campaigns, such as those carried out by and through WHO.

Dr FERREIRA SONGANE (Mozambique) described the development of his country's mental health programme in 1990, based on prevention, training and partnership, in a multisectoral approach. Although its psychiatric hospitals had largely become redundant, Mozambique lacked the resources to eliminate the stigmatization of the mentally ill. In practice, many sufferers were simply left on the streets to die.

Since it had insufficient specialists and wanted to decentralize services, Mozambique was providing psychiatry training for doctors at the middle level of the system, including a significant public and social health component. The physicians worked closely with traditional practitioners who also had expertise in the use of drugs, and who thus could help overcome social resistance to seeking treatment.

The streets of Mozambique revealed children as young as five years of age who were forced out to work or to seek food and were deprived of the education and care they needed to enjoy mental health in later years. His Government hoped that, with the help of WHO and through its highly effective Regional Office for Africa, such phenomena could be effectively eradicated.

Mr SAVVIDES (Cyprus) said that since the 1980s Cyprus had shifted the emphasis of its national policy away from outmoded mental asylums, characterized by stigmatization of the disease and violation of patients' human rights, to community-based services and the integration of mental health care into primary health care. Most patients were being released into half-way houses or hostels and to their families, and only the oldest and most institutionalized of patients remained in the old-style institutions.

\(^1\) Speaking in Japanese in accordance with Rule 89 of the Rules of Procedure of the World Health Assembly.
Among the measures introduced in the context of care in the community were the retraining of psychiatric nurses and establishment of community psychiatric services; the deployment of multidisciplinary teams at the community level; and collaboration with nongovernmental organizations and local authorities in setting up various centres, clinics, and types of accommodation. Although much had been achieved, significant problems remained, including a shortage of trained personnel, poor coordination with social services, inadequate coverage in rural areas, inadequate training of primary health care workers and poor information and communication systems.

Among the most important actions taken by Cyprus to counter stigmatization and human rights violations was the enactment of a law in 1997 for the provision of psychiatric treatment, which incorporated the 10 principles recommended by WHO. The media had been enlisted to draw attention to mental health issues, making patients more visible, emphasizing the availability of successful treatment and providing information and education to professionals and the public at large. The fact that World Health Day 2001 had been devoted to mental health had offered an opportunity to intensify efforts in that domain.

Since knowledge of the extent of mental illness and neurological problems in Cyprus was poor, an epidemiological study would be conducted in 2002 and the results would be used to direct policy. Future measures would include more training of professionals, greater multisectoral cooperation, public education, research and the removal of all barriers that prevented the full reintegration of patients into society.

Mr KRASNOV (Russian Federation) stressed that the rise and spread of mental health problems were characteristic of all societies, rich, poor, or in transition. It was wrongly assumed that poverty eradication was the prerequisite to the reduction of prevalence of mental health problems; however, those problems were themselves factors of social and economic development.

Any long-term strategy of care and prevention required greater integration of psychiatric services into the general health system, with families and even former patients contributing their unique experience, skills and advice on how to overcome certain problems. The task could not be left to specialists alone; it required the participation of all members of society, and of primary health care workers in the first instance. Although his country had limited experience in that domain, it had organized local polyclinics so as to facilitate early intervention through offering access to services that communities would otherwise shun if provided by large institutions.

Many participants had described community-based mental health care policies, but there were as many interpretations of the term "community" as there were regions, countries or towns. Whereas most villagers knew one another, in large urban apartment blocks people rarely knew their neighbours.Effective community-based care should be predicated by a definition of "community".

He suggested that a global appraisal be made of experience in mental health care in different countries in order to develop effective health care models. WHO was uniquely positioned for such a task.

Dr ABDESSALEM (Tunisia) said that mental health had long been neglected for a number of reasons. Once independent, Tunisia had immediately tackled such scourges as infant mortality and had embarked on a countrywide immunization campaign. Since 1990, it had included mental health in its general health strategy, with emphasis on legislation, organization and human resources.

The first major component of that strategy had been the integration of the mental health programme into existing structures dispersed throughout the country, to take those services closer to the users. The second component, still being finalized, was the establishment of the structures necessary for the various categories of mental health care. Counselling units had been set up in secondary schools, higher education establishments, and in some small hospitals. A decision had yet to be taken with regard to voluntary and involuntary admission to hospital. A third important measure was to attack the myriad risk factors for mental disorders through education, affording all children the opportunity to continue their studies and the fight against poverty with the creation of jobs for young people. Action was being taken to protect vulnerable groups, particularly children and the elderly,
especially with respect to violence against women and children. The authorities were also
endeavouring to ensure that persons who were or had been mentally ill were reintegrated into the
country’s social and economic systems.

He endorsed the view expressed by many speakers that legislation on its own did not provide
effective mental health care. A change of mentality was required among all persons involved in mental
health care, including psychiatrists, who were sometimes unwilling to share their power and
knowledge. It was equally important to train social workers, specialized nurses, psychologists and
psychiatrists, and to provide psychiatric training for general practitioners. In short, Tunisia’s strategy
focused on prevention and reduction of risk and affording its citizens better access to proper care in
decentralized clinics, sponsored by university faculties of medicine and psychiatry.

Professor SALLAM (Egypt) emphasized the importance of differentiating between mental
health and addiction and between mental illness in children and criminals. Prevention of mental illness
and rehabilitation were not high priorities in developing countries. Egypt had undertaken a major
reform in that regard, and a Presidential Decree had been issued to the effect that, while psychiatric
hospitals were still needed, the system should be reformed. Many speakers had advocated
incorporating mental health care into primary health care; could WHO establish an agenda for that,
according to the different countries’ needs?

There was an urgent need in developing countries to act promptly against early addiction. Ways
should be sought of “immunizing” children against addiction with a service set up for people at high
risk and for first-time users. Countries like his would greatly benefit from assistance from international
donors for prevention of addiction and rehabilitation. Therapeutic measures such as music and
agriculture could be helpful in transforming psychiatric hospitals into rehabilitation centres. Similar
treatments could be applied to violent behaviours. That problem, linked to psychological depression,
was affecting the entire world. He would welcome the introduction of a social component into mental
health strategies. As things stood, sufferers were often ignored by their relatives and friends; a change
in attitude was the first step towards improvement.

Dr KNOWLES (Bahamas) said that he had taken comfort from the realization that most
countries had problems similar to those in his own country but was sad to hear that solutions were hard
to come by, regardless of the size of a country’s gross domestic product.

The Bahamas, like Canada, was a country of scattered populations, which hindered service
delivery. In addition to the country’s usual array of mental health problems, it had suffered from being
directly situated between the major cocaine-producing Latin American countries and the United States
of America. The crack and cocaine epidemic of the 1980s had been closely followed by the AIDS
epidemic and an upsurge in violent crime.

The Bahamas had recently reviewed its mental health services and was revising its mental
health plan correspondingly. His country would welcome direction in its efforts to provide sufficient
numbers of mental health workers, especially psychiatrists. That was not seen as a glamorous
profession, nor did graduate nurses want to specialize in psychiatric care. He also asked for advice on
the care of mentally ill patients in prisons, where the necessary psychiatric services were not available,
and on the multidisciplinary care of mentally ill adolescents.

Mr MONO (Papua New Guinea) described his country’s 10-year action plan for social change
and mental health. The main challenges were: the need to increase public awareness and involvement;
the limited financial resources; poor service coverage; inadequate training of staff; community, and
home care providers; a paucity of psychiatrists and psychiatric nurses; a neglect of forensic psychiatry;
poor intersectoral collaboration; and, finally, insufficiently developed data and evaluation indicators.
To respond to those problems, month-long awareness campaigns and training seminars were held for
skills development, and a community-based psychosocial health care centre had been established.
Pocket-sized standard treatment manuals were being prepared for general practitioners, nurses and
other health care professionals, to help them deal with mentally ill patients in the hospital setting.
The Government's mental health policies were linked to social change, and included free psychiatric care and rehabilitation as an integral part of the public hospital system and the establishment and support of community-based treatment and psychosocial rehabilitation, carried out in collaboration with nongovernmental organizations and other such groups.

Mr ADAMOU (Niger) said that, since the independence of his country, mental health care had been provided at the national hospital in the capital and at three hospitals that had psychiatric units; however, with waning funds and resources, their performance had deteriorated. On the occasion of World Health Day 2001, WHO had provided certain psychotropic drugs, which had enabled the country to resume its activities in that field. Clearly, in a country as vast as Niger, three hospitals were insufficient to cover all mental health care needs. The mentally ill, whether hospitalized or not, were rejected by their families and were looked after by the State. In his country, traditional medicine existed side-by-side with modern medicine. The traditional healers were not witch doctors and did cure some mentally ill people. The intention of the authorities was to promote primary health care for mental disorders and to decentralize that care through personnel training and the provision of sufficient drugs. Niger's mental health programme was new, and there was need still to formulate policy, coordinate the activities of all those involved in mental health care and to raise awareness. All that was needed was financing. He said that he had found the round table useful and would make good use of some of the suggestions that had been made.

Professor NWOSU (Nigeria) commented that a similar situation obtained in Nigeria. She noted that mental health care had initially been the responsibility of families and communities, and had then been transferred to hospitals before being restored to the community. The disintegration of the extended family system in Africa had placed an enormous burden on the community for the management of mental health care. In that regard, poverty alleviation was a crucial instrument for integrating mentally ill patients into society and giving them adequate care. While traditional healers played a major role in treatment, the community also needed education and awareness programmes so that traditional care would be effectively integrated into the orthodox health care system. She asked that WHO devise a special programme on postpartum psychosis, a neglected area of mental illness.

Dr NEDZIPI (The former Yugoslav Republic of Macedonia) said that mental health care in his country was inadequate, and lack of resources for hospital and community care deprived many mentally ill persons of their basic human rights. With WHO's support, however, the Ministry of Health had elaborated a master plan to improve human resources and had proposed new legislation to enhance patients' rights and combat stigmatization.

Community mental health services had been set up in three pilot areas in partnership with three European municipalities. Day-care centres, protected homes, social enterprises and social clubs were supported by the public service and by nongovernmental organizations, in a multisectoral approach. Mechanisms were in place to ensure the sustainability of the community-based approach, and initiatives had been taken to increase the resources of the project and replicate it in other pilot areas.

Dr TOUYÁ (Uruguay) said that a process of de-institutionalization of mental health care had begun in 1986, with much of the responsibility passing to the community. That had resulted in fewer and shorter hospital stays, thereby improving patients' quality of life in their family environment. Psychiatric care could not fail to improve with increasing knowledge about brain function. Nevertheless, the risks for mental disorders were increased in a civilization that pushed people increasingly towards self-destruction. The most positive approaches were prevention and protection, to which end WHO should firmly support countries that set examples of strong family bonds, which were known to reduce poverty and violence. The media should be used to raise awareness.
Dr GRACIA GARCÍA (Panama) said that he had found the round table highly instructive. It would be important to determine to what extent mental health systems had been affected by the economic and social policies and crises imposed by the current development model. Panama resembled other Latin American countries in experiencing increased poverty, greater unemployment and a resultant rise in disease in general and in mental illness in particular. One immediate effect of an unstable economy was decreased spending on health and education.

In 2000, Panama had made mental health a priority and had implemented four programmes. The first had focused on obtaining accurate epidemiological data on the real impact of mental illness on society. The second had ensured early diagnosis and treatment of mental illness in a national care system through promotion campaigns and education programmes for patients, their families and general practitioners. Joint public-private sector support groups for patients and their relatives had been established to eradicate stigmatization of mentally ill patients by their families and society, so that the patients could be reintegrated into society as rapidly as possible. A community pharmacy programme had been established that gave patients access to high-quality drugs at reasonable prices. The possibility of State subsidies for drugs in the event of economic necessity was being studied.

The CHAIRMAN thanked all participants for their valuable contributions to what she considered to have been a highly successful and instructive round table.

The meeting rose at 12:35.
availability of effective interventions, many of which were cost-effective, and the human rights of
individuals with mental disorders, there was a need for global and national action on mental health.

Turning to the question of what could be done and how, she outlined the various successful and
innovative approaches that were being used to address mental health issues at the national level, such
as community-based approaches, linkages between traditional practitioners and mental health
professionals, promotion of employment for persons with mental illness, the revision of legislation and
policy formulation, the launching of campaigns against stigmatization and the provision of
opportunities for people suffering from mental illness to voice their issues.

She stressed that the training of primary health care workers to deal with mental health
problems could avoid wastage of effort and cost. Moreover, the integration of mental health and
psychiatric care within general health care, including the opening of psychiatric admission wards in
general hospitals, offered the added advantage of reducing the stigma of mental disorder. Suitable and
progressive mental health policies and legislation could go a long way towards making the necessary
services available to those who required them and to protecting their human rights. All countries had
much to learn from each other in dealing with mental health disorders, conditions that could be
managed, treated and prevented with available treatments, many of which were cost-effective.

Dr BARTOS (Romania) explained how she had learned early in her medical career the true
importance of adequate mental health services. The lack of such services allowed many persons with
mental disorders to hide behind real or virtual barriers, because prejudice, intolerance and inadequate
services still existed. In her country, despite the important social changes that had occurred, violence,
unemployment and a rapid deterioration in economic conditions and living standards were all affecting
the mental health of the population. The Government believed that health care was a collective social
good to which everyone should have free and equitable access. Better health in Romania would be
achieved through a strategy of correcting the excessive orientation towards hospital services which
was detrimental to outpatient and community care.

The Ministry of Health and the Family had submitted a bill to promote mental health and the
protection of persons with psychological disorders to ensure that they were treated in a manner that
fully respected their dignity, without discrimination and, in so far as possible, in the community. WHO
had supported the preparation of that bill and had also contributed to the evaluation of mental health at
the national level. Romania needed a national mental health plan based on: the determination and
evaluation of the real dimension of the problem; the reform and effectiveness of the system of mental
health services; and integrated, interdisciplinary and intersectoral programmes to promote mental
health. Family doctors needed to be involved to a greater extent as "gatekeepers" and special
assistance would have to be provided to vulnerable and high-risk groups. The Ministry was also
coordinating a project financed by the World Bank for the establishment of a mental health centre. She
welcomed the support provided by WHO and its initiatives to raise awareness of mental health
problems, which had prompted several new activities, which should help to overcome certain
obstacles to mental health service reform, including traditional attitudes and inertia. In transition
countries, such as her own, one of the most difficult reforms had concerned hospitals, in which most
mental health services were located, and the call for emphasis to be given to outpatient and community
services. Such a course of action was hard, given the lack of information on the real dimension of the
problem. She therefore welcomed the round table which, even if it did not knock down existing
barriers, would nevertheless weaken them.

Dr MUBARAK (Iraq) recalled that his country was experiencing a difficult situation in view of
the sanctions imposed and almost daily bombardments. Cases of mental ill-health had increased,
caused by the fear of air raids and the constant trauma of bombing attacks, which particularly affected
children, women and the elderly. Those difficulties were well known; the lengthy duration of such
problems was another source of trauma. The current situation meant that it was very difficult to
measure the social consequences of mental health problems, as it was impossible to obtain research
data. Despite the signature of a memorandum of understanding, the measures taken under the pretext
of protecting human rights, and particularly the positions taken by certain representatives on the
United Nations Security Council Committee established by Resolution 661, made it difficult to
achieve any progress in the health situation in Iraq. Close cooperation was required with WHO to
develop better approaches to mental health disorders, particularly through hospital treatment.

It was difficult to persuade trained practitioners to work in the field of mental health. His Government was not able to provide them with scholarships to study abroad, and it was difficult to bring in qualified personnel to train health practitioners in Iraq. Measures adopted to encourage newly graduated health professionals to work in the field of mental health included the creation of training programmes and rotation systems for new graduates, including incentives for them to spend two years working in mental health. The sanctions meant that the drugs required to treat mental disorders were classified as non-urgent and were in very short supply.

Iraq's situation was having a severe impact on society, and particularly on women. Frustration was coming to the surface and confrontations were developing between family members. Children experienced frustration when they saw toys advertised to which their access was restricted or prohibited, and women, confined to their houses, were experiencing depression. To relieve the situation, legislation had been adopted and other measures devised, including soft loans, to enable women to work from home. The Government was cooperating with nongovernmental and other organizations in civil society to deal with mental health disorders. Heavy penalties were imposed on institutions and enterprises discriminating against persons with mental disorders.

The treatment of mental health should be a subject of close cooperation between countries at regional and international levels and should not be treated as a political issue. Although there could not be one standard approach to mental health which would fit all countries, WHO should lead in developing action in that field.

Dr Sujudi (Indonesia) said that, as a result of legislation passed in 1960, Indonesia had adopted a social approach towards mental health care offering more open and comprehensive facilities and services. In 1974, mental health care had been integrated into selected district hospitals and health centres. Inadequate results in the identification and care of patients had led to the introduction in 1993 of training in the diagnosis and treatment of psychiatric patients for substantial numbers of personnel in such hospitals and health centres. Subsequently, the detection of mental health disorders among outpatients had increased from 0.47% to 2.15%. Community mental health activities had been promoted on a nationwide scale; they would support the development of relevant policies and strategies for improvements at provincial and district levels. Much remained to be done, as indicated by the unsafe environmental conditions and unhealthy behaviour which prevailed, but Indonesia was seeking to adopt strategies that emphasized welfare-oriented and community-based mental health care, as well as the inpatient services, and promotion and prevention activities which were important to enhancing the overall development of health.

Professor Fiser (Czech Republic) welcomed the round-table discussion, particularly since psychological and psychiatric disorders were increasing in importance in his country. The highest prevalence rates were for neurotic disorders, affective disorders and schizophrenia. The number of suicides of men in the Czech Republic was also increasing, while the suicide rate of women was decreasing. Although higher than the average in the European Union, the suicide rate of 15.5 per 100,000 population in his country was significantly lower than, for example, the countries of the former Soviet Union.

One of the most serious problems faced by his country in the field of mental health was the shortage of specialists in psychiatry; more were being trained in psychiatry, but also in psychology and psychotherapy, although problems persisted in financing that training and that of general practitioners and nurses in modern aspects of psychology and psychotherapy. Psychiatric patients were traditionally located in specialized institutions, which were frequently isolated and oriented towards the long-term, and sometimes lifelong, hospitalization of patients, thus underlining the segregation of the mentally ill and contributing to discrimination against both the discipline of psychiatry and the patients
themselves. In recent years, the number of places in institutions for the mentally ill had been increased by one-third. It was planned to organize psychiatric departments as sections of large hospitals, with modern equipment, designed for short stays with intensive diagnostics and treatment, to be followed by outpatient care. It would also be necessary to organize a system of care for chronic alcoholics and persons affected by other kinds of addiction. However, the necessary measures would require substantial funding.

Finally, he welcomed the possibility of cooperating, through his country’s Research Institute of Psychiatry and the Society of Psychiatry, with WHO and its Regional Office for Europe in the field of mental health.

Professor WANECK (Austria) said that WHO had successfully drawn public attention to mental health problems, which were often underestimated and misunderstood. Great progress had recently been made in the field of psychiatry and yet psychiatric disorders in the industrialized countries were increasing. A new consciousness had emerged, evidenced by the burgeoning number of self-help groups, as a result of which most people with mental illnesses were living within the community, able to make their own life choices. At the global level, however, much remained to be done. The Austrian health authorities vigorously pursued the WHO-advocated policy aimed at ending the exclusion of the mentally ill, particularly in the field of hospital psychiatric services, which had been decentralized and integrated, thus representing an important step forward in destigmatizing psychiatric disorders and those suffering from them. Self-help groups also played an instrumental role in the efforts to destigmatize psychiatric illness, as they provided vital back-up to the policy already in place.

To strengthen the Austrian mental health policy, a countrywide survey of mental health provision had been commissioned, bringing together, for the first time, data on psychiatric and psychosocial care for the benefit of the mentally ill, their families and those professionally concerned. Projects would be analysed and additional measures adopted in the light of the data produced by the survey, the second part of which was due at the end of 2001. Other important future objectives included the satisfaction of needs, the integration of basic care, quality assurance and the participation of patients and their relatives, care professionals, administrators and politicians. He expressed the hope that the national and international efforts undertaken would improve the information available in the field of psychiatric care and that the stigmas attached to psychiatric illness would diminish to the point where such health problems could be openly discussed without taboo.

Dr LOMBARDO (Argentina) traced the history of mental health care in his country from its origins in the 19th century, including the establishment in 1957 of the National Mental Health Institute, which had endorsed the approach of treating mental health disorders as health problems and not diseases. Nevertheless, developments in lifestyles, including the emergence of "modern" problems such as stress had led to the increased incidence of serious mental disorders. The treatment of such disorders had developed in parallel on an interdisciplinary and intersectoral basis, with recognition of the fundamental importance of community participation in health matters. Argentina currently had a high number of mental health specialists, comparable to the numbers in the most developed countries. Progress had also been made in the treatment of mental disorders with the emergence of new drugs, while the development of new outpatient services had helped persons with mental disorders to avoid social marginalization and stigmatization. In that respect, he emphasized that the isolation of many adults in modern society was a basic reason for the development of mental health disorders.

Legislation placing emphasis on promotion and prevention was currently being adopted at various levels in Argentina. A national primary mental health care act, the principal focus of which was on prevention, had recently been adopted and had been accompanied by legislation covering the treatment of various conditions related to mental health disorders. Similar legislative measures were also being adopted by the provinces. The mental health policy had been incorporated into the national health policy emphasizing the promotion of healthy lifestyles and including the prevention of substance abuse, and the development of a national programme to prevent depression and detect possible cases of suicide at an early date. The basic elements of the treatment of mental health
disorders were: the elimination of stigmatization; the organization of multidisciplinary health services covering prevention, health promotion, assistance and rehabilitation; and the social reintegration of patients. Gender was another fundamental aspect of mental health problems, since more women than men suffered from mental health disorders. Attention therefore needed to be paid to problems of gender discrimination in modern societies. Finally, it was necessary to identify the socioeconomic elements that led to the development of mental disorders, including poverty and marginalization. Mental health patients needed immediate reintegration and assistance to promote their participation in the life of the community. He welcomed the initiative taken by WHO on one of the major health problems of the coming years.

Dr PARASRAM (Trinidad and Tobago) said that, after a long period of neglect, mental health had become an integral part of his country's health sector reform programme. The new mental health plan currently being implemented took into account the relationship between mental health, social pathology and other exacerbating conditions and sought to provide a range of integrated services, with the emphasis on primary care of the individual within the community. It also comprised activities such as a legislative review, restructuring, an assessment of health needs and human resources, training, health promotion and the development of regional plans in association with provider agencies. Approval had been given for the establishment of a suicide-prevention task force; the current system of drug procurement and distribution was under review; and new generations of drugs were available at public mental health care institutions. Such policies and reviews, however, were insufficient in themselves to reverse the stigma of mental illness and related problems, a process which demanded continuous efforts. In his country, fruitful forums had been held with the media. That group could serve as an important ally in overcoming the challenges entailed in moving the mental health care agenda forward. On that score, he looked forward to the continuation of national, regional and international action aimed at improving the quality of mental health for the world's citizens.

Mr ENGQVIST (Sweden) said that, in 1995, Sweden had challenged the traditional views of mental health services, shifting from large-scale institutional psychiatric care towards municipality-based rehabilitation and integration programmes. The aim was to ensure that people with mental health problems were closer to the main stream of health services. Despite major investment and a positive response to the structural changes introduced, however, the professional and other available resources had not met the required high standards of care. A national centre had therefore been established to provide support for individuals suffering mental or functional impairment and to ensure maintenance of their dignity and respect, in which connection personnel training was important. Moreover, a national action plan presented in 2000 would substantially increase health care funding and focus efforts on improving primary health care and care for the elderly and the mentally ill. The important role and the responsibilities of general practitioners in prevention and early intervention were equally underlined. Under Swedish legislation (compliance with which was annually monitored) patients had the right of access to information, as well as the right to a second opinion and a voice in their care and treatment. Special attention was devoted to patient empowerment and the valuable assistance of patient organizations was recognized, both in the development of legislation and guidelines and in the evaluation of reform and other changes.

Although mental health conditions had generally improved in Sweden, mental ill-health had increased at an alarming rate, particularly among teenagers and young women. Special measures would therefore be taken. Mental illness was strongly connected to poverty and substance abuse. Notwithstanding the significance of genetic factors in many conditions, social support systems were crucial in diminishing the consequences of mental illness, in which context he highlighted the advantage of multiprofessional approaches and the importance of cooperation between the different actors, including nongovernmental organizations.

Together with a well-developed preventive health system, a proper education system was the key to providing the basic conditions needed to ensure that young people developed self-esteem and adopted healthy lifestyles. In that context, encouraging progress had been recorded in Sweden's efforts
to tackle domestic violence, including the development of a new training programme for professionals in the fields of health, social services and law enforcement. Sweden had also investigated gender differences in the provision of health care and was endeavouring to eliminate conditions attributable to gender discrimination.

Dr PATEL (Facilitator) presented an overview of the background information document on the relationship between mental health and socioeconomic factors. Research clearly showed those at the bottom of the economic ladder to be at much greater risk of suffering mental disorders, with strong associations between common disorders and low income, little education, female gender and unemployment. Furthermore, the poor had less access to health care, which in turn reduced the likelihood of recovery. Mental illness was also a cause of poverty, with sufferers unable to work productively, leading to loss of income, and greater use of health services, the costs of which had to be borne by the patient in many countries. Further, as health services often treated mental ill-health inappropriately, such conditions often became chronic. A vicious cycle developed of deprivation, mental illness and impaired economic development.

A main concern for public health policy-makers was to prevent mental disorders. Poverty alleviation programmes should focus on providing special help to the poorest in the form of welfare schemes, micro-credit and other economic benefits, to reduce the stress of living in poverty. Investing in education, especially of girls, was another major preventive strategy. Higher education could provide protection against a range of mental disorders.

Mental health was a crucial element whenever social policies were being developed and evaluated. It should be integrated into existing public health programmes and included in the training of all cadres of general health workers, services thus being extended to the community with minimal additional investment. Intersectoral collaboration between the public, private, nongovernmental and traditional medical sectors would be vital to achieve those goals. Health promotion, through public education and awareness campaigns would help to reduce the stigma associated with mental illness and enable sufferers to access treatment services.

Mr GUNNARSSON (Iceland), noting that mental health was vitally important to the well-being of nations and to human, social and economic status, said that it had been included as one of seven target areas in Iceland’s new health plan. In that connection, the specific objectives of his Government included the reduction, within the next 10 years, of suicides by 25% and of mental disorders by 10%. The action planned to attain those objectives included: better registration of mental disorders; better training for health care personnel; provision of better information to the public, in particular by enlisting the cooperation of the media; improvement of access to mental health care; the offering of more treatment options; and improvement of coordination between schools and the mental health services. The focus was on children, young people and the elderly, especially those in rural areas. It was hoped that the health plan would help to reduce the stigmatization of those suffering from mental health disorders and discrimination against them and their families.

Studies had shown that those suffering from mental disorders tended to be from the less well-off sectors of society and, despite the fact that Iceland had a strong social welfare infrastructure, steps were being taken to strengthen the system still further. Efforts were also being made to reduce gender disparity: the longevity of women as compared to men, together with other factors such as their greater exposure to stress, made it necessary to distinguish between the health needs of women and those of men and to take such factors into account when planning mental health care. In conclusion, he recalled that most mental illness could be treated and that many mental illnesses were preventable.

1 Document WHO/NMH/MSD/WHAA/01.3.
Dr GILIĆ (Croatia) recalled that, more than 50 years previously, his countryman Dr Andrija Štampar, one of the founders of WHO, had proposed the inclusion of mental health among other components in the definition of health for the WHO Constitution.

Good socioeconomic conditions were a prerequisite for mental health and welfare, as the example of Croatia illustrated. One in six of Croatia’s population had been displaced during the recent war. War damage had also had a dramatic effect upon productivity and unemployment, and had caused poverty and related mental health disorders. Although the new Government was addressing the ongoing effects of the war, in 1999, three out of every five cases of illness were associated with mental health disorders, such as schizophrenia, alcoholism, and reaction to stress. The Croatian health authorities were giving effect to WHO recommendations such as the transfer of patients suffering mental disorders from hospitals to primary health care, the focus on community-based mental health care, emphasis upon training of mental health care workers, and seeking to prevent stigmatization and discrimination against mental health patients, so as to enable them to participate to the fullest possible extent in the life of the community. With improving social and economic conditions in Croatia, a reduction in mental health disorders was to be expected.

Professor MATHEWS (Australia) said that the rapid pace of social change, economic pressures, war and population movements and other factors had contributed to difficulties in recognizing and providing adequate support for mental health problems. That social change had also been accompanied by the loss of traditional family support in many countries. Transitional societies, such as indigenous Australians, were having difficulty with social adjustment, and they and other vulnerable groups were likely to suffer from drug and alcohol problems, and problems related to violence and suicide, which Australia, like other countries, was taking very seriously.

Stigmatization was still a problem, and new approaches to the philosophy of care and treatment were needed. The Australian National Mental Health Strategy sought to promote the mental health of the Australian community and to prevent the development of mental health problems and mental disorders; to reduce their impact upon individuals, the family, and the community; and to protect the rights of people with mental illness.

Particular emphasis had been placed on reducing stigmatization through programmes targeted at schools to increase awareness and understanding of mental health problems, engaging with the media to promote community understanding, and working with community groups, as well as the professional health sector, to promote acceptance. Australia had underpinned its work with legislative protection of the rights of people with mental illness and had developed community plans for mental health support involving specialist care and an interdisciplinary focus. Australia’s commitment to promotion and prevention had engaged the Commonwealth and state Governments and community organizations, as well as stakeholder groups, patient groups, and also the private sector. Australia fully supported the WHO mental health initiative and was committed to an interdisciplinary focus with a view to reducing stigmatization and recognizing co-morbidities, emphasizing mental health promotion and prevention and rehabilitation.

Mr ESKOLA (Finland) noted that WHO had been active in the mental health area since the 1970s. Although mental health had received a lower priority in the 1980s, the renewed emphasis was a cause for satisfaction. As the Finnish approach to mental health was similar to that described for Sweden, he focused on the reduction of the specific problems of suicide and depression in his country, areas in which considerable success had been achieved.

The rates of suicide in Finland had increased rapidly from the 1950s through the 1980s, rising from 26.5 to 41 per 100 000 for men with rates twice as high for women. A 10-year, nationwide suicide-prevention strategy had been launched in the 1980s and had achieved a reduction of suicide rates of nearly 20% from the peak. An evaluation of the project had shown that the stigmatization of mental health disorders had been greatly reduced and on that basis a programme to address the problem of depression had been launched.
During its presidency of the European Union two years previously, Finland had identified mental health as the number one health problem. From that experience, his Government had concluded that clear changes were needed in mental health policies. First, mental health should be brought out of its political isolation into the broader sphere of public health. Secondly, instead of concentrating on mental health at the individual level, there was a need to strengthen the approach to mental health for the population as a whole, in particular as a means of promoting the integration of mental health into public health policies, strategies, and programmes. Thirdly, emphasis must be shifted from the negative concept of mental disorders to a more positive mental health model. The crucial importance of mental health was encapsulated in Finland's slogan: "There is no health without mental health".

Mr OLEARI (Italy) said that the Italian experience in the area of mental health dated from the 1978 law to reform psychiatric services and specifically to eliminate institutionalization. However, institutionalization could continue as a problem, even in the absence of psychiatric hospitals, just as stigmatization and marginalization could still occur, unless the patient was treated as a full citizen. What was needed was a network that included health, social and community services.

Many problems had been encountered after the adoption of the 1978 law, in particular in connection with specific mental health programmes involving the participation of associations of the families of psychiatric patients, which was considered to be essential. Treatment necessarily involved inpatient mental health centres, care for acute patients in general hospitals, and residential structures that were conducive to the reintegration of the patient into society.

Many national health services had encountered the problem of how to finance social and health services. Such economic difficulties had not yet been fully surmounted in Italy also. Mental health funding was not related to expected outcomes, and an effort was being made to weight the per capita contributions through which health services were funded, by taking into account such sex-related factors as neonatal mortality and infant mortality, rather than purely socioeconomic criteria. Much more remained to be done along those lines. In Italy, 5% of the health service budget was currently allocated to mental health.

All psychiatric hospitals had been closed, and general hospitals had been given responsibility for treating acute patients. He considered that the Italian approach was both positive and in line with the experience of other countries, and expected future efforts to involve consideration of the mental health patient as a citizen and the prevention of mental health problems.

Mr JUGNAUTH (Mauritius), speaking as a lawyer rather than as a medical doctor, asked why it had taken so long for governments and international organizations to recognize the issue of mental health. What were the problems, and the related solutions, in the field of mental health? In response to those questions, he said that the keywords were: recognition, identification, and treatment. Because those suffering from mental illness often attempted to hide their problem, such illness was both denied by the affected person and unrecognized as a real illness by their families. Accordingly, those who needed help were excluded from treatment.

Barriers to implementation of mental health services included public attitudes, resulting in a fear among individuals that prevented them from coming forward with their problems. A centrally-based institution in Mauritius had been constructed in a remote area as a high-security hospital for disruptive and acute psychiatric patients, with different rules and regulations from those applied to general hospitals. Those admitted to that institution could not receive relatives or close friends.

The main barrier had been the failure to recognize mental illness, which was essential if the necessary treatment were to be provided. To achieve such goals and overcome such barriers, he suggested that countries might follow the example of Mauritius in adopting a mental health act that clearly identified the fundamental freedoms and basic rights of those affected by mental illness, and provided for the protection of minors suffering from mental illness, life in the community and their rehabilitation in society. Other provisions of the act included the determination of mental illness, medical examination, confidentiality, the role of the community and culture, standards of care and treatment on a basis of equality with other patients, conditions in mental health facilities, resources for
those facilities, admission principles, review bodies, procedural safeguards, access to information, and equal treatment of criminal offenders.

Decentralization of mental treatment had been moving forward but with acute patients remaining in the psychiatric hospital. Wards for psychiatric patients in the regional hospitals were situated so as not to affect the rest of the patients.

Although Mauritius had eradicated malaria, poliomyelitis and tuberculosis, about 30% of the population still suffered from some kind of mental illness. Decentralization had been essential to reach those people and to make mental health services more available; to assure cost-effectiveness of services; to promote greater awareness in the community; and to suppress stigmatization of mental and psychiatric problems.

The main problems were societal, but there were also financial constraints, particularly in African and other developing countries, which made it difficult to decentralize. Another problem involved shortages of medical personnel, owing particularly to the emigration of trained medical personnel.

Dr CASTELLANOS (Honduras) said that the prevalence of hurricanes on the Caribbean and Atlantic coasts and the frequent earthquakes due to the Pacific Rim Fault were special factors affecting mental health in his country. They precipitated both economic difficulties for the country and mental disorders among the people. The most frequently diagnosed problems in Honduras included violence (30%), depressive illnesses (27%), epilepsy (11%), psychological disorders (6%), and behavioural problems beginning in childhood (5%). In 1975, the Ministry of Health had established a mental health department to deal specifically with such problems. Intensive work throughout the country had formed the basis for the mental health programme.

In 1998 Hurricane Mitch had killed 3000 people and wreaked extensive infrastructural and agricultural damage with lingering effects on the population. Following a detailed analysis of the general health situation, a poverty-reduction strategy had been devised that included a major primary mental health care component. Working directly with the victims of Hurricane Mitch, specific attempts had been made to enhance community participation through decentralization. A strong response had been received from both the people of Honduras and from such organizations as PAHO, WHO, and other friendly institutions and governments which had provided support. Currently under development was a strategy on mental health in disaster situations.

Gender issues figured largely in the efforts being made to bring about change in the country. Many women had been participating, particularly young single mothers from rural areas who were suffering mental disorders. In that connection, much had been done to enact laws against family violence and a special national institute for women's issues had been established. The Ministry of Health had devised a national sexual and reproductive health programme, and work was proceeding on a special law on HIV/AIDS. Destructive as it had been, Hurricane Mitch had strengthened the unity of the people of Honduras and had provided an incentive to confront mental health problems.

Professor AHYI (Benin) observed that his country, like many others, had been slow in responding to mental illadies, in part because of the belief, common in Africa, that they could be treated by traditional medicine. The recognition that many conditions did not respond to such treatment had forced a new approach and helped to raise mental health to one of the six top health priorities for Benin. With support from WHO the country had begun cooperation with Ghana and Mozambique on issues of health promotion, but that concept had rapidly led to issues of well-being and quality of life. A small national coordinating team had soon discovered that “health problems” were viewed in a prejudicial light, there being a major general confusion about illness and health: as soon as one talked about health promotion, that raised images of illness. Similarly, health centres and dispensaries were seen as focused on disease rather than on health. A conclusion was that, in Benin, the training of health care workers needed to be revised to correct those misperceptions. In the past two years there had been a move to educate the public at community level, for example by encouraging communication between generations. For instance, in one village a bench had been
placed by a communal path, enabling older people to come out of their homes and be more integrated into community life. People stopped and talked, and perceptions and attitudes soon changed.

With regard to medicines, even generic drugs were rare in Benin. Moreover, those psychotropic drugs that featured on the essential drugs list were not ordered because the population was poor and the demand for such drugs was considered to be small. Further, the Bamako Initiative encouraged cost recovery. After the introduction of the health promotion policy, there had been a reduction in the number of patients and the rate of cost recovery had also declined. A contradiction became apparent: people preferred to have more patients so that there would be sufficient funds to maintain the existing system of health rather than reducing the number of patients. Health promotion had meant social mobilization in order to reduce costs. A further important point was the culture of health, not disease—and mental health was a case in point. The conclusion reached was that there was no development without health and no health without mental health. Mental health was the portal of entry for the development of developing countries. With democratization came decentralization, but that had posed various problems. For example, social mobilization had resulted in the multiplication of demands for the expansion of services based on the successes of pilot projects with the incorporation of mental health into primary health care.

Dr CUENTAS-YÁÑEZ (Bolivia) observed that mental health programmes, whether against familial violence or alcoholism or for the administration of psychiatric hospitals, were based on a predominantly clinical vision. He advocated a more cultural approach to mental health, and recalled that Bolivia had been part of the Inca empire. At that time, some 400 years ago, itinerant “doctors” (cayaguayos) had dispensed basic mental health care. He argued that every mental health programme should take cognizance of the cultural heritage as well as of the epidemiological profile and the impact of poverty. The prevalence and incidence of mental illnesses were known to be associated with social groups; alcoholism was closely linked with intrafamilial violence, both of which were synonymous with the mechanisms of desperation during economic difficulties. Culture differentiated mental health from other health programmes, and people’s perceptions and cultural background needed to be accommodated.

Dr ANANE (Ghana) welcomed the choice of mental health as the theme for World Health Day 2001. In Ghana mental ill-health was typically regarded as aggressive or strange behaviour; general society did not consider the milder but distressing forms such as depression and anxiety as mental disorders. Mental health programmes had begun in 1888, with the enactment of the Lunatic Asylum Ordinance. That Act had been improved in 1972 with a mental health decree, followed by upgrading of facilities, strengthening of personnel and an expansion of institutional care, with a decentralization policy leading to the setting up of mental health units in general hospitals. However, progress in that area had slowed sharply with the economic decline in recent years. Owing to financial constraints, institutions were not giving the required attention to the subject, professional development programmes were constrained and many trained staff were lured abroad to better paid jobs—the proportion had reached 30% of mental health care providers, nurses in particular, in the previous year. Currently, the country had one psychiatrist for 1.5 million population. Low pay and the stigmatization associated with mental illness did not encourage recruitment. Although the Ministry of Health had implemented a motivational programme for all health professionals, that step had been limited by financial constraints and offset by the increasing incidence of mental illness, especially depression, which might underlie the fatalism engendered by spreading poverty. Ghana therefore supported the view that coordinated global efforts to mitigate the ravages of poverty would be a major step to counter mental illness.

Ghana had set its priorities. The Government’s mental health policies stressed decentralization of mental health services, not only through the establishment of units in tertiary and regional hospitals but also through the integration of mental health into primary health care. Also, even with the current meagre resources, model programmes for training of both medical and non-medical staff in prevention, identification and treatment of mental disorders had been drawn up. Major focuses were
attitudinal change, particularly for senior health workers and policy-makers, and the need to ensure that all health professionals were knowledgeable about mental health. Finally, the focus should be on a biophysical model for mental health care, which recognized the biological, psychological and social roots of mental disorders. A purely medical approach would be bound to fail; a sector-wide approach including communities was needed for effective care. Prevention must be seen to be as important for mental health as for general health. Effective communication, including parenting skills, crisis management and the use of non-professionals in the community would be vital for prevention of mental health problems. Since 1978 Ghana had had a three-monthly training programme for community psychiatric nurses, who were subsequently placed in all districts.

He noted that gender issues might often be seen as mental health problems. Societal attitudes about expected gender roles, including the childbearing role of women, often caused intense stress: female infertility was an instance. As in other countries, more women reported depression than men.

In order to achieve success, mental health workers were needed to take the lead, but they were in short supply. He urged support for disadvantaged countries in training and retaining personnel.

Dr URBANEJA-DURANT (Venezuela) reported her country's experience in carrying out extensive political and institutional changes that had enabled progress by ensuring that universal rights such as the right to health were met. That right must include the right to mental health, and health must be seen as an integral part of well-being and development. Obstacles to those goals were often related to poverty and inequality. Venezuela had worked out three strategies to try to overcome those obstacles: incorporating guarantees for rights in the country's constitution; ensuring application of the constitutional provisions through governmental policies; and health system reform.

Venezuela's constitution enshrined health as a basic right, without any discrimination on grounds such as mental ability or gender. It included respect for diversity and differences between individuals, which demanded a major change in attitudes.

Promoting health was essential for guaranteeing overall rights. That meant intersectoral approaches, improved access to more effective and appropriate services, tackling discrimination, and provision of decent living conditions for health. Gender differences were recognized, for instance in access to health services, discrimination and quality of life. The National Women's Institute had designed specific policies and strategies together with national plans in that regard. A council for the protection of children and young people had been established to ensure shelter, proper nutrition and feeding, and access to education, especially for street children. For disabled people there was a national committee for disabled persons and legislation for improved protection was being enacted. Steps were being taken to improve the living conditions for indigenous people whose rights were guaranteed in the constitution. Laws were in place to guarantee individual rights in times of emergency and disasters.

Her country had changed its model of health care, emphasizing health, rather than disease, as the starting point. Prevention and health promotion formed critical strategic elements for health care workers; they needed to understand that in integrated health care, health must be promoted in places regularly frequented by people, such as schools, sports venues, and outpatient clinics. In parallel, the profile of a health worker was being changed in favour of that integrated health care approach. That would help to remove the stigmas that blocked access to the mental health care which people needed; otherwise mental health problems and stigmatization would be exacerbated.

Specifically with regard to psychiatric care, she said that she was convinced of the need to care for both acute and chronic cases, with involvement not only of patients but also of their families and communities. That would ensure proper treatment, both in hospitals and in communities, with rapid reintegration into society.

Dr KOVAC (Yugoslavia) said that in the past 10 years the population of his country had experienced the traumas of war, sanctions, and consequent impoverishment. That had occurred at both
family and community levels, and materially as well as spiritually, through the collapse of traditional social and cultural values, and the loss of hope. Mental health was impaired as never before. The incidence of classical mental disorders had increased, as had conditions such as post-traumatic stress syndrome, anxiety, neurosis, substance misuse and marked depressions with psychosomatic symptoms. Those were reactive pathologies to which people were not susceptible in normal conditions. The consequences were increased social pathologies, evidenced as greater delinquency, crime and violence. The presence of large numbers of refugees, with associated mental disorders, posed an additional problem. Children, many orphaned or living in collective centres, constituted the most vulnerable population. Some had experienced traumas at an early age.

The past 12 months had seen considerable improvement in mental health. The Ministry of Health and Social Policy was finalizing a multidisciplinary project to reduce and eliminate suffering and to facilitate treatment. The support of WHO in those efforts would be welcomed.

Ms ABDALLAH (United Republic of Tanzania) observed that some 85% of the population of her country lived in rural areas where there were practically no mental health services apart from traditional healers. In most cases mental illness was associated with curses or supernatural causes. Her Government had developed a mental health policy, but traditional practices still needed to be integrated into modern medicine. She requested assistance from WHO in that area.

Specific causes of mental disorders in her country included the rapid breakdown of traditional psychological support systems and social norms, poverty and rural-urban migration in the absence of social skills and strategies to adapt. A second cause was the long-term presence of refugees, whose settlements were breeding grounds for mental disorders. In surrounding areas there had been increases in crime, resulting in insecurity among the indigenous population. Mental health services thus needed to serve local populations as well as refugees.

Mrs CABA (Dominican Republic) described how the traditional barriers to improving mental health in her country, such as attitudes of health workers and managers towards people with mental disorders, remained unchanged. The formulation of mental health services was thus restricted, particularly in general hospitals. Integration of mental health into primary health care needed money and time, the high cost of drugs forming part of the problem. As part of health sector reform, the Government was working on a subsystem of mental health care with community and nongovernmental organizations in order to strengthen the provision of services at different levels.

The theme of World Health Day 2001 had provided a unique opportunity to enlist allies in the process of improving mental health care. A campaign had been launched to strengthen the human rights of people with mental disorders, and to try to improve the way they were treated. Its targets included people in the business sector and the workplace, where issues such as alcohol abuse and stress needed to be addressed. In addition her country was working to improve its present inadequate system of monitoring and record-keeping. Coverage of primary mental health care needed to be improved, too. Although for some 22 years there had been good results with community-based mental health care, the network was concentrated in the capital. Crisis care centres were urgently needed in hospitals, but that development had been thwarted by the resistance of health care personnel, often hospital administrators. The lack of a crisis intervention unit for children and young people presented a serious gap in the system. Rehabilitation and social reinsertion programmes were also needed.

With regard to gender issues, progress had been made through work with nongovernmental organizations, other ministries such as those for women's affairs, the judiciary, and in particular the police. Campaigns had been run on prevention of and dealing with violence in the family, and "solidarity networks" for women had been established throughout the capital and in some other cities. The Government was trying to re-educate health personnel to have a more positive attitude to mental health care. In the education sector, considerable support in the early detection of the effects of domestic violence came from teachers. The current focus was on violence against women, children and young people, together with ensuring routine screening for risk factors of domestic violence. Refuges for the victims of such violence were planned.
Mr CHUA Jui Meng (Malaysia) recounted a visit to a mental institution that had a clock tower with no clock; that had brought to his mind the thought that, on entering the place, there was no time, no reality and, for many inmates, no hope – they had been marginalized and stigmatized by society and, worst of all, by their own families. For the whole of the previous year, the Government had run a healthy lifestyle campaign in the mass media on the theme of mental health, including prevention. He echoed the description by the delegate of Trinidad and Tobago of the mass media as allies; every year, Malaysia, had given awards to journalists for the best writing on HIV/AIDS, as well as to the newspapers they worked for. As poor or unbalanced reporting about mental health issues could spark fear and discrimination, he proposed that similar awards be given to the journalists and the mass media that projected a more positive picture of what mental illness meant; that would be a start.

Mrs KIMTO (Chad) recalled that her country had suffered many years of civil war. Added to that was a difficult economic situation and the fact that health coverage reached only 11% of the population. The need for mental health care was enormous, for instance, for children, people with HIV/AIDS, war widows, alcoholics, prisoners and refugees. Furthermore, mental disorders were traditionally considered as deriving from evil spirits or curses. At the time of independence in 1970 the country had had one asylum in the capital, where patients were shut away and made the objects of curiosity and mockery. The building had been destroyed in the civil war. Currently the psychiatric unit of the main national hospital acted as a referral centre and provided an open service with care and treatment. The Government accorded mental health a top priority. The national programme of mental health had organized a consensus workshop in 1999 which had helped to identify the current situation, priority areas, strategies, interventions, funding and the main actors. To achieve social mobilization in favour of mental health issues, the Ministry of Public Health had involved traditional and religious authorities in the programme. The number of associations concerned with mental health had grown and were linked in a network. Every year a mental health day was celebrated on 10 October in order to mobilize public opinion and to raise awareness of the need to prioritize mental health, particularly as Chad was in a post-war situation. WHO's World Health Day offered a good opportunity to undertake additional activities, for instance in communities and schools, including the use of mass media. A community, multidisciplinary approach was considered to be the most logical. Within the ministry an intersectoral, interministerial committee for mental health had been created, charged with the task of creating a coordinated mental health programme covering care, social reinsertion, awareness and information, and advocacy at the highest levels. The major role of traditional medicine in Chad justified cooperation with relevant structures and bodies.

Legislation enacted on mental health had been effective, but practical difficulties remained. Qualified staff, psychotropic drugs, infrastructure and funds were all lacking. The Government aimed to strengthen the national programmes for the promotion of mental health, to formulate a national plan for the distribution of drugs and to create referral centres. A new centre was being built in N'Djamena. The Government was also integrating mental health into the health activities of district health authorities.

Dr SALIOU DIALLO (Guinea) said that his country had earlier introduced a mental health policy and programme with a strategy of decentralizing all the health structures that would facilitate referrals. That meant the integration of mental health into the basic minimum package of health activities, particularly in primary health care. That required changes in attitude and culture with regard to mental disorders by decision-makers, health care personnel and the general population, with promotion of healthy lifestyles. Unfortunately many obstacles were being met, such as the great gap between supply and demand, the paucity of trained staff, the high cost of drugs, the civil disturbances in Liberia and Sierra Leone with the resulting influx of refugees and incursion of rebels, all on top of poverty and exclusion. With a calming of tensions and the implementation of decentralization, Guinea looked forward to an improved situation.
Dr WINAI WIRIYAKITJAR (Thailand) remarked that his country had experienced two major crises in the past decade: HIV/AIDS and the economic recession. There was an increasing number of mental health problems, including suicide: the annual rate had increased from 7.2 to 8.6 per 100 000 population over the past five years. The Government had tried not to cut health expenditure but to use the economic crisis as an opportunity to review its health strategies.

The World Health Day theme and related activities showed that discrimination and access to mental health care were major concerns in most countries. Thailand's experience with psychotropic drugs was that side-effects increased stigmatization and reduced compliance. Newer drugs had fewer side-effects but were more expensive. For that reason he proposed that access to such drugs should be given high priority in the WHO medicines strategy. Also, he wanted WHO to consider recommending that Member States ensure that such drugs were appropriately represented on essential drug lists. He concluded by expressing the hope that the output of the round tables would be more than a report; he expected a concrete result that would improve mental health and alleviate the suffering of those with mental disorders.

The CHAIRMAN, after an exchange of courtesies, closed the meeting.

The meeting rose at 12:40.

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For the report of the Chairman to the Health Assembly, see document WHA54/2001/REC/2, ninth meeting.
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 WHA54/2001/REC/1. The verbatim records of plenary meetings at which these reports were approved are reproduced in document WHA54/2001/REC/2.

COMMITTEE ON CREDENTIALS

First report

[A54/42 – 15 May 2001]

The Committee on Credentials met on 15 May 2001. Delegates of the following Member States were present: Austria, Bangladesh, Bosnia and Herzegovina, Liberia, Libyan Arab Jamahiriya, Luxembourg, Malaysia, Mozambique, Paraguay, Uganda.

The Committee elected the following officers: Dr A.S.M. Mushior Rahman (Bangladesh) – Chairman; Mrs A. Schleder-Leuck (Luxembourg) – Vice-Chairman; Dr N.S. Bartee (Liberia) – 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 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 World 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 World Health Assembly that the delegates of these Member States be provisionally seated with all rights in the Assembly pending the arrival of their formal credentials: Afghanistan, Albania, Azerbaijan, Bangladesh, Belize, Benin, Comoros, Congo, Cyprus, Djibouti, India, Italy, Jordan, Malawi, Malaysia, Mauritania, Monaco, Nicaragua, Nigeria, Portugal, Saint Lucia, Senegal, Sierra Leone, Slovenia, Solomon Islands, Spain, Syrian Arab Republic, The former Yugoslav Republic of Macedonia, Trinidad and Tobago, Vanuatu.

States whose credential it was recommended should be recognized as valid (see fourth paragraph above)

Algeria, Andorra, Angola, Argentina, Armenia, Australia, Austria, Bahamas, Bahrain, Barbados, Belarus, Belgium, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Cape Verde, Central African Republic, Chad, Chile, China, Colombia, Cook Islands, Costa Rica, Côte d’Ivoire, Croatia, Cuba,

1 Approved by the Health Assembly at its fourth plenary meeting.
Czech Republic, Democratic People’s Republic of Korea, Democratic Republic of the Congo, Denmark, Dominica, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, Finland, France, Gabon, Gambia, Georgia, Germany, Ghana, Greece, Grenada, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, Hungary, Iceland, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Israel, Jamaica, Japan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People’s Democratic Republic, Latvia, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Maldives, Mali, Malta, Mauritius, Mexico, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Netherlands, New Zealand, Niger, Norway, Oman, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Samoa, San Marino, Sao Tome and Principe, Saudi Arabia, Seychelles, Singapore, Slovakia, Somalia, South Africa, Sri Lanka, Sudan, Swaziland, Sweden, Switzerland, Thailand, Togo, Tonga, Tunisia, Turkey, Tuvalu, Uganda, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Uruguay, Uzbekistan, Venezuela, Viet Nam, Yemen, Yugoslav, Zambia, Zimbabwe.

Second report

[A54/47 – 18 May 2001]

On 18 May 2001, 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 World Health Assembly pending the arrival of their formal credentials: Albania, Azerbaijan, Bangladesh, Belize, Benin, Comoros, Cyprus, Djibouti, India, Italy, Jordan, Malawi, Malaysia, Mauritania, Monaco, Nicaragua, Nigeria, Portugal, Saint Lucia, Senegal, Sierra Leone, Slovenia, Spain, Syrian Arab Republic, The former Yugoslav Republic of Macedonia, Vanuatu.

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 World Health Assembly recognize their validity.

COMMITTEE ON NOMINATIONS

First report

[A54/39 – 14 May 2001]

The Committee on Nominations, consisting of delegates of the following Member States: Argentina, Belize, Chad, China, Costa Rica, Croatia, Democratic People’s Republic of Korea, Ecuador, Eritrea, France, Gambia, Guinea, Israel, Jordan, Malta, Nepal, Nigeria, Papua New Guinea, Qatar, Russian Federation, Sudan, United Kingdom of Great Britain and Northern Ireland, Vanuatu, Venezuela, and Dr Libertina Amathila, Namibia (ex officio), met on 14 May 2001.

1 Approved by the Health Assembly at its eighth plenary meeting.
2 Approved by the Health Assembly at its first plenary meeting.
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 Hong Sun Huot (Cambodia) for the Office of President of the Fifty-fourth World Health Assembly.

Second report\(^1\)

\[\text{[A54/40 – 14 May 2001]}\]

At its first meeting held on 14 May 2001, the Committee on Nominations decided to propose to the Assembly, in accordance with Rule 25 of the Rules of Procedure of the World Health Assembly, the following nominations:

**Vice-Presidents of the Assembly:** Dr A.M. Kasi (Pakistan), Mrs M. Arguello (Nicaragua), Mr P.J.E. Tapsoba (Burkina Faso), Dr I.B. Zelenkevich (Belarus), Mr Ri Tcheul (Democratic People’s Republic of Korea);

**Committee A:** Chairman – Professor S.K. Ongeri (Kenya);

**Committee B:** Chairman – Mr D.Á. Gunnarsson (Iceland).

Concerning the members of the General Committee to be elected under Rule 31 of the Rules of Procedure of the Health Assembly, the Committee decided to nominate the delegates of the following 17 countries: Bahrain, Bhutan, Bolivia, China, Cuba, Democratic Republic of the Congo, Dominica, France, Guinea-Bissau, Iran (Islamic Republic of), Japan, Mali, Niger, Russian Federation, Sweden, United Kingdom of Great Britain and Northern Ireland, United States of America.

Third report\(^2\)

\[\text{[A54/41 – 14 May 2001]}\]

At its first meeting held on 14 May 2001, 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 M. Fikri (United Arab Emirates) and Dr C.T. Otto (Palau);
Rapporteur: Mrs L. Popescu (Romania);

**Committee B:** Vice-Chairmen: Dr M. Dahl-Regis (Bahamas) and Dr Pakdee Pothisiri (Thailand);
Rapporteur: Dr J.M. Kunene (Swaziland).

\(^1\) Approved by the Health Assembly at its first plenary meeting.

\(^2\) See summary records of the first meetings of Committees A and B (pp.11 and 161, respectively).
GENERAL COMMITTEE

Report¹

[A54/44 - 16 May 2001]

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting on 16 May 2001, the General Committee, in accordance with Rule 102 of the Rules of Procedures of the Health Assembly, drew up the following list of 12 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 12 Members to be entitled to designate a person to serve on the Executive Board: Colombia, Cuba, Egypt, Eritrea, Ethiopia, Grenada, Kazakhstan, Myanmar, Philippines, Republic of Korea, Saudi Arabia, United Kingdom of Great Britain and Northern Ireland.

In the General Committee's opinion, these 12 Members would provide, if elected, a balanced distribution on the Board as a whole.

COMMITTEE A

First report²

[A54/43 – 15 May 2001]

On the proposal of the Committee on Nominations,³ Dr M. Fikri (United Arab Emirates) and Dr C.T. Otto (Palau) were elected Vice-Chairmen, and Mrs L. Popescu (Romania), Rapporteur.

Committee A held its first meeting on 15 May 2001 under the chairmanship of Professor S.K. Ongeri (Kenya).

It was decided to recommend to the Fifty-fourth World Health Assembly the adoption of the resolution relating to the following agenda item:

12. Programme budget
   12.1 General programme of work [WHA54.1].

¹ See document WHA54/2001/REC/2, verbatim record of the seventh plenary meeting, section 1.
² Approved by the Health Assembly at its seventh plenary meeting.
³ See the third report of the Committee on Nominations, above.
Second report

[A54/45 – 17 May 2001]

Committee A held its second and third meetings on 16 May 2001 under the chairmanship of Professor S.K. Ongeri (Kenya).

It was decided to recommend to the Fifty-fourth World Health Assembly the adoption of the resolution relating to the following agenda item:

13. Technical and health matters
   13.1 Global strategy for infant and young child feeding
       Infant and young child nutrition [WHA54.2].

Third report

[A54/48 – 18 May 2001]

Committee A held its fourth and fifth meetings on 17 May 2001 under the chairmanship of Professor S.K. Ongeri (Kenya). During the fifth meeting Dr C.T. Otto (Palau) later took the chair. The six and seventh meetings were held on 18 May under the chairmanship of Professor S.K. Ongeri (Kenya) and Dr M. Fikri (United Arab Emirates).

It was decided to recommend to the Fifty-fourth World Health Assembly the adoption of two resolutions relating to the following agenda items:

13. Technical and health matters
   13.6 HIV/AIDS
       Scaling up the response to HIV/AIDS [WHA54.10]
   13.8 Revised drug strategy
       WHO medicines strategy [WHA54.11].

Fourth report

[A54/50 – 19 May 2001]

Committee A held its eighth meeting on 19 May 2001, under the chairmanship of Professor S.K. Ongeri (Kenya), Dr M. Fikri (United Arab Emirates) and Dr C.T. Otto (Palau).

It was decided to recommend to the Fifty-fourth World Health Assembly the adoption of three resolutions relating to the following agenda items:

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1 Approved by the Health Assembly at its seventh plenary meeting.
2 Approved by the Health Assembly at its eighth plenary meeting.
13. Technical and health matters
13.4 Strengthening health services delivery
   • Strengthening nursing and midwifery [WHA54.12]
   • Strengthening health systems in developing countries [WHA54.13]
13.3 Communicable diseases
   • Global health security: epidemic alert and response [WHA54.14].

Fifth report¹

[A54/51 – 21 May 2001]

Committee A held its ninth and tenth meetings on 21 May 2001. The ninth meeting was under the chairmanship of Professor S.K. Ongeri (Kenya), Dr M. Fikri (United Arab Emirates) and Dr C.T. Otto (Palau), and the tenth meeting was under the chairmanship of Professor S.K. Ongeri (Kenya).

It was decided to recommend to the Fifty-fourth World Health Assembly the adoption of three resolutions relating to the following agenda items:

13. Technical and health matters
13.3 Communicable diseases
   • Control of schistosomiasis
     Schistosomiasis and soil-transmitted helminth infections [WHA54.19]

12. Programme budget
12.2 Proposed programme budget for 2002-2003
   Proposed appropriation resolution for the financial period 2002-2003 [WHA54.20]

13. Technical and health matters
13.9 International Classification of Functioning, Disability and Health (ICIDH-2)
   International classification of functioning, disability and health
   [WHA54.21].

¹ Approved by the Health Assembly at its ninth plenary meeting.
COMMITTEE B

First report

[A54/46 – 18 May 2001]

On the proposal of the Committee on Nominations, Dr M. Dahl-Regis (Bahamas) and Dr Pakdee Pothisiri (Thailand) were elected Vice-Chairmen, and Dr J.M. Kunene (Swaziland), Rapporteur.

Committee B held its first, second and third meetings on 16 and 17 May 2001 under the chairmanship of Mr D.A. Gunnarsson (Iceland).

It was decided to recommend to the Fifty-fourth World Health Assembly the adoption of seven resolutions and one decision relating to the following agenda items:

16. Staffing matters
   16.2 Amendments to the Staff Regulations and Staff Rules
   Salaries of staff in ungraded posts and of the Director-General [WHA54.3]
   16.4 Appointment of representatives to the WHO Staff Pension Committee [WHA54(9)]

15. Financial matters
   15.1 Reports
       • Unaudited interim Financial report on the accounts of WHO for 2000 and comments thereon of the Administration, Budget and Finance Committee
       Unaudited interim financial report on the accounts of WHO for 2000 [WHA54.4]
   15.2 Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent that 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 [WHA54.5]
   15.3 Special arrangements for settlement of arrears [WHA54.6]
   15.4 Real Estate Fund [WHA54.7]
   15.5 Casual income [WHA54.8]
   15.6 Assessment of new Members and Associate Members
       Assessment of the Federal Republic of Yugoslavia [WHA54.9].

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1 Approved by the Health Assembly at its eighth plenary meeting.
2 See the third report of the Committee on Nominations, above.
Committee B held its fourth, fifth, sixth and seventh meetings on 18 and 21 May 2001 under the chairmanship of Mr D.A. Gunnarsson (Iceland) and Dr M. Dahl-Regis (Bahamas).

It was decided to recommend to the Fifty-fourth World Health Assembly the adoption of four resolutions relating to the following agenda items:

17. Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine [WHA54.15]

18. Collaboration within the United Nations system and with other intergovernmental organizations
   • International Decade of the World's Indigenous People [WHA54.16]

15. Financial matters
   15.7 Scale of assessments for 2002-2003
       Assessments for the financial period 2002-2003 [WHA54.17]

13. Technical and health matters
   13.5 Tobacco control
       • Other activities
           Transparency in tobacco control process [WHA54.18].

Committee B held its eighth meeting on 22 May 2001 under the chairmanship of Mr D. Á Gunnarsson (Iceland).

It was decided to recommend to the Fifty-fourth World Health Assembly the adoption of the resolution relating to the following agenda item:

Supplementary agenda item: Effective functioning of the governing bodies in WHO
   Reform of the Executive Board [WHA54.22].

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1 Approved by the Health Assembly at its eighth plenary meeting.
2 Approved by the Health Assembly at its ninth plenary meeting.