WHA48/1995/REC/3

WORLD HEALTH ORGANIZATION

FORTY-EIGHTH WORLD HEALTH ASSEMBLY

GENEVA, 1-12 MAY 1995

SUMMARY RECORDS AND REPORTS OF COMMITTEES

GENEVA
1995

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACC	-	Administrative Committee on Coordination
ACHR	-	Advisory Committee on Health Research
AGFUND	-	Arab Gulf Programme for United Nations Development Organizations
ASEAN	-	Association of South-East Asian Nations
CIDA	-	Canadian International Development Agency
CIOMS	-	Council for International Organizations of Medical Sciences
DANIDA	-	Danish International Development Agency
ECA	-	Economic Commission for Africa
ECE	-	Economic Commission for Europe
ECLAC	-	Economic Commission for Latin America and the Caribbean
ESCAP	-	Economic and Social Commission for Asia and the Pacific
ESCWA	-	Economic and Social Commission for Western Asia
FAO	-	Food and Agriculture Organization of the United Nations
FINNIDA	-	Finnish International Development Agency
IAEA	-	International Atomic Energy Agency
IARC	-	International Agency for Research on Cancer
ICAO	-	International Civil Aviation Organization
IFAD	-	International Fund for Agricultural Development
ILO	-	International Labour Organisation (Office)
IMO	-	International Maritime Organization
ITU	-	International Telecommunication Union
NORAD	-	Norwegian Agency for International Development
OAU	-	Organization of African Unity
OECD	-	Organisation for Economic Co-operation and Development
PAHO	-	Pan American Health Organization
SAREC	-	Swedish Agency for Research Cooperation with Developing Countries
SIDA	-	Swedish International Development Authority
UNCTAD	-	United Nations Conference on Trade and Development
UNDCP	-	United Nations International Drug Control Programme
UNDP	-	United Nations Development Programme
UNEP	-	United Nations Environment Programme
UNESCO	-	United Nations Educational, Scientific and Cultural Organization
UNFPA	-	United Nations Population Fund
UNHCR	-	Office of the United Nations High Commissioner for Refugees
UNICEF	-	United Nations Children's Fund
UNIDO	-	United Nations Industrial Development Organization
UNRWA	-	United Nations Relief and Works Agency for Palestine Refugees in the Near East
UNSCEAR	-	United Nations Scientific Committee on the Effects of Atomic Radiation
USAID	-	United States Agency for International Development
WFP	-	World Food Programme
WIPO	-	World Intellectual Property Organization
WMO	-	World Meteorological Organization

PREFACE

The Forty-eighth World Health Assembly was held at the Palais des Nations, Geneva, from 1 to 12 May 1995, in accordance with the decision of the Executive Board at its ninety-fourth session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

Resolutions and decisions,[1] annexes and list of participants - document WHA48/1995/REC/1

Verbatim records of plenary meetings - document WHA48/1995/REC/2

Summary records and reports of committees - document WHA48/1995/REC/3

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

CONTENTS

SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

COMMITTEE A

First meeting

Second meeting

Third meeting

Fourth meeting

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

Page

Eighth meeting

Ninth meeting

Tenth meeting

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

Page

Fifth meeting

Sixth meeting

Seventh meeting

Eighth meeting

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Dato Dr Haji Johar NOORDIN (Brunei Darussalam)

Vice-Presidents

Mr C. DABIRÉ (Burkina Faso)
Dr J. R. DE LA FUENTE RAMÍREZ (Mexico)
Dr A. MARANDI (Islamic Republic of Iran)
Mrs I. DROBYSHEVSKAYA (Belarus)
Mr THAN NYUNT (Myanmar)

Secretary

Dr H. NAKAJIMA, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Bahrain, Belize, Bulgaria, Comoros, Eritrea, Finland, Malta, Mauritania, Pakistan, Peru, Sri Lanka, and Tuvalu.

Chairman: Mr A. S. CHAUDHRY (Pakistan)
Vice-Chairman: Mr SENNAY KIFLEYESUS (Eritrea)
Rapporteur: Mr J. SORMUNEN (Finland)
Secretary: Mr T. S. R. TOPPING, Senior Legal Officer, Office of the Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Bhutan, Canada, Chad, Chile, China, Cook Islands, Cyprus, Democratic People's Republic of Korea, Djibouti, Ecuador, France, Ghana, Guinea, Jamaica, Lebanon, Namibia, New Zealand, Nicaragua, Qatar, Russian Federation, Sao Tome and Principe, Slovakia, South Africa, Turkey and United Kingdom of Great Britain and Northern Ireland.

Chairman: Dr P. PHILLIPS (Jamaica)
Secretary: Dr H. NAKAJIMA, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Bolivia, Botswana, China, Cuba, France, Indonesia, Japan, Kenya, Malawi, Morocco, Mozambique, Oman, Panama, Russian Federation, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, and United States of America.

Chairman: Dato Dr Haji Johar NOORDIN (Brunei Darussalam)
Secretary: Dr H. NAKAJIMA, Director-General

MAIN COMMITTEES

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

Committee A

Chairman: Dr Fatma H. MRISHO (United Republic of Tanzania)
Vice-Chairmen: Professor N. FIKRI BENBRAHIM (Morocco) and Dr E. NUKURO (Solomon Islands)
Rapporteur: Dr D. HANSEN-KOENIG (Luxembourg)
Secretary: Dr B.-I. THYLEFORS, Chief, Programme for the Prevention of Blindness

Committee B

Chairman: Professor A. WOJTCZAK (Poland)
Vice-Chairmen: Mr M. S. DAYAL (India) and Dr J. E. SAMOYOA (Honduras)
Rapporteur: Dr H. EL KALA (Egypt)
Secretary: Mr A. K. ASAMOAH, Chief, Administration and Staff Support Service

AGENDA[1]

PLENARY MEETINGS

1. Opening of the session
2. Appointment of the Committee on Credentials
3. Election of the Committee on Nominations
4. Election of the President and the five Vice-Presidents
5. Election of the Chairman of Committee A
6. Election of the Chairman of Committee B
7. Establishment of the General Committee
8. Adoption of the agenda and allocation of items to the main committees
9. Review and approval of the reports of the Executive Board on its ninety-fourth and ninety-fifth sessions
10. Review of *The world health report 1995* (incorporating the Director-General's report on the work of WHO)
11. [deleted]
12. Election of Members entitled to designate a person to serve on the Executive Board
13. Awards
    - 13.1 Léon Bernard Foundation Prize
    - 13.2 Dr A.T. Shousha Foundation Prize
    - 13.3 Jacques Parisot Foundation Medal
    - 13.4 Child Health Foundation Prize and Fellowship
    - 13.5 Sasakawa Health Prize
    - 13.6 Dr Comlan A.A. Quenum Prize for Public Health in Africa
    - 13.7 United Arab Emirates Health Foundation Prize

[1] The agenda was adopted at the third plenary meeting subject to a decision on the wording of item 31 which, as given here, was agreed at the eleventh plenary meeting.

14. Approval of reports of main committees

15. Closure of the Forty-eighth World Health Assembly

Supplementary agenda item 1: Transfer of Mongolia to the Western Pacific Region

COMMITTEE A

16. Election of Vice-Chairmen and Rapporteur

17. Monitoring of progress in implementation of strategies for health for all by the year 2000, third report

18. Proposed programme budget for the financial period 1996-1997

    18.1 Budgetary reform

    18.2 General review[1]

    18.3 Financial review

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

    Emergency and humanitarian action (resolution WHA46.6)

    Health and medical services in times of armed conflict (resolution WHA46.39)

    Intensified cooperation with countries in greatest need (resolutions WHA43.17, WHA44.24 and WHA46.30)

    World Declaration and Plan of Action on Nutrition (resolution WHA46.7)

    Tobacco or health (resolutions WHA43.16, WHA44.26 and WHA46.8)

    Maternal and child health and family planning: quality of care (resolution WHA47.9)

    International programme on chemical safety (resolutions WHA45.32 and WHA46.20)

    International programme to mitigate the health effects of the Chernobyl accident (resolution WHA44.36)

    Control of diarrhoeal diseases and acute respiratory infections: sick child initiative (resolutions WHA40.34 and WHA44.7)

    Global strategy for the prevention and control of AIDS[2] (resolutions WHA40.26, WHA41.24, WHA42.33, WHA42.34, WHA43.10 and WHA45.35)

[1] Appropriation section 6: Administrative Services referred to Committee B.

[2] Item referred to Committee B.

New, emerging, and re-emerging infectious diseases (resolutions WHA39.27, WHA44.8, WHA45.35, WHA46.6, WHA46.31, WHA46.32 and WHA46.36)

COMMITTEE B

20. Election of Vice-Chairmen and Rapporteur

21. Review of the financial position of the Organization

    21.1 Interim financial report on the accounts of WHO for 1994 and comments thereon of the Administration, Budget and Finance Committee

    21.2 Status of collection of assessed contributions and status of advances to the Working Capital Fund

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

    21.4 Arrears of contributions of South Africa

    21.5 Report on casual income

22. WHO response to global change

    22.1 Progress reports on implementation of recommendations

    22.2 Renewing the health-for-all strategy

    22.3 Technical discussions

23. External audit matters

    23.1 External audit report on the Regional Office for Africa

    23.2 Report on the implementation of the recommendations of the External Auditor

24. Appointment of External Auditor

25. [deleted]

26. Scale of assessments

    26.1 Assessment of new Members and Associate Members

    26.2 Scale of assessments for the financial period 1996-1997

27. Review of the Working Capital Fund

28. Real Estate Fund

LIST OF DOCUMENTS

Assembly documents[1]

A48/1 Rev.2	Agenda[2]
A48/2	Review and approval of the reports of the Executive Board on its ninety-fourth and ninety-fifth sessions
A48/3	World Health Report 1995: Summary
A48/4 and Corr.1	Monitoring of progress in implementation of strategies for health for all by the year 2000 (third report)
A48/5	Emergency and humanitarian action (report by the Director-General)[3]
A48/6	Health and medical services in times of armed conflict (report by the Director-General)
A48/7	Intensified cooperation with countries in greatest need (report by the Director-General)
A48/8	Progress in implementation of the World Declaration and Plan of Action for Nutrition (report by the Director-General)
A48/9	Tobacco or health (report by the Director-General)
A48/10	Maternal and child health and family planning: quality of care. Reproductive health: WHO's role in the global strategy (report by the Director-General)[4]
A48/11	International Programme on Chemical Safety (progress report by the Director-General)
A48/12	International Programme on the Health Effects of the Chernobyl Accident (report by the Director-General)
A48/13	Control of diarrhoeal diseases and acute respiratory infections: integrated management of the sick child (progress report by the Director-General)
A48/14	Implementation of the global AIDS strategy (report by the Director-General)
A48/15	Communicable disease prevention and control: new, emerging, and re-emerging infectious diseases (report by the Director-General)[5]

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

[2] See page xiii.

[3] See document WHA48/1995/REC/1, Annex 1.

[4] See document WHA48/1995/REC/1, Annex 2.

[5] See document WHA48/1995/REC/1, Annex 3.

A48/16	Budgetary reform (note by the Director-General)
A48/17 and Corr.1 and Corr.2	Report of the Executive Board to the World Health Assembly on the proposed programme budget for the financial period 1996-1997 and response by the Director-General
A48/17 Add.1	Proposed programme budget for the financial period 1996-1997 (report by the Director-General)
A48/18	Interim financial report for the year 1994
A48/18 Add.1	Interim financial report for the year 1994 - Annex: extrabudgetary resources for programme activities
A48/19	Status of collection of assessed contributions and status of advances to the Working Capital Fund (report by the Director-General)
A48/20	Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution (second report of the Administration, Budget and Finance Committee of the Executive Board to the Forty-eighth World Health Assembly)
A48/21 and Add.1	Arrears of contributions of South Africa (report by the Director-General)
A48/22	Report on casual income (report by the Director-General)
A48/23	WHO response to global change (progress report by the Director-General)
A48/24	Renewing the health-for-all strategy (report by the Director-General)
A48/25	Report of the External Auditor on the Regional Office for Africa
A48/26	Implementation of recommendations of the External Auditor (report by the Director-General)
A48/27 and Corr.1 and Corr.2	Appointment of an External Auditor (report by the Director-General)
A48/27 Add.1	Appointment of an External Auditor (report by the Director-General)
A48/28 and Corr.1	Scale of assessments for the financial period 1996-1997 (report by the Director-General)
A48/29	Real Estate Fund (report by the Director-General)[1]
A48/30	United Nations Joint Staff Pension Fund (annual report of the United Nations Joint Staff Pension Board)
A48/31	United Nations Joint Staff Pension Fund (appointment of representatives to the WHO Staff Pension Committee)

[1] See document WHA48/1995/REC/1, Annex 4.

A48/32	Agenda item 31
A48/33	Collaboration within the United Nations system and with other intergovernmental organizations - general matters (report by the Director-General)
A48/34 and Add.1	Joint United Nations Programme on AIDS (report by the Director-General)[1]
A48/35	Collaboration within the United Nations system: International Conference on Population and Development, 1994 (report by the Director-General)
A48/36	Collaboration within the United Nations system: World Summit for Social Development, 1995 (report by the Director-General)
A48/37	Women, health and development and Fourth World Conference on Women (Beijing, September 1995) (report by the Director-General)
A48/38	Collaboration within the United Nations system: health assistance to specific countries (report by the Director-General)
A48/39	External audit report on the Regional Office for Africa (report by the Director-General)
A48/40	Committee on Nominations: first report
A48/41	Committee on Nominations: second report
A48/42	Committee on Nominations: third report
A48/43	Interim financial report for the year 1994 (first report of the Administration, Budget and Finance Committee of the Executive Board to the Forty-eighth World Health Assembly)
A48/44	Real Estate Fund (third report of the Administration, Budget and Finance Committee of the Executive Board to the Forty-eighth World Health Assembly)
A48/45	Assignment of Mongolia to the Western Pacific Region
A48/46	Scale of assessments - Assessment of new Members and Associate Members: assessment of Palau (report by the Director-General)
A48/47	Committee on Credentials: first report
A48/48	First report of Committee B
A48/49	Report of Committee B to Committee A
A48/50	First report of Committee A
A48/51	Committee on Credentials: second report

[1] See document WHA48/1995/REC/1, Annex 5.

A48/52	Election of Members entitled to designate a person to serve on the Executive Board
A48/53	Second report of Committee B
A48/54	Third report of Committee B
A48/55	Second report of Committee A
A48/56	Third report of Committee A

Information documents[1]

A48/INF.DOC./1	Monitoring of progress in implementation of strategies for health for all by the year 2000 (summary of findings on indicators)
A48/INF.DOC./2	Community water supply and sanitation: needs, challenges and health objectives (report by the Director-General)
A48/INF.DOC./3	Health, environment and sustainable development: WHO's role as "task manager for health"
A48/INF.DOC./4	Agenda item 31
A48/INF.DOC./5 and Rev.1	Agenda item 31[2]
A48/INF.DOC./6 and Corr.1	Agenda item 31
A48/INF.DOC./7	Proposed programme budget for the financial period 1996-1997. Heading 2.4: WHO publications and documents
A48/INF.DOC./8	Amendments to the Statutes governing the foundations administered by WHO
A48/INF.DOC./9	Collaboration within the United Nations system: women, health and development and World Conference on Women
A48/INF.DOC./10	*The world health report 1995 - bridging the gaps*
A48/INF.DOC./11	Contributions of Members and Associate Members to the programme budget for the financial period 1996-1997

[1] Issued in English and French.

[2] Also available in Arabic.

SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

FIRST MEETING

Monday, 1 May 1995, at 17:20

Chairman: Dato Dr Haji Johar NOORDIN (Brunei Darussalam)
President of the Health Assembly

1. ADOPTION OF THE AGENDA AND ALLOCATION OF ITEMS TO THE MAIN COMMITTEES (Document A48/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 33 of the Rules of Procedure of the Health Assembly, its first task was to consider item 8 (Adoption of the agenda and allocation of items to the main committees) of the provisional agenda, which had been prepared by the Executive Board and issued as document A48/1.

Deletion of agenda items and allocation of remaining items

The CHAIRMAN indicated that, if there was no objection, two items on the provisional agenda should be deleted, namely item 11 (Admission of new Members and Associate Members) and item 25 (Supplementary budget for 1994-1995).

It was so agreed.

Noting that item 26.1 (Assessment of new Members and Associate Members) would be considered, the CHAIRMAN said that the words "if any" should be deleted.

He informed the Committee that, subsequent to a communication received from the Government of Mongolia, it was proposed to include a supplementary agenda item entitled "Transfer of Mongolia to the Western Pacific Region".

The delegate of the UNITED STATES OF AMERICA asked why the proposal to include a supplementary item on the agenda had not been submitted to the Executive Board for consideration at its ninety-fifth session.

The LEGAL COUNSEL replied that the request from the Government of Mongolia had arrived after the Executive Board session.

The delegate of CHINA endorsed the proposal to include the supplementary item on the agenda.

There being no objection, it was so agreed.

The delegate of the UNITED ARAB EMIRATES, referring to item 31 (Health assistance to the populations covered by resolution WHA47.30), proposed that the wording should be the same as that used

in previous years, namely "Health conditions of the Arab populations in the occupied Arab territories, including Palestine".

The delegates of MOROCCO, OMAN and CUBA seconded the proposal.

The delegate of the UNITED STATES OF AMERICA pointed out that the wording of item 31 conformed with the language of resolution WHA47.30 and had been approved by the Executive Board at its ninety-fifth session. Time should be devoted not to the wording of the agenda item, but to ways in which WHO could help to improve the health conditions of the Palestinian people, who had begun to take control of their own affairs. The Health Assembly should recognize that the peace process was advancing and tackle the substantive work needed rather than debate political issues. The United States could therefore not accept the proposal of the delegate of the United Arab Emirates.

The LEGAL COUNSEL explained that the Executive Board, as was its function in accordance with Rules 4 and 5 of the Rules of Procedure of the Health Assembly, had prepared the provisional agenda, bearing in mind paragraph 4(5) of resolution WHA47.30 which requested the Director-General "to report to the Forty-eighth World Health Assembly on the aspects of health assistance to the populations covered by this resolution". Of the two proposals for the wording of item 31 the Committee, in accordance with Rule 68 of the Rules of Procedure of the Health Assembly, should consider first the proposal, namely that of the United Arab Emirates, Morocco, Oman and Cuba, which was the furthest removed in substance from the proposal originally presented by the Executive Board.

The delegate of CUBA maintained that the Executive Board was not empowered to change the wording of an agenda item; that would be a violation of the sovereignty of the Health Assembly. The Executive Board proposed a provisional agenda precisely because the Health Assembly alone could decide on a change of wording.

The CHAIRMAN OF COMMITTEE B, in an attempt to reach a consensus, proposed that an asterisk should be added at the end of the agenda item, which would refer to a footnote specifying the title of resolution WHA47.30, namely "Health conditions of the Arab populations in the occupied Arab territories, including Palestine".

The delegate of FRANCE, seconded by the delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, endorsed the proposal of the Chairman of Committee B.

The REPRESENTATIVE OF THE EXECUTIVE BOARD explained that the Board, after lengthy deliberation and a vote, had agreed not to change the wording of item 31, leaving it to the Assembly to decide on its final formulation.

The delegate of the UNITED STATES OF AMERICA stated that, in order to reach a consensus, he could accept the proposal of the Chairman of Committee B.

The CHAIRMAN asked the Committee if it would accept the proposal of the Chairman of Committee B by consensus.

The delegate of the UNITED ARAB EMIRATES pointed out that his proposal was not a new one: he simply advocated a return to the wording of item 31 which had been used for twenty years. The wording of the provisional agenda did not take into account the situation of Arabs in the occupied territories, for there were Palestinian territories and other occupied Arab territories.

The delegate of OMAN proposed that the title of resolution WHA47.30 should appear in brackets at the end of item 31, instead of in a footnote indicated by an asterisk. The item would therefore read "Health assistance to the populations covered by resolution WHA47.30 (Health conditions of the Arab populations in the occupied Arab territories, including Palestine)".

The delegate of MOROCCO said that he did not understand why the title of resolution WHA47.30 should have been omitted from item 31 when that wording had been used for so long.

The delegate of ISRAEL, speaking as a non-member of the Committee at the invitation of the CHAIRMAN, informed the Committee of the background to negotiations on the formulation of resolution WHA47.30, the contents of which were authoritative; the wording of item 31 reflected accurately the language of that resolution. The United Arab Emirates had cosponsored resolution WHA47.30, from which it now dissociated itself, and was attempting to return to the politicization of the Assembly debates. Nonetheless, in a spirit of compromise, he would accept the proposal of the Chairman of Committee B.

The delegate of the ISLAMIC REPUBLIC OF IRAN said that, since there had been no change in the situation of the Arab populations in the occupied Arab territories, there was no reason to change the wording of the agenda item. The original wording should be retained as it was; that was the least the Health Assembly could do for the Palestinians.

The delegate of the UNITED STATES OF AMERICA reiterated his support for the proposal of the Chairman of Committee B, and opposed the proposal of the delegate of Oman.

The LEGAL COUNSEL recapitulated the four proposals before the Committee.

The observer for PALESTINE, speaking at the invitation of the CHAIRMAN, said that he would prefer the original wording of item 31, i.e. that of earlier years, to be retained. It was not pertinent to add either an asterisk with a footnote, or a text in brackets, because the title of the resolution had no political connotations. In order to advance in the peace process, progress had to be made in implementing resolution WHA47.30.

The CHAIRMAN proposed that the discussion on the wording of item 31 should be temporarily suspended in order to complete the rest of the Committee's work.

It was so agreed. (For resumption, see section 3 below.)

The CHAIRMAN observed that the Executive Board had allocated the items on the provisional agenda to Committee A and Committee B according to the terms of reference of those committees as laid down in Rule 34 of the Rules of Procedure and with a view to ensuring a balanced distribution of the work.

Referring to the agenda items to be considered in plenary session, namely items 1 to 15, he noted that the Health Assembly had already dealt with items 1 to 7 that afternoon. The Committee was at present dealing with item 8, on which he would transmit its recommendations to the plenary meeting the following morning. The remaining items (9 to 16) and the supplementary item would be examined in plenary session, as scheduled.

He took it that the Committee wished to recommend to the Health Assembly that it should accept the allocation of the other items to the main committees as set out in the provisional agenda.

The delegate of the UNITED STATES OF AMERICA noted that additional information had been requested on the proposals contained in the draft programme budget for the period 1996-1997 (document PB/96-97). However, the documentation provided to the Assembly did not provide an adequate breakdown of financing, and his delegation might move that the debate on item 18 (Proposed programme budget for the financial period 1996-1997) should be suspended until such time as it had received details. Considering that, the General Committee might have to be reconvened earlier to reallocate items from Committee B to Committee A.

The CHAIRMAN observed that his proposals were made on the understanding that certain items might subsequently be transferred from one committee to the other depending on their workload.

The Committee agreed to the allocation of items as set out in the provisional agenda.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The CHAIRMAN reminded the Committee that the Executive Board in decision EB95(16) had decided that the Forty-eighth World Health Assembly should close no later than Friday, 12 May, and drew attention to the preliminary timetable prepared by the Executive Board (document A48/GC/1). In the absence of any objections to the timetable, he concluded that the Committee approved it.

It was so agreed.

The General Committee then drew up the programme of work of the Assembly for Tuesday, 2 May, Wednesday, 3 May, Thursday, 4 May, Friday, 5 May and Saturday, 7 May.

Referring to the list of speakers for the debate on agenda items 9 and 10, the CHAIRMAN suggested that, in accordance with established procedure, the order of speakers on the list, which already contained 100 names, should be strictly followed, and that new names should be entered in the order in which they were received by the Assistant to the Secretary of the Assembly. The list of speakers would appear in the Journal. If the Committee had no objection, he would inform the Health Assembly of those arrangements at the plenary meeting the following morning.

It was so agreed.

The General Committee decided to meet next on Friday, 5 May at 17:10 in order to draw up the programme for the following week and the list for the annual election of Members entitled to designate a person to serve on the Executive Board.

3. ADOPTION OF THE AGENDA AND ALLOCATION OF ITEMS TO THE MAIN COMMITTEES (Document A48/1) (resumed)

After the CHAIRMAN had reopened the discussion of the wording of item 31, the delegate of OMAN announced that he withdrew his proposal.

The delegate of FRANCE suggested that the Committee could reach a consensus on the proposal of the Chairman of Committee B and thus avoid a vote on three successive proposals.

The delegate of CUBA, observing that item 31 was not scheduled for debate until Monday, 8 May, asked whether a decision on the wording of the agenda item could not be postponed until the next meeting of the Committee on Friday, 5 May, giving time for the Members involved to reach an agreement.

The delegate of the UNITED STATES OF AMERICA maintained that the matter should be decided at the present meeting. He supported the suggestion of the delegate of France that the Committee should try to reach consensus on the proposal of the Chairman of Committee B, which had seemed close before the discussion was suspended.

The delegate of the UNITED ARAB EMIRATES maintained his proposal.

The LEGAL COUNSEL, responding to the question of the delegate of Cuba, stressed that there was no precedent for such a course of action. It would create an exceptional situation because the Assembly was to adopt its complete agenda the following morning. However, it would be legally acceptable for the Committee to recommend that the Assembly should adopt the provisional agenda without deciding upon the title of item 31, provided that the wording of the item was formulated within the next few days and adopted by the Health Assembly before Committee B opened the debate on that matter.

The delegates of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND and the RUSSIAN FEDERATION supported the proposal of the delegate of Cuba.

The Committee recommended for adoption by the Health Assembly all the items of the provisional agenda with the exception of the title of item 31, upon which a decision would be taken at the next meeting of the General Committee.

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

The meeting rose at 18:50.

SECOND MEETING

Friday, 5 May 1995, at 17:20

Chairman: Dato Dr Haji Johar NOORDIN (Brunei Darussalam)
President of the Health Assembly

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

The CHAIRMAN reminded Members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and by Rule 102 of the Rules of Procedure of the Health Assembly. To help the General Committee in its task, three documents were before it: (1) a table, by Region, of Members of the Organization which were or had been entitled to designate persons to serve on the Executive Board; (2) a list indicating the present composition of the Executive Board by Region, on which were underlined the names of the 11 Members whose appointees' term of office would expire at the end of the Forty-eighth World Health Assembly and which had to be replaced, namely: for the African Region, Cameroon and Swaziland; for the Region of the Americas, Canada, Jamaica and Mexico; for the South-East Asia Region, Mongolia; for the European Region, Portugal and United Kingdom of Great Britain and Northern Ireland; for the Eastern Mediterranean Region, Qatar and Syrian Arab Republic; and for the Western Pacific Region, Japan, together with one vacancy by virtue of the ratification of Article 24 of the Constitution; and (3) 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 suggestions were made by the General Committee, he noted that the number of candidates was the same as the number of vacant seats on the Executive Board. He therefore presumed that the General Committee wished, as was allowed under Rule 80 of the Rules of Procedure, to proceed without taking a vote 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: Algeria, Argentina, Australia, Bahrain, Barbados, Bhutan, Brazil, Croatia, Egypt, Ireland, Republic of Korea, and Zimbabwe. The list would be transmitted to the Health Assembly at least 24 hours before it was due to meet to elect the Members.

It was so agreed.

2. ADOPTION OF THE AGENDA (Document A48/1) (continued from the first meeting)

After the CHAIRMAN had reopened the discussion on the wording of agenda item 31, the delegate of MOROCCO, seconded by the delegate of OMAN, proposed the following wording: "Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine". He noted that that proposal had obtained the support of all the parties involved.

The delegate of the UNITED STATES OF AMERICA, welcoming the proposal, said that the concerned delegations had agreed that the entire issue would be handled by consensus. The resolution to be adopted under item 31 would be based on the previous year's consensus text, and any change would also be agreed by consensus.

The delegate of the UNITED ARAB EMIRATES, associating himself with the previous speaker, invited the Committee to reach a unanimous agreement.

The delegate of FRANCE supported the proposal and emphasized the prevailing spirit of consensus.

The proposed wording for agenda item 31 was approved by acclamation.

3. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The General Committee heard reports from Dr MRISHO (United Republic of Tanzania), Chairman of Committee A, and Professor WOJTCZAK (Poland), Chairman of Committee B, on the progress of work in their committees.

The CHAIRMAN called attention to a proposed programme of meetings for the following week.

The delegate of MOROCCO proposed that on Wednesday, 10 May there should be no official meetings so that delegates could respect the *Eid al adha* religious holiday, celebrated throughout the Islamic world. The United Nations General Assembly had adopted a resolution along those lines, with which the United Nations office in Vienna, the Commission on Human Rights and the Committee on Disarmament had complied.

The LEGAL COUNSEL, noting that it was entirely for the Committee to decide on the Health Assembly's programme of work, observed that it was likely that additional meetings would be necessary if the Health Assembly was to close on Friday, 12 May, as scheduled.

The delegate of the UNITED ARAB EMIRATES drew attention to United Nations General Assembly resolution 49/221 on the calendar of conferences and meetings of the United Nations for 1995.

The CHAIRMAN proposed that the work scheduled for Wednesday, 10 May should be added to the programme for Thursday, 11 May.

The delegate of OMAN, supported by the delegate of MOROCCO, suggested that it might be better to distribute the work scheduled for Wednesday between Tuesday, 9 May and Thursday, 11 May.

The ASSISTANT DIRECTOR-GENERAL (Administration and Finance) indicated that there would be an additional cost, amounting to US$ 30 000, should it be necessary to hold a night meeting on Thursday, 11 May in order to conclude work in time for the closure.

The delegate of FRANCE said that the matter at issue had more than financial implications. A wider debate had opened up, which called for a substantive discussion. He suggested that the Executive Board

should decide on the principle of organizing work in the light of religious requirements, and should ascertain whether organizational requirements were compatible with respect for all beliefs, customs and religions.

The CHAIRMAN proposed that the General Committee should meet on Tuesday, 9 May, and that the work scheduled for Wednesday, 10 May should be redistributed between Tuesday, 9 May and Thursday, 11 May.

The delegate of OMAN suggested that the Committee should meet on Monday, 8 May in order to reallocate the work scheduled for Wednesday, 10 May to Tuesday, 9 May and Thursday, 11 May.

The DIRECTOR, CABINET OF THE DIRECTOR-GENERAL, suggested a programme of meetings for Saturday, 6 May, Monday, 8 May, Tuesday, 9 May, and Thursday, 11 May, observing Wednesday, 10 May as a religious holiday. If there were no objection, the next meeting of the General Committee would be held on Tuesday, 9 May. He stressed that it was essential to respect the scheduled timing for closure of the Assembly and to ensure a quorum for adoption of the appropriation resolution for the financial period 1996-1997. That might entail a night meeting on Thursday, 11 May.

There being no further comment, the General Committee agreed on the suggested programme of work.

The meeting rose at 18:10.

THIRD MEETING

Tuesday, 9 May 1995, at 17:55

Chairman: Dato Dr Haji Johar NOORDIN (Brunei Darussalam)
President of the Health Assembly

1. PROPOSED SUPPLEMENTARY AGENDA ITEM

The CHAIRMAN drew attention to a request from the Libyan Arab Jamahiriya that the Assembly should consider the subject of damage caused by mines. In view, however, of the heavy programme of work and the observance of Wednesday, 10 May as a religious holiday, it did not seem possible to add an item to the agenda at that time.

The delegate of the RUSSIAN FEDERATION, supported by the delegate of the UNITED ARAB EMIRATES, agreed that, although the matter was important, the timetable of the Assembly did not allow for a serious discussion. He suggested that, in accordance with established practice, the Executive Board should first consider the matter at its ninety-seventh session and make a recommendation for the Forty-ninth World Health Assembly.

The delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, supported by the delegate of the UNITED STATES OF AMERICA, agreed that it would not be practical to add such an agenda item at that late stage. Further, the debate was likely to be of a broad-ranging political nature, inappropriate for the Assembly. The matter could be more suitably addressed in such forums as the forthcoming conference of the United Nations Department of Humanitarian Affairs on the clearance of land mines. With regard to its request for technical cooperation, the Libyan Arab Jamahiriya should discuss its requirements directly with the Director-General and his staff.

The CHAIRMAN concluded that the subject would not be taken up at the current Assembly and would be discussed at another time.

It was so agreed.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

After the Committee had heard the reports of Dr MRISHO (United Republic of Tanzania), Chairman of Committee A, and Professor WOJTCZAK (Poland), Chairman of Committee B, on the progress of the work of those committees, the CHAIRMAN proposed that the following matters should be transferred from Committee A to Committee B: under agenda item 18.2 (Proposed programme budget for the financial period 1996-1997: General review), two draft resolutions entitled "Consolidating budgetary reform", and "Reorientation of allocations" and the discussion of Appropriation section 6 (Administrative services); and under agenda item 19 (Implementation of resolutions - Global strategy for the prevention and control of AIDS), the discussion of resolution EB95.R14. The Chairman of Committee B would decide on the order in which the items would be discussed.

It was so agreed.

The General Committee then approved the programme of meetings for the remainder of the Assembly, on the understanding that, if necessary, the President was authorized to reschedule meetings so that the Assembly would adjourn no later than Friday, 12 May, in the afternoon.

3. CLOSURE

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

The meeting rose at 18:20.

COMMITTEE A

FIRST MEETING

Tuesday, 2 May 1995, at 14:40

Chairman: Dr Fatma H. MRISHO (United Republic of Tanzania)

1. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 16 of the Agenda (Document A48/42)

The CHAIRMAN expressed gratitude for her election and welcomed those present, particularly the delegates of the new Member State, Palau, which had joined the Organization since the Forty-seventh World Health Assembly, thus becoming the 190th Member State of the Organization.

She then drew attention to the third report of the Committee on Nominations (document A48/42),[1] in which Professor N. Fikri Benbrahim (Morocco) and Dr E. Nukuro (Solomon Islands) were nominated as Vice-Chairmen and Dr D. Hansen-Koenig (Luxembourg) as Rapporteur.

Decision: Committee A elected Professor N. Fikri Benbrahim (Morocco) and Dr E. Nukuro (Solomon Islands) as Vice-Chairmen and Dr D. Hansen-Koenig (Luxembourg) as Rapporteur.

2. ORGANIZATION OF WORK

The CHAIRMAN suggested that the normal working hours should be from 9:00 to 12:30 and from 14:30 to 17:30.

It was so agreed.

3. MONITORING OF PROGRESS IN IMPLEMENTATION OF STRATEGIES FOR HEALTH FOR ALL BY THE YEAR 2000, THIRD REPORT: Item 17 of the Agenda (Documents A48/4 and Corr.1 and A48/INF.DOC./1)

Professor BERTAN (representative of the Executive Board) said that, on the basis of national and regional monitoring reports, the Director-General had prepared the third report on progress in implementation of strategies for health for all by the year 2000, which was submitted to the Health Assembly for its review and approval, in documents A48/4 and Corr.1. The coverage, values and trends of the global health-for-all indicators were presented separately in document A48/INF.DOC./1. The information collected had been extensively used in the preparation of *The world health report 1995*.

When reviewing the item, the Executive Board had noted the progress achieved during the period 1990-1993. Data reported by Member States on life expectancy, maternal mortality and the nutritional status of children at birth had shown encouraging results. However, there were considerable differences between regions and countries in trends in infant mortality and under-five mortality. Progress had been made in the

[1] See page 274.

control of leprosy, poliomyelitis, and dracunculiasis, but the resurgence of tuberculosis had become a major source of concern. Millions of deaths were still caused every year by preventable diseases, and the incidence of HIV infection and AIDS continued to increase.

Noting that only 69% of Member States, representing 86% of the world population, had reported on their findings in time for analysis, the Executive Board had urged Member States to make vigorous efforts to improve their response rate, especially as WHO was the only body in a position to carry out such monitoring effectively. National reports could be of use in deciding on priorities for health action and resource mobilization. Board members had also urged that the information collected should be widely disseminated. WHO should enhance its technical cooperation with certain countries in order to improve their information systems, as the validity of the data was sometimes uncertain, and should adopt measures to simplify monitoring procedures and tools.

In the light of the Executive Board's comments, the Director-General had revised the third report on monitoring and prepared a plan of action, presented in paragraph 315 of document A48/4, to strengthen monitoring and evaluation of progress towards health for all. She also drew attention to paragraph 314 of the report, in which the Health Assembly was invited to review Member States' needs, interests, constraints and priorities in monitoring and evaluating their progress in the implementation of their health-for-all strategies, as well as WHO's support to that process if needed.

Dr VIOLAKI-PARASKEVA (Greece) commended the high quality of the two documents under review. The monitoring exercise had provided an opportunity for countries to report on many aspects of health development. Life expectancy was increasing globally, but there were considerable disparities between countries and regions in infant mortality. Immunization-preventable diseases still caused two million deaths per year and the AIDS pandemic was spreading. Noncommunicable diseases caused 75% of deaths in developed countries and 40% in developing countries. Regarding health care delivery, the provision of social services had become one of the major responsibilities of the authorities in the developed countries, since access to such services strengthened a sense of security and confidence in the political establishment. An assessment of the differences in access to health care in different countries was called for. Referring to paragraphs 311 and 312 of document A48/4, she noted that many countries lacked a mechanism for periodic monitoring, as well as adequate health-for-all indicators.

The report revealed positive results in the implementation of primary health care, but Member States must continue to develop their health systems and make optimum use of available financial resources, focusing on primary health problems. Support to the least developed countries should be increased, with particular emphasis on the rational use of available resources and the mobilization of additional funds for strengthening health infrastructures from national, international and bilateral sources, as well as nongovernmental organizations. Better use should also be made of available WHO resources, and that implied increased coordination between programmes so as to avoid overlapping. Furthermore, a rational basis should be established for health policies and programme priorities and the provision of well-designed health services. Global monitoring should be strengthened and simplified, effective communication strategies and national indicators being used for resource allocation. While commending the efforts that had been made to collect monitoring reports from Member States, she considered that document A48/INF.DOC./1 should be regarded as a progress report presenting indicators rather than a collection of accurate values on which regional or global analysis could be based.

Dr KHOJA (Saudi Arabia) said that documents A48/3 and A48/4 contained much essential information deserving careful attention. However, certain health areas had not been taken sufficiently into account from the point of view of implementation and research. Insufficient data were provided on adolescent health although the subject was an important one, as could be seen from paragraphs 21-25 of document A48/3. Adolescence was a pivotal stage in human development when human needs were vital, and those needs were increasing globally. The preventive and psychological aspects of adolescent health were only briefly mentioned in the documents. Saudi Arabia attached great importance to those aspects and had recently set up a national committee for developing a national programme and manual on mental and psychological health in primary health care.

Although the indicators provided by WHO were satisfactory, account should also be taken of other diseases. In addition, there was the question of rehabilitation programmes. The possibility should be

considered of holding regional seminars to reach consensus on health-for-all strategies, as well as on the promotion of health development in areas such as life expectancy. A regional group of experts should be set up to consider possible further development of the strategy for achieving health for all by the year 2000.

Mr HIRAI (Japan) said that, if the health-for-all strategy was to be effectively implemented, a higher response rate from Member States would have to be achieved. He commended the WHO Secretariat for the efforts that it had made to collect the monitoring reports; without the valuable information they contained it would be difficult to assess the progress of the strategy. Although some countries saw a national report on monitoring as an administrative obligation imposed by WHO, he urged all Member States to make a concerted effort to improve the response rate.

Dr VAN ETTEN (Netherlands) welcomed the report on monitoring and the summary of findings on indicators. Despite the improvement in the health status of the world population, for which the report provided evidence, he was concerned that great differences in life expectancy, mortality and morbidity between rich and poor countries still remained. It was the responsibility of all Member States to ensure that such disparities should no longer exist.

The poor response from Member States to the request for national reports was disappointing, less than 70% of Member States having reported their findings in good time. Moreover, information useful for analysis and publication was available for only 17 of the 89 indicators. Questions might therefore be raised as to the reliability of the data. The monitoring process must be reviewed and its current deficiencies examined. One approach might be to develop simpler indicators and have fewer of them. Strengthening WHO's cooperation with other international organizations in collecting and analysing data might also prove helpful. A user-friendly publication on the progress made in implementation of the health-for-all strategy might be made available to the general public.

He sought clarification on the proposal to replace the three-year health-for-all monitoring cycle by a two-year cycle, since he could not see the advantages of such a change, which would also increase the workload.

Mrs OULTON (Canada) noted the progress made towards the health-for-all goal during the period 1991-1993 and favoured continued monitoring and evaluation of the strategy. Despite a poor response from some countries, particularly in the Americas and Europe, the overall analytical work was very good and the conclusions deserved close attention.

It was clearly time to review the health-for-all strategy. Data collected for monitoring purposes should be useful at country, regional and world level, but the regional information currently provided was of limited use to Member States. She hoped that process revisions would provide useful country-level information and combine monitoring and evaluation in a single exercise that would allow, during a two- to three-year period, a report to be made by WHO to Member States. In the intervening years, key thematic reports could be provided.

Dr VASSALLO (Malta) congratulated those who had compiled the report despite the problems encountered. It was disturbing that returns from countries had been fewer and slower to arrive than in previous exercises. Criticisms had also been made of regional offices that had passed on insufficiently processed information. The need to strengthen information systems in countries had been stressed even during the first monitoring exercise, and WHO had been urged to assist countries that needed help in that respect - a prerequisite for improving the quality and credibility of national reports and their contribution to the monitoring and evaluation processes.

Regional committees had been urged to ensure that regional health-for-all databases were adjusted to include at least the basic set of indicators presented in the WHO common framework. Further investigation was perhaps required to ascertain what was being done to remedy the underlying causes of under-reporting as well as the inadequate processing of information at regional level. It would also be useful to find out whether the problem of inadequate data processing was one shared by all regions, and its extent.

It was necessary to maintain an up-to-date and reliable global database on health for all. The European regional health-for-all database had proved invaluable to policy-makers in formulating national health policies and in monitoring Member States' individual and collective progress towards regional targets. His delegation

supported the plan of action to strengthen the monitoring and evaluation processes, but believed that matters would not improve significantly unless a more critical analysis was made of the reasons for the continuing problems in the collection and collation of data and remedial action taken. The credibility of future monitoring and evaluation reports depended on such action. Simplification of the monitoring process might be helpful. The proposed two-year cycle would be helpful, at least in some regions, only if data made available routinely were automatically processed by regional offices and an ad hoc evaluation was conducted every six years or at longer intervals.

Dr SATCHER (United States of America) commended the Organization on its work of compiling the report. His delegation recognized the difficulties encountered at reporting levels and supported efforts to bolster local reporting capacities. It shared the concern that the monitoring and evaluation process should not be viewed merely as an administrative exercise but serve as a managerial process for national health development. WHO's assistance was needed to strengthen national efforts to collect data and to report accurate and timely information. It could also play an important role in promoting the use of data for decision-making purposes.

He welcomed the plan to develop new indicators that would be more sensitive to progress, and recognized the need for corrective action in order to move more rapidly towards the achievement of goals. He supported the move from a three-year to a two-year reporting cycle.

Dr MEREDITH (United Kingdom of Great Britain and Northern Ireland) said that it was disappointing that the report was limited both in its coverage and in the range of indicators, and that analysis and presentation of essential information was possible for only 17 of the 89 indicators or subindicators. Nevertheless, it was important for an assessment of the global situation to be made so that geographical differences and long-term trends could be reviewed, problems and successes highlighted, and budgetary resources shifted and targeted at identified areas of need.

In the European Region, Member States' needs, interests, constraints and priorities had been subjected to thorough review in connection with planning to identify health indicators. The exercise had shown the need: to build on available data and indicators; to ensure that the data served the needs of individual Member States; to avoid duplication of work and the imposition of unnecessary burdens on Member States; to assess available options with due regard for the costs and benefits involved; to consolidate the work already being done by Member States and by relevant international organizations; to develop a staged approach to developments and, lastly, to include measuring exercises that identified health outcomes.

A smaller, more focused set of indicators for global monitoring, supplemented by further development of more locally relevant regional indicator sets might potentially be of greater use to Member States and therefore likely to secure better coverage and a better response by countries than the global database on health for all currently maintained at WHO. Steps had already been taken in the European Region to adjust its own health-for-all database to include at least the basic set of indicators for global monitoring in relation to data collection. He welcomed the plan of action outlined in paragraph 315 of document A48/4, commending in particular the suggestion that there should be liaison with other international agencies in order to improve WHO's capability to collect, validate and report information on progress towards health for all.

Mr ÖRTENDAHL (Sweden), voiced the views of the five Nordic countries (Denmark, Finland, Iceland, Norway and Sweden) on the interrelated issues of health-for-all monitoring, strategic development for health and the organizational development of WHO. Since 1981, health for all had been the leading strategy for health development, defining objectives but not modalities, while the basic implementation strategy had been that of primary health care as developed in the Declaration of Alma-Ata and subsequent pronouncements on health promotion. The results of the monitoring exercise indicated that the measures required to bring health to all by the year 2000 were not being applied: equity in health was far from being achieved within as well as between countries and continents. The correlation between primary health care as an implementation tool and positive health development remained weak. Indeed, the principles first set out at Alma-Ata had yet to be put into practice in many countries.

The world health report 1995 and the health-for-all monitoring exercise clarified the situation somewhat. They showed, for example, that the importance of the "gender perspective" on health was

sometimes still unrecognized, and that the vulnerability of economic development and the impact on health of migration caused by war, poverty and internal conflict had not been fully grasped and understood.

In 1981, when the Global Strategy for Health for All had been formulated, WHO had had few partners and little competition. Nevertheless, it had not been altogether successful in influencing the international community. The lack of transparency and governance in the United Nations system, and notably the duplication and even triplication of efforts, led to the loss of important financial and intellectual resources. Efforts by the Economic and Social Council to set the United Nations house in order were still far from completion. Moreover, WHO suffered from trying to be everything at once, and the result was a confusion about its operational, coordinating and normative roles that tended to discourage countries from investing financially in its activities.

The five Nordic countries were agreed that health for all could not be achieved without a renewed interest in implementation strategies, for which WHO should assume leading responsibility. The monitoring process and *The world health report 1995* gave ample evidence of that. Strong central leadership within the United Nations family could bring WHO to such a position, but effective coordination at the national level was also called for. The Nordic countries were active both at home and abroad in the programme evaluation process, with the revitalization of the health-for-all strategy as their objective. They hoped that Member States would be able to celebrate the fiftieth birthday of the Organization in the belief that it was indeed moving towards equity and solidarity in the realization of that goal.

Dr WIUM (Norway), speaking further on behalf of the Nordic countries, referred to the monitoring process as described in chapters 1 and 8 of the report, which they found to be an important document. WHO was the only United Nations body in a position to produce regular and comprehensive information on the world health situation. However, in order to measure progress it was essential that such information should be valid, reliable and comparable, which the report made it plain was not at present the case. In the third monitoring exercise the response rate and response quality had indeed been slower and lower than in previous exercises, a regrettable outcome that could be attributed to the large number of indicators involved and the imprecision of some of the questions. Moreover, even with the best will in the world it was not possible for all Member States to respond to the monitoring system in its present resource-consuming form. Only a handful of the health-for-all indicators were in fact comparable; much of the data collected in the report was useless for either national or international purposes. Note should be taken of a recommendation of the Regional Committee for Europe that the period between in-depth evaluations should be extended from three years to six, which would match the periodicity of the General Programme of Work. The recommendation further requested the Regional Director to pay special attention to relevance, quality and comparability of exchangeable data. It also acknowledged that other organizations in Europe had access to useful data and proposed the development of contacts with such organizations to avoid duplication of work.

In its currently constrained financial circumstances, WHO should not continue to collect poor-quality data; a renewal of the monitoring process was called for. The list of indicators should be radically revised and include sex-specific indicators, notably with regard to infant mortality, immunization coverage and tropical diseases. Data compiled by other agencies should also be utilized in the monitoring process; reporting on health development should not be based on a single source of data.

The Nordic countries particularly endorsed subparagraph (c) of the plan of action proposed in paragraph 315 of the report. It was also important that the monitoring process should identify responders and provide them with appropriate feedback so that they might appreciate the benefit to be gained from the exercise. WHO should consequently reduce in number and simplify the health indicators and, in collaboration with a number of carefully selected Member States, initiate a pilot project to select data of improved relevance, validity, quality and comparability.

Mr DEBRUS (Germany), noting that the monitoring report was based on replies received from 131 Member States, remarked that the data resulting from the monitoring procedure would be useful to individual countries in determining how their health indicators related to those of other countries, provided of course that the facts and data communicated to WHO were comparable, the survey methods employed homogeneous and the terms used defined according to uniform criteria - conditions not always easy to assess. Unfortunately, as pointed out in paragraph 311 of the report, many countries viewed the monitoring exercise as an administrative task imposed by WHO in a quest for information. In his view, the two main reasons

for that attitude were the enormous amount of data countries were expected to compile and the frequency with which reports had to be prepared. Indeed, the proposed change to biennial reporting would involve countries in additional expenditure and effort without any real gain in information, since modifications in public health systems and public health care were not rapid enough to register over such a short period. Curtailment of the reporting cycle was thus not a valid response to global change. It was encouraging that the Regional Committee for Europe had in fact decided to continue with the traditional three-year reporting cycle. Perception of the monitoring exercise as an administrative obligation imposed by WHO on Member States was an alarming sign of the loss of identification of some Member States with the Organization. The Health Assembly, in its consideration of the monitoring procedure, ought thus to consider how that identification might be restored, a development that would constitute an important step in the reform process.

Mr HALIM (Bangladesh), commended the report in document A48/4, which he thought clearly illustrated the deep divide between the health indicators for the least developed countries and those for the developed countries and gave an indication of the wider problems of the former. The least developed countries faced financial and technical constraints in furnishing their vast rural populations with adequate primary health care services; increased backing would thus be required from WHO and the donor community. Bangladesh, which was prone to natural disasters, was also concerned with emergency preparedness and relief management, a matter alluded to in paragraph 245 of the report. Steps had already been taken, with support and assistance from WHO and donor countries, to set up a centre for emergency preparedness and response. The idea of establishing a global database at WHO to measure progress in implementing the global strategy for health for all by the year 2000 and the Director-General's recommendations on the subject were welcome.

Dr CAI Jiming (China), welcoming the report, observed that the major political, economic and social changes which had occurred since the second monitoring exercise had had a negative impact on health services and health status in many countries, especially the least developed among them and those with economies in transition. Nevertheless, the health situation throughout the world was improving overall, although many inequalities between different countries and different regions in the financial and human resources available for health promotion were still apparent. At the turn of the century, WHO and its Member States would have to pay greater attention to ensuring equitable distribution of health resources, promoting individual health, and protecting the environment as a means of promoting health.

He shared the concern expressed by other speakers at the low level of participation in the monitoring exercise. The implication was that the monitoring systems of some Member States remained incomplete, and that a number of monitoring indicators remained intractable. China consequently endorsed the plan of action set out in the report and hoped that the Organization would provide Member States for which monitoring was a difficult task with assistance in training personnel, strengthening information networks and facilitating the exchange of experience at the regional and global levels.

It was also important, in the course of the health-for-all endeavour, to bear in mind the significance of traditional medicine and the reliance placed on traditional practitioners in many developing countries, and to ensure that traditional medicine occupied a meaningful place in health-for-all programmes.

Dr MILAN (Philippines) expressed concern that recourse to a common framework for monitoring progress in implementing health-for-all strategies had had little impact on some of the constraints under which countries laboured with regard to data collection, retrieval, reporting and processing, so that the analysis of findings and formulation of global profiles and trends were hampered. Her delegation firmly endorsed the recommendations contained in paragraph 314 of document A48/4.

The health expenditure gap between developed and developing countries should be considered not only with reference to a standard minimum desirable level - 5% of GNP - but also with due regard to the situations prevailing in individual countries. It might, for example, be the case that countries situated on the flat or even declining portion of the medical benefit curve would find further increases in health expenditure to be counterproductive, and conclude that it would be more judicious, especially when faced with dwindling resources, to divert available funds to other sectors, where they could have very positive, albeit indirect, effects on health.

More attention should be paid to the problems of undercoverage and underutilization. The challenge was to harmonize effective demand for and supply of health services, provided that the former was of the appropriate kind. The rationing of health care was on the face of it inconsistent with the principle of health for all, but it might become an unavoidable reality in the future. The ethical implications of using quality-adjusted or disability-adjusted life years to weigh the costs and benefits of health interventions continued to be controversial, and she suggested that consideration should be given to ways in which the Health Assembly and the Member States might address those implications, especially in relation to equity goals. She supported the plan of action outlined in paragraph 315 of the report before the Committee.

Professor LE VAN TRUYEN (Viet Nam) said that the majority of people in his own and in many other developing countries still relied principally on indigenous traditional practitioners and local medicinal plants to meet their primary health care needs. It was thus important for the potential input and utilization of traditional medicine to be taken into account in the implementation of health-for-all strategies.

Dr PAVLOV (Russian Federation) remarked that WHO had taken on a very complex but important task in monitoring progress in implementation of health-for-all strategies. The information presented in document A48/4 enabled Member States to evaluate the complex demographic, socioeconomic and health care circumstances prevailing in various regions of the world, with a view to formulating their own health protection policies and raising the health status of their own people.

Unfortunately, not all indicators had been fully worked out so as to embrace all facets of the activity of States, governments and health bodies; more work needed to be done. Many countries had either not submitted the information required for the third report, or had provided data on only a limited number of indicators. Consideration should be given, when compiling the fourth report, to restriction to the most important indicators or coverage of the maximum number. He asked what would be the relative costs and benefits of those monitoring options to the Organization and the Member States. Such matters were all covered in the programme budget, but it would have been helpful if they had been presented in the report itself. Thought had to be given to future monitoring reports and their frequency.

He had noted with concern that, while many countries had achieved some success as measured against their health indicators, in others the findings had deteriorated, largely owing to strains on financial, material and human resources and to inadequate and ineffective use of technology. A closer look must be taken at the health care reform process in the economically developed countries, as well as in countries with economies in transition and developing countries. Section 6.1 of the report referred to "health sector reform" without providing data on strengthening reforms by means of legislation; it would be extremely useful for all Member States to exchange experience in that area.

Finally, he expressed appreciation of the report and suggested that the Health Assembly should reaffirm the need to create a global health-for-all database, taking full account of the observations made during the discussion.

Dr ADAMS (Australia) congratulated those producing the report, but expressed disappointment at the relatively poor response to the call for data. The collection effort must be intensified, and undertaken in a more focused manner. Some countries had found it difficult to provide the required information, and he expressed support for the suggestion by the delegate of Norway that there should be fewer indicators and more specific goals and targets. Future reports might present the data in graphic form clearly showing what progress had been made in attaining the key goals and targets that constituted health for all. Australia endorsed the recommendation, included in the plan of action set out in paragraph 315 of the document, that a revised list of indicators should be submitted for approval by the Executive Board at its ninety-seventh session in January 1996 as a step towards simplifying the global monitoring and evaluation process.

Dr GEORGE (Gambia) agreed that the report was a very important tool for monitoring progress towards health for all, but questioned the practicality of gathering data for 89 indicators. He was concerned at the gaps between countries and between regions, and considered that attention should be focused on a small number of indicators that would furnish information regarding the quality of services provided. Coverage indicators by themselves had serious limitations, because even where coverage was reported to be high the system might not be achieving what was expected of it because of a lack of equipment or supplies or

inadequate performance by health workers. He would like to see indicators that highlighted the availability of such key inputs.

He noted the high rate of immunization coverage, but also the fact that some regions still suffered from epidemics such as measles. Indicators were needed that would provide information on the correct administration of immunizations provided. He expressed support for the monitoring process and called for a trimmer and more efficient framework.

Dr DRISSI (Morocco) commended the report, but added that the indicators did not permit assessment of the impact of health care within the health-for-all strategy on the improvement of countries' health status. That was because they concentrated on morbidity and mortality figures and paid insufficient attention to such determinants of health as access to information, social services and basic health infrastructure. The indicators also did nothing to facilitate explanation of the health-for-all strategy to the population of a country. If it was to succeed, the strategy must enjoy general support, and for that to be secured the progress achieved had to be explained to people in a simple and clear fashion. Reports should be more accessible to the lay reader, and should feature in general publications. Another method of securing people's support would be by responding to their expressed need for greater access to high-quality curative and diagnostic services, which had thitherto been somewhat neglected in the health-for-all strategy.

Dr RAI (Indonesia) also praised the report but suggested that a section should be added to indicate how far the world was from achieving the target of health for all by the year 2000. If it could be clearly shown which countries were lagging behind, global efforts could be better targeted. In considering the proposed programme budget for the financial period 1996-1997, the Health Assembly should carefully inquire whether the findings set out in the report had been reflected in the budget allocations.

Dr AL-JABER (Qatar) voiced apprehension concerning the value of the statistical information relating to regions: different standards of health care implementation could exist in different countries of the same region. Specifically, in the Eastern Mediterranean Region, there were major differences in infant mortality rates. While hoping it would be possible to find a way of helping individual countries that lagged behind, he called for statistical representations that reflected regional realities more clearly, including comparisons between groups of countries. He noted that the report before the Committee contained no reference to health policies for youth or for the handicapped, and hoped that the omission would be rectified.

Dr KHOJA (Saudi Arabia) said that the report contained some very valuable and precise information that merited careful study. He stressed that in some cases, those in charge of health care needed re-training, which would require considerable efforts on the part of WHO. School and university curricula ought also to be amended to reflect achievements in the domain of primary health care. There were financial problems, too: insufficient resources went hand in hand with substantial waste. Programmes were not always adequately implemented, and case studies on the application of modern technology should be undertaken. The qualitative aspect also required closer scrutiny, i.e. greater accuracy in following up the implementation of health strategies up to the year 2000 and beyond, taking into account both recent developments and past criticism. It was important to show what had been learnt over the past ten years and the improvements which had taken place during that time.

Dr ABU BAKAR Dato' SULEIMAN (Malaysia) commented on the difficulties faced by many countries in making their reports on the monitoring process. In view of the importance of that process, he supported the appeal to countries to work harder to submit timely returns, as well as to integrate the monitoring mechanisms proposed by WHO into the framework of the managerial process for health development at the national level. Bearing such difficulties in mind, he doubted the utility of reducing the current health-for-all monitoring cycle from three to two years. However, he supported the plan of action proposed in paragraph 315 of the report before the Committee.

Professor LEOWSKI (Poland), commending the report's candid discussion of monitoring difficulties, pointed out that the summary of findings on indicators (document A48/INF.DOC./1) showed that with regard to at least two basic indicators, namely life expectancy at birth and infant mortality, the situation had

worsened in recent years. Surprisingly, that had occurred not in the least developed countries, but in the group of countries with economies in transition. He felt that a three-year decrease in life expectancy over a period of three or four years was a dramatic finding which ought to be taken extremely seriously, as it could well be evidence of an emergency.

He supported proposals made by previous speakers, in particular the delegates of Germany and Norway, to revise the list of indicators and simplify the monitoring and evaluation process.

Professor GRANGAUD (Algeria) remarked that the crux of the problem was to reach agreement on the choice of correct indicators, since the epidemiological situation varied from one country to another. Algeria had seen a resurgence of diphtheria, notwithstanding the fact that most infants had been vaccinated. The classical indicators would not have enabled the experts to forecast that the affected group would be older children and young adults, who had failed to come for booster shots.

Professor BERTAN (representative of the Executive Board) singled out two points that had been stressed by the Executive Board during its discussion of monitoring. In the Board's view, WHO should undertake to review and simplify existing monitoring procedures and tools, as well as reducing the number of indicators, by furthering the collection of accurate information, which was crucial to the quality of those indicators. Every effort should also be made by governments and WHO to improve the surveillance system in the various countries.

Dr JARDEL (Assistant Director-General) welcomed the comments made, which would help WHO to improve monitoring and evaluation processes in future. A number of speakers had referred to the monitoring process per se: it had to be realized that that process covered a number of cycles such as the General Programme of Work cycle every six years, the biennial budgetary cycle, the evaluation and monitoring cycle every two, three or six years, and the annual world health report, which should include the points emerging therefrom. It was accordingly necessary to be in a position to submit to the Executive Board a logical approach to monitoring and evaluation which would be consistent with those other ongoing processes and could be expressed in a plan of action enabling a decision to be reached on the form such evaluation should take.

Due note had been taken of a large number of suggestions on matters which had not been covered by the report or had been covered inadequately, such as the quality of care, the health of adolescents and the use of traditional care methods. An attempt would be made to integrate them into the evaluation process without increasing the number of indicators.

Concerning the collection and collating of information, various suggestions had been made in favour of reducing the number of indicators and improving their definition, although it was clear that that in itself was not sufficient. It would also be necessary to facilitate work at country level, in particular by assisting countries to improve their information systems and by setting up databases using information from different sources. A crucial question was frequency, i.e. a two-year or a three-year cycle; on that it did not seem that a consensus would be reached at the present time, but the implications would be studied with a view to submitting proposals to the Executive Board.

With regard to the analysis of information, he had noted the views expressed by various delegations and he thanked the delegate of Australia in particular for his proposal to provide a clearer picture of progress achieved by comparison with WHO targets.

Lastly, several comments had been made on the publication and use of such information, which would be the subject of recommendations to the Executive Board. In addition to its dissemination to a qualified public health audience, there was also room for its circulation to a wider general public through the media using *The world health report*. Countries' comments on that publication, particularly as to its usefulness, would be welcome, with a view to defining WHO's priorities more precisely. He hoped that it would be possible to improve the analysis of progress in the health-for-all programme and that sufficient - though necessarily modest - resources would be available. He was also hopeful that at its January 1996 session, the Board would be able to reach a decision on a new monitoring process that would satisfy the Health Assembly.

The meeting rose at 17:05.

SECOND MEETING

Wednesday, 3 May 1995, at 9:00

Chairman: Dr Fatma H. MRISHO (United Republic of Tanzania)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda

BUDGETARY REFORM: Item 18.1 of the Agenda (Resolution EB95.R4; Documents PB/96-97, A48/16, and A48/17 and Corr.1 and Corr.2)

The CHAIRMAN noted that the proposed programme budget for the financial period 1996-1997 was the first to be presented under the Ninth General Programme of Work and had been structured accordingly, with a new format.

Dr CHOLLAT-TRAQUET (Cabinet of the Director-General), commenting on a series of overhead projections, said that the presentation was intended to explain the guiding principles underlying the preparation of the new programme budget, summarizing the major innovations and demonstrating how resolution WHA46.35 on budgetary reform had been implemented. A document containing a printout of some of the overhead projections and a summary text would be circulated subsequently.

Three considerations had determined the policy basis for the preparation of the 1996-1997 programme budget, as of 1993: the orientation of the Ninth General Programme of Work with a view to meeting the prescribed targets, the recommendations of the Executive Board Working Group on the WHO Response to Global Change, and the provisions of resolution WHA46.35 on budgetary reform.

With regard to the implementation of resolution WHA46.35, emphasis had been laid on a clear, simple budget presentation and on channelling resources to the priorities outlined in the Ninth General Programme of Work, following the criteria adopted a number of years earlier by the Executive Board. The budgeting was based on the 1994-1995 figures in order to ensure, *inter alia*, better comparability between budgets.

According to the general principles applied in WHO, programme budgeting started at country level, where priorities were identified through government/WHO mechanisms which selected activities in accordance with the country's needs. At the regional and intercountry levels, WHO's activities were selected to support cooperative activities in the various regions. At the interregional and global levels, priority activities encompassed global coordination, standard-setting and methodology, ensuring that the programme budget as a whole was in line with overall WHO policy as laid down in relevant resolutions and in the general programmes of work.

The preparation of the 1996-1997 programme budget had differed from that of preceding ones in that it had taken place against a background of new developments: the restructuring of the Organization's programmes to strengthen priority areas and identify areas of lesser urgency so as to free resources; the implementation of the recommendations on global change and related reforms, which had progressed more rapidly than had been foreseen; and the funding crisis caused by the increase in Member States' requests combined with zero budget growth.

Regarding format and the conformity of the proposed programme budget with resolution WHA46.35, the presentation was clearer and simpler and the document was half the size of previous programme budgets. It was easier to read, because the text was more concise and substantive, making for easier analysis. Finally, the work planned was presented in the form of expected results, which was a first step towards evaluation. The budgetary tables were also more concise and simple and more conducive to comparison and to strategic programme budgeting, as the Board itself had recognized.

In compliance with a very important provision (paragraph 2(b)) of resolution WHA46.35 requesting a significant reduction in the "lead time" between the beginning of preparation of the programme budget and its approval, and because of the difficulty of shortening the lead time in view of the time needed for consideration of the regional programme budgets by the Regional Committees and the dates of the Executive Board and the Health Assembly, a strategic approach to the budgeting of WHO activities had been proposed, allowing for the elaboration of detailed plans of action nearer the date of implementation of the various activities. The strategic approach comprised four major features. First, programmes had been regrouped under 19 headings; secondly, activities were presented in the form of expected results; thirdly, projected trends for 1998-2001 were listed opposite the proposed activities for 1996-1997; and finally, a detailed plan of action would be developed for each of the expected "outputs", making it possible to determine and specify the use of finances and staff. The detailed action plans would be developed between October and December of the year preceding budget implementation, would serve as a basis for evaluation, and would establish a direct link between the evaluation of the implementation of WHO activities and the financial report - an extremely important innovation.

Pursuant to paragraph 2(c) of resolution WHA46.35, the policy orientation and strategic priorities were summarized at the beginning of each of the six chapters of the programme budget. In order to respond to paragraph 2(e) of the resolution, and reallocate human and financial resources to reflect the priorities, the shifts of regular budget resources resulting from the restructuring and prioritization process were summarized in the grey boxes presented at the beginning of each chapter. To give a better picture of the financial situation affecting the implementation of WHO programme activities, each budgetary table was followed by additional information on trends in extrabudgetary resources and availability and/or support from other sources such as nongovernmental or other organizations.

To respond to paragraph 2(d) of the resolution and establish realistic and measurable targets in accordance with each health priority established, targets from the Ninth General Programme of Work, as well as the specific targets of certain programmes, had been identified for each of the 19 headings. Global targets were therefore given in the programme budget document, whereas regional targets were to be found in the regional programme budgets. However, as the achievement of targets did not always depend on WHO's action alone but sometimes on other organizations and, in particular, on national authorities, WHO's role in the implementation of the programme was clearly specified.

Regarding the important question of evaluation, paragraph 2(f) of resolution WHA46.35 requested that the improved budget and accounting system should establish a process of regular evaluation of progress towards the agreed targets. The budget alone could not fulfil that requirement and a specific system was being set up for the purpose. However, the document summarized the existing mechanisms and the main achievements of programmes under each of the headings.

One of the major innovations of the programme budget was that it had been presented in draft form, first to the Executive Board and currently to the Health Assembly. The Board, after reviewing the draft, had adopted resolution EB95.R4, endorsing the concept of strategic budgeting and requesting the Director-General to "shift" an additional 5% - over and above the 5% already transferred - of the regular budget from areas of lesser urgency to specific priority headings identified by the Board. The priorities identified by the Board had significantly altered the shift in resources, but it was interesting to note the overall consistency between them and the priorities already identified by the Director-General.

In considering the proposed programme budget for the financial period 1996-1997, the Health Assembly would consequently be required to consult the draft programme budget presented to the Executive Board in January 1995 (document PB/96-97) together with document A48/17, Part I of which contained the report of the Board, Part II the report of the Director-General in response to resolution EB95.R4, Part III amended budgetary tables, Part IV, updated in document A48/17 Add.1, proposed cost increases and currency adjustments, and Part V matters for the particular attention of the Health Assembly. The annexes to document A48/17 contained an annotated list of the new programme budget headings, amendments to the text of the programme budget, and a subject index. The proposed programme budget would no doubt be further modified in the light of discussions at the current Health Assembly, and the approved programme budget for 1996-1997 would be available during the summer of 1995.

Considerable efforts were required to carry out the budgetary reform exercise in so short a time. The Director-General had made some suggestions in document A48/17 on the role the Programme Development Committee and the Executive Board could play in preparing for the reforms.

Mr AITKEN (Assistant Director-General) said that the second part of the presentation could be described as a statistical breakdown of the process just explained.

A first chart represented the approved regular budgets for 1994-1995 of organizations in the United Nations system, since WHO's budget process must be seen as part of the wider United Nations budgeting system. It could be seen that WHO, with an approved regular budget of US$ 822 million, accounted for the second largest share of the "pie". Since all agencies in the system had been subject to the "zero real growth" policy, it would be appreciated that, although the figures might change over the years, the proportions would remain roughly the same.

The next chart illustrated extrabudgetary funding for the United Nations system in 1992-1993. WFP had the greatest amount of extrabudgetary funds of all the programmes in the United Nations system; UNHCR and UNICEF also had large extrabudgetary resources. WFP and UNHCR were active predominantly in emergencies, and the chart reflected the increasing role of the United Nations in such situations. Further, neither the first nor the second chart included funds to support the peace-keeping activities of the United Nations. WHO spent 5% of the extrabudgetary funding of the United Nations system. The first chart showed that the regular budget of the United Nations system was US$ 5.8 billion per biennium, the second showed that extrabudgetary funding accounted for 2.5 times as much. A third chart showed the combined contributions of regular and extrabudgetary (or voluntary) funding; the latter predominated as, of the six largest organizations (the United Nations, WFP, UNHCR, UNICEF, UNDP and WHO) only two (the United Nations and WHO) had any regular budget funding. In WHO, regular-budget and extrabudgetary funding were in some cases linked, as had been noted by the Executive Board.

The fourth chart showed the percentage of the 1996-1997 budget that was allocated to each of the 19 headings in the proposed programme. The six appropriation sections in which the 19 headings were grouped were identified. The governing bodies accounted for about 2% of the budget. Appropriation section 2, Health policy and management, covering four headings, represented the largest segment of the regular budget, and within that section national health policies and programme development and management accounted for 11.4%. Appropriation section 3, Health services development, comprised the headings primary health care (which accounted for 8.7% of the budget), human resources, essential drugs and quality of care; the four headings together accounted for 20% of the budget. The next group of four headings made up Appropriation section 4, Promotion and protection of health, and represented 16% of the budget. Three headings made up Appropriation section 5, Integrated control of disease, including 5.2% of the budget allotted to control of communicable diseases, for a total of 11.9%. The final section, Appropriation section 6, Administrative services, represented 16% of the regular budget. The chart showed clearly the distribution of the budget among the 19 headings and the balance among them; the same data were shown in statistical terms in Table 2 of document A48/17. The reduction to 19 headings, in contrast to the large number of programmes listed previously, had been particularly useful in discussions of changes in priorities.

The next chart showed extrabudgetary funding. It was dominated by the heading "Control of communicable diseases", which, it was estimated, would receive 41% of all extrabudgetary funding. The Global Programme on AIDS represented about 13% of that funding, but when the joint and cosponsored United Nations programme was established a new management structure would be introduced. Thus, communicable diseases other than AIDS represented only about 28% of extrabudgetary funding. In a chart showing both regular and extrabudgetary funding for WHO, the control of communicable diseases was again seen to dominate. Family health was an example of a programme that was not particularly well funded from the regular budget but was increased markedly by extrabudgetary funding.

The next three charts illustrated other aspects of the apportionment of the budget. The first showed expenditure from the regular budget and extrabudgetary funding at the country, intercountry and regional, and global and interregional levels; extrabudgetary funding was accounted for primarily at the global and interregional level, although of course the activities were ultimately for individual countries. The second chart showed the share of the budget by region. About two-thirds of the WHO budget was spent at the regional level and about one-third at the global and interregional level. The pattern changed when extrabudgetary funding was considered. Extrabudgetary funding for the Region of the Americas included all the funding, regular and extrabudgetary, of PAHO. The final chart showed the breakdown of the regular budget by established posts at headquarters and in the regional offices and the posts of WHO Representatives (49%) and by other activities (51%). Those last could include short-term staffing and operations.

Dr KANKIENZA (representative of the Executive Board) said that, during its review of the proposed programme budget for the financial period 1996-1997, the Board had also considered a report by the Director-General which placed the general principles of programme budgeting and priority-setting adopted by the governing bodies of WHO in the context of the response to resolution WHA46.35 on budgetary reform and of the process of global change. The review had covered the basic policies of programme budgeting, the mechanisms set up to that end by resolutions of the Board, the Health Assembly and the regional committees, and the budgeting methods used in WHO at all levels. It emphasized the idea that priorities were established during the processes of policy-making, programming and budgeting.

The Board had also reviewed the comments of its Programme Development Committee and Administration, Budget and Finance Committee and reports by the Director-General on budgetary reform (document EB95/13) and programme support costs (document EB95/18). The Board had expressed its appreciation to the Director-General for having fulfilled the requirements of resolution WHA46.35 by preparing a clearer, simpler programme budget document; by shortening the time between preparation of the budget and its implementation, by developing plans of action closer to the time at which the programme was executed; by determining strategic and financial priorities within the agreed global objectives and reallocating human and financial resources to those priorities; by taking into consideration the common accounting standards for organizations within the United Nations system; and by giving the actual increases in costs during the previous complete financial period in comparison with those forecast. The Board had found that the content and format of the proposed programme budget and the computer-assisted presentations had greatly facilitated its work. The new programme budget was indeed revolutionary. It was a tool for implementing policy that set out expectations and trends and would assist the governing bodies in following policies on priorities and allocations, leaving management to the Director-General. It would also enable the Board to follow achievements and the outcomes of funding, to identify and eliminate obstacles to good performance and to question strategic approaches. The Board had endorsed the concept of strategic budgeting used in the 1996-1997 programme budget document and the regrouping of the budget under 19 headings.

The Board had requested the Director-General to consider whether at least an additional 5% of resources might be shifted from three areas of the proposed programme budget that were considered to be of lesser urgency - namely, the governing bodies, including documents and official records; procurement and overall staff costs; and administrative services - to five areas of priority identified by the Board: eradication of specific communicable diseases; prevention and control of specific communicable diseases; reproductive health, women's health and family health; promotion of primary health care and other areas that contributed to primary health care, such as essential drugs and vaccines and nutrition; and promotion of environmental health, especially community water supplies and sanitation.

The Board had recommended that in reallocating resources the Director-General should take into account: the needs of the least developed countries and of populations in greatest need; the burden and nature of diseases prevalent within Member States; the probable effect of allocation of additional resources to specific areas of work; and the existing ratio of regular to extrabudgetary funding for the areas of work in question.

He was pleased to note that the Board's recommendations were reflected in the Director-General's report to the Forty-eighth World Health Assembly, and Dr Chollat-Traquet had shown how that had been achieved.

Some members of the Board had expressed concern about the size of the proposed cost increase for the 1996-1997 biennium and about the concept of "biennialization". It had been requested that every effort should be made to reduce the cost increase to less than 10%. In its resolution EB95.R4 the Board had invited the Director-General to continue efforts to implement the remaining provisions of resolution WHA46.35 and, especially, to establish realistic, measurable targets in accordance with each health priority, to improve the evaluation of programmes on the basis of the agreed targets and results, and to reorient further resources in accordance with the priorities. It had requested the Director-General to report to the Executive Board at its ninety-seventh session in January 1996 on progress made, and had entrusted the follow-up of progress in the development and preparation of plans of action for the implementation of the 1996-1997 programme to its Programme Development Committee and Administration, Budget and Finance Committee.

Dr MUKHERJEE (India) commended the presentation but expressed concern about the number of changes proposed in order to reallocate 5% of the regular budget. The proposed programme budget for the

South-East Asia Region in 1996-1997 had been formulated after extensive consultation with national health administrators and had been reviewed by the Regional Committee in 1994. Programme allocations had been proposed at both country and intercountry level. Activities and specific components had been identified in 1995 during the elaboration of the annual plan of action for 1996. A working group comprising senior officers of the seven Member States had reviewed the health situation in the Region and had identified five areas on which the intercountry programme should focus: eradication of specific communicable diseases; prevention and control of specific communicable diseases; promotion of primary health care and areas related to primary health care; environmental health; and reproductive health, women's health and family health. Rapid and unplanned shifts in resource reallocation might jeopardize the continuity of WHO activities at country level. The difficulty could be resolved only by a closer dialogue, in order to set priorities, agree on specific targets for programmes, and ensure clearer output at the country, regional and global level. He therefore suggested that if changes were to be made they should be postponed until the regional committees had had time to consider them.

Dr EMIROĞLU (Turkey) thought that the content and format of the proposed programme budget would facilitate the work of the Committee. Regarding the proposed shift of at least an additional 5% of the regular budget resources from areas of less urgency to specific priorities, that relatively small amount should be devoted to specific areas of real priority, and preferably to less developed countries and populations in greatest need. The priorities of countries and regions differed, however. Dividing the money into small amounts and allocating them to several areas of equal priority would not result in large, effective changes. It would be preferable to select one or two areas, such as the eradication of specific communicable diseases, child health and vaccines, or reproductive and women's health.

Mrs PERLIN (Canada) commended the presentation of the proposed programme budget, which would help in digesting a very substantive document on a very complex subject.

In 1992, WHO had embarked on a process of global change to ensure that its leadership in world health continued into the twenty-first century. Health problems were changing, but not necessarily diminishing. New areas of concern were emerging, some diseases were re-emerging and the concept of health was broadening. It was therefore essential for WHO to establish clear objectives and priorities, to use its resources effectively and efficiently in achieving its objectives, to be accountable for results and to assess its activities continuously in the light of current circumstances. That was the meaning of strategic budgeting. She commended the Director-General on the considerable efforts made in adopting the new strategic approach in preparing the programme budget for 1996-1997 and expressed her full support.

A budget was not an end in itself, but a snapshot at one point in a dynamic process of programme planning, implementation and evaluation. The 1996-1997 programme budget was the culmination of an extensive consultation process at all levels and in all regions of WHO.

The initial presentation to the Executive Board in draft form was another important step in the process. The result of the Executive Board discussion was a consolidation of a shared set of broad priorities, the identification of criteria and priority areas deserving additional resources - and those where savings might be made - and a further shift in resources for consideration by the Health Assembly.

An important aspect of the strategic approach was continuous assessment of programme effectiveness in relation to stated priorities. Canada fully endorsed the approach taken in the document of setting clear and measurable objectives for the programmes and determining evaluation mechanisms to assess results.

The process involved a number of important principles which should be further developed and strengthened: the involvement of Member States and the Executive Board at early stages of the planning process; the identification of high and lower priorities for allocation of resources; flexibility to shift resources; efficiency and productivity gains in the areas of administrative support and services, resulting in reallocation to areas of greater need; and accountability for results on the part of programme managers through the setting of measurable objectives and provisions for evaluation.

Since programme budget preparation was a continuous and dynamic process involving priority-setting, programme planning and evaluation of results, she welcomed the ideas and proposals regarding preparation of the next biennial programme budget set out in document A48/17. Those proposals did however, highlight the importance of devising means to assess results against the stated objectives of the 1996-1997 programme

budget. She therefore requested, for comparison purposes, actual expenditure data for previous bienniums and forecast expenditures for the current biennium.

An assessment should be made of the process and mechanisms used in the preparation of the current programme budget with a view to identifying measures - or desired changes in the process - in order to improve the effectiveness of the strategic planning that was the foundation of any budget.

Canada and some other delegations would be proposing a resolution relating to the programme budget and covering a number of the points she had outlined.

Dr ONO (Japan) commended the Director-General on his efforts in preparing the proposed programme budget, which responded quite well to resolution WHA46.35 on budgetary reform. The new format of the programme budget, with its clear charts and tables and streamlined programme headings, was certainly more user-friendly than previous documents and would facilitate Health Assembly discussions, which should focus on policy issues. The new format of the appropriation sections helped draw attention to the total amount of proposed resources under each section and made for a better understanding of WHO's programme activities. The shift of 5% of budget resources to high priority areas, in accordance with resolution EB95.R4, had been accomplished with remarkable speed.

Dr KHOJA (Saudi Arabia) commended the Director-General on the proposed programme budget and welcomed the new orientations. He endorsed the criteria for choosing and setting the priorities for the Organization's activities set out in paragraph 9(b) of document A48/17.

From the technical rather than the accounting viewpoint, any working budget depended on what had been achieved in the past, together with an analysis of current problems and the means available for solving them. He would therefore like to have seen more coordination and harmony between the contents of documents A48/3 and A48/4, concerned respectively with *The world health report 1995* and the third report on monitoring of progress in implementation of strategies for health for all, and document A48/17, containing the Board's report on the programme budget and the Director-General's response. Monitoring was essential if the health and social problems of the majority of the Organization's regions were to be tackled effectively, and should therefore be a high priority in the budget.

With reference to paragraph 16 of document A48/17, he would have liked the priorities listed to include quality control of primary health care services, with supervision and evaluation on a scientific basis, and also, chronic and noncommunicable diseases such as hypertension, diabetes, asthma and cardiovascular diseases, which had become epidemic in some countries.

He expressed surprise at the reduction proposed for healthy behaviour and mental health (paragraph 17, item 4.2) since that area was of considerable importance. It was his understanding that the introduction of a mental health component into primary health care was one of the main objectives of WHO (as indicated in the *British Journal of General Practice*, 1995, 45, 211-215), and he hoped it could be translated into a programme with adequate funding.

Mr BOYER (United States of America) stressed his country's great interest in the reform, both in WHO and throughout the United Nations system, of the budgetary process, into which the insertion of more substance would be welcome. Since the Organization's aim was to improve health status, budget and programme goals should be expressed accordingly. The programme should be evaluated in terms of health "output" and improvement, not simply in relation to programme "inputs". It was the overall result of the process that was important.

The new-format programme budget (document PB/96-97), distributed initially to the Executive Board in January, was a great improvement over previous programme budget documents and formed a sound basis for further improvement. It was a good start, but he stressed that it was still only transitional, on the way to a much ameliorated budgetary process.

While he agreed with previous speakers that the format had been simplified, he did not find the document user-friendly, for it did not contain enough detail on planned spending. Since, for example, the programme budget lines had been condensed from 59 to 19, it was not possible to tell what details were included under those 19 headings or how the current budget related to the preceding ones. It was essential for the governing bodies to know precisely the proposed expenditure in such areas as AIDS, tuberculosis, malaria, substance abuse, the Health Assembly, and the Director-General's Development Programme if

increases or decreases were to be made, yet that information could not be found in the document. Moreover, its presentation was unequal; it was almost impossible to tell how much was proposed for some important programmes, while more details of spending were provided on relatively small ones.

Another problem was the apparent shifting of programmes from one category to another since the previous biennium. For example, Appropriation section 2, a very large category containing almost one third of the budget, embraced such disparate elements as "programmatic" expenses; the cost of senior management; the direction of the Organization, including the preparation of the budget; and infrastructure, including a new computer system. The lack of transparency made it difficult for members of the governing bodies to understand what was in the document.

He agreed with Canada that it was important to be able to compare proposed programme budget figures not only with previous budgets but also with actual expenditure for previous bienniums. It was relatively meaningless to compare a budget for the future with figures that had not been implemented.

Ms PETERSSON (Sweden), speaking on behalf of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), warmly commended the Director-General on the proposed programme budget, which was simpler, easier to understand and more clearly set out than in the past. At the ninety-fifth session of the Executive Board it had shown its worth as a vehicle for setting priorities as resources were reallocated from administrative costs to high priority areas. The scope for reallocating resources should be greater still in the discussion on the budget for the 1998-1999 period.

A strategic budget was a prerequisite for the future of the Organization. WHO could continue to be the world's leading health agency only if its decision-making was transparent and open, and if Member States could exert their due influence. The decision-making process should respond to new health needs and allow flexibility and reallocation of financial and human resources. The proposed programme budget for 1996-1997 was an important step in the right direction.

The success of a programme budget could not, however, be judged before it was implemented and the results followed up and evaluated. The Nordic countries believed that the 1996-1997 budget had to be backed up by changes within the Organization. Increased efficiency at global, regional and country levels could not be achieved without the skill and willingness to minimize overhead costs and move towards an integrated and flexible organization allowing for the full use of the creativity and skills of the staff. WHO should be able to deliver focused responses to priority needs, not by creating new programmes but through strategic activities in fewer programmes. To avoid duplication of work and increase efficiency, the division of labour within the Organization had to be plain and visible for all Member States. The Organization must have a clear mission, well-defined responsibilities and a high degree of accountability.

All possible efforts should be made to implement the remaining provisions of resolution WHA46.35 on budgetary reform. WHO urgently needed an improved programme evaluation based on agreed targets and results for its activities. Noting that the Nordic countries still lacked information on the staff situation and the shift between personnel and other costs, she requested a clear presentation of the changes.

More than 50% of WHO's expenditure was funded from extrabudgetary resources. In some programmes the regular budget accounted for an even smaller part of the total funds, making the programmes very dependent on a few donor countries. Cuts in extrabudgetary grants from those countries might jeopardize the implementation of programmes of high priority. A fair balance should be sought between the regular budget and extrabudgetary resources and a common framework should be developed for planning and decision-making on priorities and programmes.

The question of how to offset cost increases was of major concern to the Nordic countries. Resources were scarce worldwide. Cost increases had to be met by increased productivity, better use of available resources and, if necessary, adjustment of priorities. The current Health Assembly must find a solution that took due account of the financial constraints facing many countries and that was also fair with respect to other major international organizations. A consensus had to be reached on how to compensate for cost increases; in the view of the Nordic countries, the amount for doing so proposed by the Director-General was still too high.

Mr DEBRUS (Germany) thanked the Director-General for the proposed programme budget document, which had been sent to Member States in good time and contained many improvements. It had, however, at least two disadvantages compared with the old format. First, the previous programme budget (for 1994-

1995) had broken down proposed expenditure into such categories as salaries, official travel, contractual services, general operating expenses, and supplies and materials, making it possible to compare, for example, the amount spent on salaries with that spent on programme activities. With the new format, such comparisons were not possible.

Secondly, the statements in each of the six appropriation sections were worded with such a lack of specificity that it was no longer possible to determine the amount to be allocated to any individual programme and thus to infer the technical or political priority accorded to it. In the past, the proposed programme budget had indicated the proportion of resources allocated to any individual programme in relation to the global budget.

He would welcome the views of other delegations on the points he had raised.

Dr PAVLOV (Russian Federation) welcomed the new format of the proposed programme budget, which reflected WHO's strategic planning. WHO had adopted a number of resolutions on the establishment of priorities for its future work and ways of increasing the involvement of Member States and regional organizations. He felt that the procedures for establishing those priorities required further improvement; perhaps bodies such as the new Standing Committee of the Regional Committee for Europe could provide suggestions.

The Organization should continue to observe a number of basic principles, including a commitment to reviewing its priorities regularly, reducing administrative costs and ensuring that its resources were disbursed more efficiently, which was particularly important at a time of zero-growth budgets. It was also important to continue the search for new and effective procedures for the development and monitoring of the programme budget at country, regional and global levels.

Dr VIOLAKI-PARASKEVA (Greece) commended the simple and clear presentation of data in the proposed programme budget and the earlier presentation. The proposed activities were consistent with the priorities and targets laid down in WHO's Ninth General Programme of Work. The new programme budget document was half the size of the previous one, and provided a clear and concise picture of WHO's planned expenditure. The fundamental changes in approach to the preparation of the programme budget had meant extra work, but the result presented relevant issues in a most helpful way.

While WHO's main priorities must reflect global needs, it was also important to consider regional priorities and the health problems faced by individual Member States. She also felt that the distribution of resources between headquarters and the regions should be reviewed, particularly in the European Region.

She noted with concern that the resources allocated to primary health care had apparently been reduced, which was surely incompatible with the urgency of the problems of primary health care infrastructure that many countries faced. She called upon the Director-General to ensure that all Member States were fully involved in the definition of programme activities at regional and global levels.

Mr DURAND-DROUHIN (France) said that the new format of the proposed programme budget was clearer and simpler and made the document a strategic tool for management and decision-making. His delegation also welcomed the adoption of the principle of reallocation of resources, which would allow WHO to deal with urgent problems that arose unexpectedly.

The budgetary reform process was going well, but a number of further changes were needed, some of which had been mentioned by Canada and the United States of America. There should be greater partnership and transparency in the preparation and implementation of the programme budget. In a number of areas, more information was needed than the new concise programme budget document provided. The restructuring of the Organization's activities under 19 headings had reduced the amount of information provided to Member States, so he hoped that they would be invited to participate in the preparation of the detailed plans of action for the programmes concerned, which he understood was due to take place in October-December 1995. In addition, the proportion of the regular budget made available for reallocation should be increased as quickly as possible, to as much as 10% of the total, in order to make the budget even more flexible. WHO should also try progressively to ensure that the reallocated funds were used as efficiently as possible. It had proved difficult at the January 1995 session of the Executive Board to establish priorities for the use of reallocated funds, given the diversity of problems facing the different regions and countries. There were, however, two essential criteria. First, the most pressing needs of the poorest countries should be given priority, by adopting

a combination of the vital programme-based approach with a regional or country-by-country approach. Secondly, it was essential to review the cost-effectiveness of the budgetary reforms - in other words, the incremental value of the reallocated resources.

A further point was that it would be essential to develop both quantitative and qualitative indicators which would allow the Organization to evaluate the results of its reform and reallocation efforts.

Finally, he was concerned to note the growing importance of extrabudgetary contributions for WHO's activities: the resulting imbalance in WHO's work threatened not only those programmes which depended largely on extrabudgetary resources but also the ability of the Organization to keep control over its own activities and carry out the tasks entrusted to it. Sooner or later, the issue would have to be resolved: perhaps the two new committees of the Executive Board, the Programme Development Committee and the Administration, Budget and Finance Committee, could consider the matter and make suggestions.

Dr DOFARA (Central African Republic) expressed support for the decision to shorten the Health Assembly in non-budget years. However, he was concerned about the reduction in the budget of the African Region in the areas of: National health policies and programmes development and management; Human resources for health; and General programme development and management. African countries were trying to improve their information systems, which would require skilled planning, and they would need WHO expertise if the progress made so far was not to be jeopardized.

Dr PHUNG DANG KHOA (Viet Nam) hoped that the reallocation of resources would adequately reflect the importance of traditional medicine (both drugs and methods of treatment) in the primary health care systems of many developing countries, including his own. Not only was traditional medicine highly effective and well accepted, meeting the needs of large sections of the population, but it was often all that developing countries could afford. He hoped that WHO would use some of the resources generated by the reallocation for the promotion of traditional medicine in national primary health care programmes.

Professor CALDEIRA DA SILVA (Portugal) congratulated the Director-General on the programme budget document which had been so ably introduced earlier in the meeting. The proposed shift in resources of 5% of the total budget would make the Organization's programme a much more realistic one. However, the document still did not place enough emphasis on areas which might be regarded as an investment for the future, such as health education, healthy behaviour and environmental issues. A programme budget drawn up according to the principles of strategic budgeting should surely emphasize programmes likely to yield sustainable results, rather than areas such as national health policies and programme development and management, which had been allocated almost 12% of the regular budget. He hoped that future programme budgets would adequately reflect that priority.

Mr CHAE Thae Sop (Democratic People's Republic of Korea) expressed high appreciation of WHO's efforts in presenting the programme budget more simply and clearly, in accordance with the resolutions of the Forty-sixth and Forty-seventh World Health Assemblies.

It was clear from document A48/17, containing the report of the Executive Board and the response of the Director-General, that some degree of success had been achieved in narrowing the gap between the programme budget proposals and their actual implementation, in fixing strategic and financial priorities, and in ensuring that the major part of efforts and resources were expended in meeting real needs. Since most of the requirements of resolution WHA46.35 had been met, efforts should now be concentrated on meeting those that remained, especially in the areas of target establishment and programme evaluation, and on ensuring that further resources were allocated realistically and practically and in accordance with the highest priorities.

Mr VAN REENEN (Netherlands) welcomed the new format of the proposed programme budget document, which was much clearer and more user-friendly than that used in the past. He associated himself with previous speakers, in particular the delegate of Canada, in supporting the strategic budgeting approach, which would allow the Director-General more scope to shift resources when further elaborating the budget. However, it was important that WHO's governing bodies should keep watch on how resources were being spent, and on the rationale underlying that spending. It was perhaps an inevitable disadvantage of strategic budgeting that the budget headings were very broad, and did not allow much insight into how resources were

distributed between the subprogrammes. He was therefore glad to note that detailed plans of action were to be prepared nearer the time of implementation, which would mean that the Executive Board in January 1996 would have the opportunity to consider those plans and make appropriate adjustments.

He proposed that the Director-General should submit a progress report on experience with strategic budgeting to the Forty-ninth World Health Assembly. In that way, the experience gained and possible deficiencies identified could be taken into account in the preparation of the programme budget for 1998-1999. It would also be useful to have an evaluation of the new process by the end of the 1998-1999 biennium, so that any necessary adjustments could be made.

The Netherlands was very much concerned to note the imbalance between budgetary and extrabudgetary resources that existed in a number of international organizations. The Director-General, in paragraph 5 of his introduction to the proposed programme budget (document PB/96-97), stated that he intended, in collaboration with donors and the Executive Board, "to rationalize the governance of extrabudgetary funds." The Netherlands fully supported that intention, and would urge all those involved in the governance of extrabudgetary-funded programmes to participate in the rationalization process.

He had noted that there was an inherent conflict between the strategic budgeting concept and WHO's traditional budgeting concept, based on a "bottom-up" approach. The Director-General had identified the problems arising from that conflict, and had put forward in document A48/17 a number of proposals for their solution, notably closer cooperation between the Secretariat and governing bodies at all levels, including that of the regional committees. The Director-General had also indicated that, should those proposals not be sufficient, he would have to call for a revision of the programme budgeting procedure and of regional programme budget policies. In that connection, the Netherlands suggested that, in the preparation of the 1998-1999 programme budget, the budgeting procedures of the regions should be harmonized with those of headquarters. Consideration might be given to a formula whereby the Health Assembly would lay down certain broad guidelines and priorities but leave scope for the incorporation into the programme budget of regional and country priorities.

Dr DURHAM (New Zealand) thanked the Director-General and his staff for their efforts to comply with resolution WHA46.35 and with recent requests by the Executive Board, and for the presentations made earlier in the meeting.

New Zealand supported and encouraged a process of continuing refinement of WHO's budget and activities in line with identified priorities. In particular, it favoured further revision of the programme budget priorities where appropriate, together with the establishment of targets and expected results, both quantitative and qualitative, to permit better programme evaluation. It welcomed the involvement of the Executive Board, and commended WHO's efforts to adjust the programme budget according to priorities identified. It fully supported the new strategic approach, but believed that comprehensive and accessible information was vital if the Assembly was to fulfil its role effectively. In particular, detailed information on actual expenditure by item in previous bienniums, and on other matters referred to by previous speakers, would be helpful in the new process.

For the future, the Executive Board and Member States should be involved more closely and at an earlier stage in the programme budgetary process and in the priority-setting it involved. Priorities, both high and low, should be identified early in the process, and should be system-wide, so that they could be applied both regionally and globally, although she agreed with the delegate of the Netherlands that the regions should be afforded some flexibility in that regard. The priorities determined should have both a current and a future orientation. Finally, she welcomed the flexibility of the new approach, which enabled both the Executive Board and the Health Assembly to review the programme budget proposals.

Mrs HERZOG (Israel) expressed appreciation of the efforts to make the proposed programme budget more user-friendly, and the transfer of US$ 41.5 million to priority needs, although there would of course always be differences of opinion as to what should be classified as priorities.

She agreed with previous speakers that there should be sufficient flexibility to allow funds to be shifted as necessary at any given time. Priorities were subject to change, which was why both the Board and the Health Assembly discussed the programme budget every biennium and made recommendations. It was incumbent on all Member States to ensure that WHO's activities continued to be meaningful and were

adapted to changing needs. She hoped the Director-General, when planning WHO's future work, would take note of the constructive criticisms made by the Health Assembly.

Evaluation of results was most important and was a process that could usefully be adopted by Member States in tackling their own health problems. The lack of balance between WHO's extrabudgetary and regular budget resources was indeed a cause for concern; she agreed with the views expressed by the delegate of France.

Dr DOSSOU-TOGBE (Benin) commended the Director-General for the work done to implement the Health Assembly's decisions regarding the presentation of the programme budget for the financial period 1996-1997. Moreover, the Executive Board's report and the Director-General's response, in document A48/17, were clear and the changes made to the initial document commendable.

The current discussion had demonstrated the great importance of extrabudgetary resources. They had the drawback that their allocation by donors depended on certain conditions being met; that, in turn, implied a need to devise specific procedures to motivate donors.

He was also concerned to note from Table 3 in Part III of document A48/17 that the projected extrabudgetary resources for the 1996-1997 biennium had declined in comparison to those for 1994-1995, in a very marked proportion for funds at country level and somewhat less at the intercountry and regional levels, but had increased at the global and interregional level. Might not the decrease be the result of underutilization of resources allocated for the 1994-1995 biennium at country level and, if so, what measures were being envisaged to improve the absorption capacity of countries?

Ms KERN (Australia) said the budget reform was a large and complex task that had been undertaken with surprising speed. What had been achieved had been well done, but the task was only about halfway to completion, and it was important that gains made should not be lost through fear of difficulties ahead. The voluminous and detailed programme budget provided in previous bienniums had been debated at length by the Executive Board and the Health Assembly but had proved in practice to be fundamentally unchangeable. That was not true of the new, shorter programme budget, which did give WHO's governing bodies a new opportunity to influence the overall direction of the Organization and to set priorities, rather than leaving all the decisions to the Director-General. Australia welcomed that development, which was probably the most significant reform in WHO in the past two years. She commended the Director-General and his staff for succeeding in their difficult task.

However, the new programme budget format could not remain fixed; it would have to evolve as health needs and WHO's needs evolved. Australia, like the United States of America, wished more details to be provided on how much was being spent, for example, on malaria and tuberculosis, from both regular budget and extrabudgetary sources, as well as for activities which were not disease-specific, such as the sick child initiative, together with further details on staffing resources.

In considering the proposed programme budget every biennium, Member States needed to know what the expenditure had been for the previous biennium, whether that expenditure had differed significantly from the budget proposals, and what its outcome had been - in other words, whether it had been a good investment. Regarding the proposed programme budget for 1996-1997, what process would be involved in allocating funds to activities below the 19-headings level, and would it be possible to provide details of resources allocated to those activities both financially and in terms of staffing? When would it be possible for that level of detail to be provided without jeopardizing the benefits of the new strategic approach? Too much detail could cause as many difficulties as too little; only enough should be given to meet the requirements of the various Member States.

In conclusion, she joined the United States delegate in urging that more attention should be given to providing details of expenditure in the programme budget document, and looked forward to seeing the draft resolution mentioned by Canada, which would take into account the many points made in the course of the current debate.

The meeting rose at 12:05.

THIRD MEETING

Thursday, 4 May 1995, at 9:00

Chairman: Dr Fatma H. MRISHO (United Republic of Tanzania)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

BUDGETARY REFORM: Item 18.1 of the Agenda (Resolution EB95.R4; Documents PB/96-97, A48/16, A48/17 and Corr.1 and Corr.2, and A48/17 Add.1) (continued)

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) said that he fully supported the principle of strategic budgeting and agreed with the views that had been expressed by several other delegations, especially that of Canada. He looked forward to improvement and further development of the strategic budget in future bienniums. It was important for the 1996-1997 biennium that detailed plans of action should be prepared for the approval of the Executive Board in January 1996. In the longer term, strategic budgeting should be seen as a process of continuous consultation with Member States and adaptation in the light of their views, which meant that they should be involved in the planning cycle at an earlier stage. In adopting the changes in budgetary procedure, WHO had taken a historic and important step.

Dr EL ISMAILI LALAOUI (Morocco) shared the concern of other delegations at the difficulties WHO faced with continuously increasing demands, especially from the countries in greatest need, and a zero-growth budget. A number of activities identified as priorities might not be realizable for lack of resources. Therefore, it would be necessary not only to make a 5% budgetary transfer (to priorities which remained to be described in detail), but also to do away with inessential expenditure or wasteful procedures. For example, the optimum use of resources for financing documentation at WHO and for the logistics of procedures relating to the working methods of the Health Assembly might be further scrutinized. Considerable effort and even changes in mentality and behaviour might be required, but the resulting reform could have extremely positive results for WHO and markedly improve its financial situation.

Dr CAI Jiming (China) noted that, in the face of financial difficulties, WHO had fully assimilated the proposals of the Executive Board and Member States, formulating new policies and strategies and allocating resources appropriately on the basis of the needs of global development, as reflected in the proposed programme budget for 1996-1997. Unnecessary spending was reduced, savings were made in general expenditure, focused use was made of limited resources, and priority programmes were emphasized. The reorientation of funds was reasonable and scientific and reflected the requirements of the current situation. He agreed that the emphasis in the programme budget should be on the priorities of the Ninth General Programme of Work. Areas of priority, such as 2.1 (General programme development and management), 2.2 (Public policy and health), 2.3 (National health policies and programmes development and management), 3.4 (Quality of care and health technology) and 5.1 (Eradication/elimination of specific communicable diseases), were accorded increased funding in order to ensure their implementation. Other priority programmes, however, such as 3.1 (Organization and management of health systems based on primary health care), 4.1 (Family/community health and population issues) and 5.2 (Control of other communicable diseases), had had their resources reduced in comparison with the 1994-1995 budget. If the overall strategic programme was not to be affected, it was to be hoped that WHO would make the appropriate adjustments.

Dr CICOGNA (Italy) supported the suggestions of the delegate of Canada that Member States should be involved in the early stages of the preparation of the programme budget and that flexibility should be

allowed in the reallocation of resources. The new presentation of the proposed programme budget was an improvement but, although he fully supported the concept of strategic budgeting, he considered that yet further amelioration was needed. In particular, he shared the concern of the United States of America about the lack of information with regard to the actual amounts allocated to different priorities and activities. It would be necessary to have that information before the budget could be approved.

Dr THEIN MAUNG MYINT (Myanmar) endorsed the views expressed by the delegate of India at the previous meeting. WHO and its Member States were faced with a dilemma. On the one hand, the Member States had set themselves the very ambitious goal of achieving health for all by the year 2000. On the other hand, two decades of economic recession, combined with deep changes in the socioeconomic and epidemiological situations, had severely affected the health budgets of many developing countries, at the very time when additional resources were required to build and sustain national health systems based on primary health care in order to meet urgent health priorities, especially those of vulnerable and underserved populations.

The Ninth General Programme of Work provided the policy framework for sound, realistic action by all partners in health development. The goals and targets set in it clearly indicated the commitment of the world health community to undertaking the planned activities, in order to tackle existing and emerging health problems and thus achieve greater global equity in health status. Nevertheless, in view of the current situation he could accept the reforms being proposed. His country would, however, require extrabudgetary resources in order to fulfil its commitment to achieving the goals of health for all. He was confident that nongovernmental organizations would manifest the international solidarity necessary for supporting countries in solving their health problems.

Mr GUAPINDAIA-JOPPERT (Brazil), believing that rationalization of budgetary expenditure within WHO was desirable, expressed his agreement with the delegations that had urged that administrative productivity should be increased, that Member States should participate more actively in the initial stages of framing future programme budgets, and that resources should be reallocated to health programmes of highest priority that lacked adequate funds. The need for continuous monitoring of the use of resources for each appropriation section should be kept in mind in the preparation of future programme budgets. Noting the increasing importance attached to budgetary matters in the Region of the Americas, he added his support to the statement by Canada in favour of budgetary discipline.

Dr DLAMINI (Swaziland) said she shared the concern of other delegates about the lack of information on the precise budget allocations under each of the 19 headings, but would not wish the provision of that information to slow the process of strategic budgeting. She welcomed the introduction of monitoring and evaluation to ensure that the budget was used appropriately to address the priority health needs identified in the third report on monitoring of progress in implementation of strategies for health for all by the year 2000 (document A48/4). She hoped that Member States would be involved in plans of action to be prepared for the 1996-1997 programme budget and that there would be closer cooperation between the Secretariat and Member States at all levels and between the governing bodies. In conclusion, she noted that, at the fifth conference of African ministers of health, recently organized by the Organization of African Unity, the WHO Representative had stated that the Director-General of WHO wished to allocate at least 5% of the 1996-1997 budget to areas of priority most of which were on the African continent; she hoped that desire would be reflected in the deliberations of the Health Assembly.

Dr ABELA-HYZLER (Malta) endorsed the statements made by the delegates of Canada and Australia. He welcomed the identification of priorities by the Executive Board, the Administration, Budget and Finance Committee and the Programme Development Committee. Although he was not averse to shifting at least 5% of the regular budget allocations, both regional and global, to such priorities, over and above the 5% that had already been proposed by the Director-General, he wished to be reassured that the proposals had a rational basis in monetary terms. Turning to the introduction to the proposed programme budget (document PB/96-97), he considered as unacceptable the statement in paragraph 6 that WHO might have to use regular budget funds to supplement extrabudgetary resources in some areas that had not been identified as priorities, and wished to be reassured that it would not be acted upon. On the other hand, he welcomed the proposal

in paragraph 5 to rationalize the governance of extrabudgetary resources. Although he approved the new format of the programme budget document, he hoped that simpler language would be used in the future. Finally, he expressed concern at the proposed deletion of certain activities, to be specified when the relevant appropriation sections were discussed.

Dr THIERS (Belgium) said that WHO should continue the efforts undertaken to maintain the level of budgetary expenditure, while at the same time seeking to make increasingly effective use of the available resources. The three principles of flexibility, transparency and increased cost-effectiveness that had been mentioned by certain delegates should be adhered to rigorously. The new WHO worldwide management information system might be an ideal tool for achieving transparency. With regard to programme content, he considered that more extrabudgetary and regular budget support should be given for work with countries in greatest need. Backing should also be given to all activities that made for the provision of better information about the health situation in different countries in order to provide international reference data.

Dr CHÁVEZ PEÓN (Mexico) thanked the Director-General for the speedy preparation of the documentation on budgetary reform with its important strategic planning component. There was now a basis for much simpler analysis of each budgetary area. The concept of flexibility would allow the Assembly to propose to the Executive Board, where necessary, the reallocation of resources. It was important to stress the special treatment given to those areas that had been selected as being of high priority. Finally, he joined the delegate of Malta in asking why a transfer figure of 5% had been chosen.

Mr HALIM (Bangladesh) shared the view of several previous speakers that, despite considerable progress in reformulating the programme and budget documentation, there was still room for improvement. While the arrangement under 19 headings made document PB/96-97 more understandable than previous programme budgets, specific disease projections, along with measurable targets, would make for a more pragmatic and transparent presentation. The status of implementation of the previous budget might be shown with the new one, to facilitate understanding of world health trends.

Referring to the proposal to reallocate 5% of the budget, he agreed with the delegate of India that the extensive efforts already invested in formulating national and regional programmes and budgets should not be set at naught by a hasty decision from headquarters. Existing priority programmes of a particular country or region might be jeopardized; changes had to be considered with the utmost care and the country concerned consulted.

While supporting the strategic budgeting approach, he felt that the necessity of elements provided from the country level should not be neglected. In priority-setting, emphasis should be laid on the countries in greatest need in view of their special circumstances.

In response to the concern expressed by some countries about the growth in extrabudgetary funding of programmes, he urged the donor community to maintain contributions until the programmes could be taken over by the WHO regular budget or by the country concerned.

Finally, he joined previous speakers in hoping that, in the final version of the programme budget, the implementation status of the 1994-1995 programme budget would be shown so as to improve further the budget document for the following biennium.

Dr PICO (Argentina) commended the Director-General on the presentation of the proposed programme budget, which he found sufficiently clear and precise, and stressed the importance of the strategic planning approach. He expressed broad agreement with the views expressed by Australia, Brazil, Canada, Mexico and the United States of America, and underlined the concept of flexibility in the budget, which was a useful instrument. He also stressed the importance of making more rational use of resources in the quest for efficiency, which was the only way of achieving social equity. Recognition of the need to lay emphasis on the priority areas that would be progressively identified, combined with flexibility, would generate a very favourable response from all concerned.

Dr ESPINOZA (Ecuador) joined previous speakers in welcoming the document on budgetary reform. He too wished to emphasize the importance of budgetary flexibility in providing some room for manoeuvre

within the Health Assembly, that great body which stood for social equity and solidarity. He expressed satisfaction with the transparent and flexible approach proposed by the programme budget.

Dr CHOLLAT-TRAQUET (Cabinet of the Director-General) thanked speakers for their words of encouragement and especially for their understanding. As many of them had pointed out, the reform was a continuous process; it would require further improvements not only to programme budgeting methods at all levels of the Organization but also to documentation. Discussions had shown that some new and also some complementary approaches needed to be developed to give full effect to the concept of strategic budgeting.

She was aware that a time would come when details would be required; as the delegate of Australia had pointed out, the problem was to choose the best time. Resolution EB95.R4 had confirmed one of the provisions of resolution WHA46.35: that the details should be provided as near as possible to the time of implementation so that they were as realistic as possible.

The new strategic approach to budgeting, as many speakers had pointed out, implied some changes. Consideration was being given, first, to greater consultation at an early stage on the priority areas of the programme budget. There was already unanimity on the Ninth General Programme of Work and on the priority that should be given to countries in greatest need. Above all, more attention should be given to setting priorities, because resources were extremely limited and the Organization was facing a budgetary crisis. The process of selecting priorities was a complex one that should involve the Organization at all levels, as the delegates of Canada, Japan, Malta and the United Kingdom had pointed out.

Secondly, consideration was being given to closer partnership with the Member States, called for by the delegates of Bangladesh and Viet Nam, with the regional committees, as advocated by the delegates of Greece and India, and with the Executive Board and the Assembly. The newly established Programme Development Committee and Administration, Budget and Finance Committee had already proved effective mechanisms after only one session. Should they be taken further? Noting that in document A48/17 the Director-General had made a number of recommendations on enhancing partnership, she pointed out that members of the Executive Board had recently taken part in the development teams on global change. In response to the call for participation and partnership to be extended to the formulation of approaches and methods, guidelines relating to the budget, to evaluation and to the Organization's management methods would be made available either through the Programme Development Committee or directly to the Executive Board.

The question of the management and distribution of extrabudgetary funds was highly complex and, as the delegates of Benin, France, the Netherlands and Sweden had pointed out, reform was required. The matter was already being looked into and Member States would be kept informed regularly. She cautioned, however, that coordination was often very costly. A great deal of ingenuity would be required to achieve the desired aims without adding unduly to administrative expenses and the cost of holding meetings.

Thirdly, strategic planning implied greater transparency and more evaluation. It was fully realized that, since the details were not supplied beforehand, the quality of actions had to be demonstrated subsequently. Improved qualitative evaluation was therefore necessary. In connection with the request of the Netherlands, consideration was even being given to an evaluation of the management process itself after the preparation of the programme budget for 1998-1999. Qualitative evaluation began with the setting of realistic goals. The Ninth General Programme of Work represented enormous progress in that respect, as the delegates of Brazil, the Democratic People's Republic of Korea and the United States of America had noted. But some of the goals were too general; they should be specified in relation to WHO's activities.

Finally, there should be more transparency, especially for communication and easy access to WHO's information system and, in relation to the budget, through financial and other evaluations.

All those points required technical improvements of WHO's programme budgeting and management methods; a number of delegations had made proposals to that end. There seemed to be general agreement that the first step was to draw up detailed plans of action linked directly to the "outputs" specified in the draft programme budget. Apart from details of activities which would help bring about the desired results, the plans of action should also give information on the resources to be used. As already noted, 50% of WHO's resources under the regular budget went on personnel; it had therefore been decided to provide information in that regard. If the evaluation was to be useful and to influence the preparation of future programme budgets, it would have to be presented at the same time as the financial report and lead directly to the elaboration of the following programme budget. It would therefore be linked to the goals adopted in the

programme budget. Several delegates, notably those of Israel and Saudi Arabia, had called for an evaluation of the impact of WHO's activities at country level. Such evaluation could only be carried out in close collaboration with the Member States and with the support of the information system, which she hoped could also rapidly supply data on the health situation of Member States.

In response to the delegates of Malta and Mexico, who, among other speakers, had suggested a margin for manoeuvre to allow reallocation of certain amounts during the implementation of the programme and obviate the arbitrary shifting of 5% or 10% of the budget, she cautioned against excessive flexibility in programme budgeting and suggested that the matter should be taken up jointly by the Programme Development Committee and the Administration, Budget and Finance Committee.

As many speakers had pointed out, WHO's regional programme budget policy and its *modus operandi* at the various levels of the Organization would need to be reviewed. Efforts would be continued to detect duplication of work. However, she reassured the delegate of Morocco that after two successive transfers of 5% to priority areas, duplication was becoming increasingly rare in the programme budget and in the Organization.

With reference to the observation of the delegate of Sweden that the programme budget should be essentially an instrument for implementing WHO's new policies, strengthening the strategic approach would show much more clearly to what extent the budget led to implementation of the various policies and contributed to the social equity for which Argentina and Ecuador had called. For the time being, emphasis had been placed on contents and methods, but she agreed with the delegate of Germany that those methods should be neither too heavy nor too costly.

As the delegate of Australia had observed, the halfway point had been reached in budgetary and management reform at WHO. The discussions of the past two days had confirmed her impression that it was halfway along the right road.

Mr AITKEN (Assistant Director-General), replying to a point raised by several speakers, said that an endeavour would be made in the next budgeting exercise to provide comparative figures for actual and budgeted expenditure. Some regions had already started to do so.

In answer to the question put by the delegate of Benin, there was a technical reason for the apparent decline in extrabudgetary funding at country level. Owing to uncertainties about the UNAIDS programme, funds for AIDS had been grouped in the current programme budget at global level, where previously they had been shown spread throughout the Organization. A further point that might help to reassure the delegate of Benin was that an effort was being made to direct the attention of donors to specific country needs.

GENERAL REVIEW:[1] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58)

Dr CHOLLAT-TRAQUET (Cabinet of the Director-General) said that immediately after the ninety-fifth session of the Executive Board in January 1995 the Director-General, as Chairman of the Global Policy Council, had discussed with the Regional Directors how to shift the sum of US$ 41.2 million, representing exactly 5% of the budget, from activities at all levels that the Board had designated as less urgent to those designated as having high priority. The less urgent provisions comprised those for the governing bodies (including documents and official records), procurement and overall staff costs, and administrative services; the high priority areas were the eradication of specific communicable diseases, prevention and control of other communicable diseases, reproductive health, women's health and family health, promotion of primary health care and other areas that contributed to its promotion, such as essential drugs and vaccines and nutrition, and environmental health, especially community water supply and sanitation. The Board had requested that under those programmes special emphasis should be laid on the needs of the least developed countries and on populations in greatest need, on the burden and nature of diseases prevalent within Member States, on the impact likely to result from allocation of additional resources to specific areas of work, and on the ratio of regular to extrabudgetary funding for the areas of work in question.

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

With those criteria in mind, the Global Policy Council had accordingly reallocated the US$ 41.2 million, first transferring US$ 1.2 million from governing bodies and US$ 900 000 from supply services and other support programmes at headquarters. Next, US$ 10 million earmarked for fellowships in countries had been "shifted" to specific priority programmes, though not without some difficulty. There remained a sum of US$ 30 million, which had then been divided *pro rata* between headquarters and the regional offices.

Paragraphs 16 to 27 of document A48/17 gave details of how those operations had been carried out. In the shifting of resources, a number of adjustments had had to be made to respect the specific features of programmes and of the different levels of the Organization. She drew attention to the comments made in those paragraphs on the difficulties encountered, and to the Director-General's remarks on the reallocation and the future programme budget for 1998-1999 in paragraphs 28 to 33.

The shifts of resources had, of course, resulted in changes to most of the budget tables in the proposed programme budget reviewed by the Executive Board. The revised tables were presented in part III of document A48/17, to which members of the Committee should therefore refer, when reviewing the proposed programme budget by subject heading.

As she had noted at the Committee's second meeting, part IV of document A48/17 had been updated; it was replaced by document A48/17 Add.1, which proposed a new approach to the questions of cost increases and to adjustments of exchange rates.

The annexes to document A48/17 should help to provide further clarification of the programme budget document. Annex 1 contained an annotated list of programme budget headings for the financial period 1996-1997, enumerating the activities, or groups of activities, included under each heading; Annex 2 contained proposals for amendments that would be needed in the final text of the programme budget as a result of the shifts in resources, and Annex 3 contained an index to the principal subjects to be found in the programme budget.

Mr BOYER (United States of America) shared the view of the Executive Board Working Group on the WHO Response to Global Change that the Organization often tried to take on too much: the programme budget for the current biennium, 1994-1995, contained 59 separate programmes, which was too many. He therefore welcomed the Board's recommendation that WHO should try to focus its programme activities better by concentrating on what it did best, so as to obtain better value for money, moving resources into areas of high priority, and, at the same time, gradually reducing spending on areas of lower priority or of a largely administrative nature, in which savings were possible. The Board's recommendation had been a historic one for the Organization in that, for the first time, one of the governing bodies had asserted itself sufficiently to ask for a change in the way money was being spent.

He was pleased that the Director-General himself had responded with enthusiasm, and at what had been achieved at headquarters level. However, he was disappointed at the apparent reluctance of the regional offices to adjust their budgets by 5%. For example, it was stated in paragraph 18 of document A48/17 that in the African Region overall allocations had not changed, and again in paragraph 20 that in the South-East Asia Region it had been difficult to make shifts between programmes, and that shifts of resources from one country to another would be "imprudent". Paragraph 22 stated that in the European Region a mathematical *pro rata* shift would not be appropriate, paragraph 24 that in the Eastern Mediterranean Region the areas identified by the Board for reductions in funding did not apply in any substantive sense, and paragraph 25 that in the Western Pacific Region it was difficult to initiate drastic changes. Thus, while headquarters had responded well to the request for a shift of resources, the regional offices had argued that they were unable to do so because it had come too late. As had been pointed out by earlier speakers, one of the goals of budgetary reform was to make the budget decision more meaningful by moving it closer to the period of implementation. However, it was implied in document A47/17 that a request for change made by the Executive Board a full year in advance of implementation had come too late. That would suggest that discussion of the programme budget both at the January session of the Board and at the current Health Assembly was meaningless, since neither governing body had the right to propose changes. He himself endorsed the concept of a decision by one of WHO's governing bodies to move funds from lower to higher priority activities, and hoped that that process could continue. He trusted that the Director-General would acknowledge that the "shareholders" of the Organization had a role to play in the development of the programme budget.

Mr DEBRUS (Germany) observed that, in an effort to offset the stagnation that resulted from zero growth, the Organization was having to rely increasingly on extrabudgetary resources, which unfortunately led to high support costs which had an impact on the regular budget. Action was needed to decide what percentage of support costs could realistically be paid from the regular budget.

Paragraph 22 of the Introduction to the proposed programme budget (document PB/96-97) stated that it was planned to set up a new division to support health policies and strategies, but did not indicate where the new posts for that division were to come from: he would appreciate information on that point. Table 1 of the document indicated that there was to be a massive shift of regular budget resources towards the decision-making bodies, amounting to almost 51% in comparison with the 1994-1995 level. In his view, the information given in the Introduction was not sufficient to explain a shift on such a scale, and the establishment of a Standing Committee of the Regional Committee for Europe could not alone account for such a large increase in appropriations.

Table 5 showed that, regrettably, the allocation for the European Region had once again been reduced: it was now to account for only 5.96% of the regular budget at regional and global/interregional levels, compared with 6.2% in the 1992-1993 budget and 6.05% in the current biennium. As he understood it, that decrease was due to the fact that, while the amount allocated to the European Region was the same in nominal terms as under the 1994-1995 regular budget, the global budget for 1996-1997 had actually been increased in real terms. Document A48/17 Add.1 indicated that there was to be no adjustment of budgetary rates of exchange for the Swiss franc or Danish krone; he feared that that would reduce still further the percentage allocation for the European Region.

Dr CAI Jiming (China) said that WHO fellowships, which were a significant aspect of WHO's cooperation with developing countries, had produced fruitful results, notably by improving the capability of countries to reach the goal of health for all. The ability of countries to improve the health of their people and to prevent and cure disease depended on a supply of qualified health personnel; training was thus vital.

The development of human resources in the health field was one of China's top priorities. Since August 1994, China had sent 1140 people on WHO fellowships to 20 countries. A survey had shown that over 70% of students had returned home to serve their country after completion of their studies. The procedure established by the Ministry of Health for selecting and training candidates for WHO fellowships was rigorous. After recruitment, those selected were given language training, and once abroad they were required to maintain regular contact with the institutions which had sent them. On their return, certain students were chosen to take part in seminars in order to pass on the expertise they had gained abroad: hitherto, 12 such seminars had been held, with 157 persons taking part. The Ministry of Health had established a fund to support those activities. Despite some defects which were now being remedied, the WHO fellowship programme in China had proved very successful, and had played a vital role in improving the quality of the country's health personnel.

Professor LOUKOU (Côte d'Ivoire) congratulated the Director-General on the new format of the programme budget and endorsed the criteria governing the proposed reallocation of 5% of resources. He thanked the Executive Board and those Member States which had advocated greater support for the poorest countries. However, the estimated increase in resources due to the devaluation of the CFA franc (document A48/17 Add.1, paragraph 2) did not compensate for the loss of purchasing power of the countries concerned for the bulk of their imports, which came from the countries of the north, whose currencies were stronger.

Mr PÉREZ (Spain) said that, while he was in general agreement with the proposals contained in document A48/17, he was greatly concerned at some of the proposals in paragraph 17, which in his view threatened the status of Spanish as an official language of the Organization. Among the measures proposed was the publication of annexes to documents, and possibly the Journal of the World Health Assembly and the Programme of Work of the Executive Board, in English and French only. Following strong press interest, his Government had written to the Director-General to express its concern. Such a measure would be discriminatory and would conflict with the principle of multilingualism enshrined in Rules 87 and 90 of the Rules of Procedure of the Health Assembly and Rule 22 of the Rules of Procedure of the Executive Board. After all, Spanish was more than a regional language; it was widely used throughout the world and its importance was recognized in all other international organizations. The number of documents and

publications in Spanish was already too low: documents for the governing bodies and all publications aimed at health professionals or the general public, such as the new world health report, should be produced in a Spanish version.

While his Government approved of the Director-General's proposals for a reallocation of resources amounting to 5% of the regular budget, it would consider any reductions that threatened the status of the Spanish language, such as staff cuts affecting Spanish translation, editing or word-processing, as discriminatory and unacceptable. He hoped that paragraph 17 would be amended to reflect his concerns; if not, Spain would reserve the right to take whatever action was necessary to defend the use of the Spanish language and the multilingual traditions of the Organization.

Dr TAITAI (Kiribati), while approving in general the Executive Board's proposal to shift resources from lower-priority to higher-priority areas, stressed that priorities differed from one country to another. For example, WHO fellowships were still extremely important to his country. He accordingly appealed to the Organization to continue its support for the fellowships programme and other activities of concern to Kiribati.

Mr VAN REENEN (Netherlands) commended the presentation of the programme budget and expressed support for the proposed reallocation of resources, which was a step in the right direction. However, the resources thus released were to be distributed to a large number of activities, so that no one programme would receive enough to make much difference. Further, the proposed reductions were mostly in the areas of overheads or infrastructure: there had apparently been little attempt to assign priorities to substantive programmes and reduce the resources allocated to the less important ones, except in the European and Eastern Mediterranean Regions. It was of course generally preferable to cut overheads rather than reduce substantive programme activities, but there was a limit to the savings such an approach could achieve.

Dr GEORGE (Gambia) commended the Director-General on document A48/17 and acknowledged the difficulty of the choices that had had to be made. He approved in principle the four priority areas that would benefit from the proposed reallocation of resources outlined in paragraph 6 and the emphasis on support for the countries in greatest need, but he was concerned about the implications for the programmes whose resources were to be reduced. For example, human resources development was essential to the achievement of health for all and currently accounted for over 60% of technical assistance to developing countries. He therefore requested an explanation of the proposal to reduce expenditure in that area, particularly in the African Region. Sustainable health development could be assured only if local staff were trained to take over from WHO technical experts.

Dr MAREY (Egypt) supported the proposed reallocation of resources, and expressed appreciation of WHO's increased support for those countries in greatest need. However, Member States were entitled to choose the areas where reallocation should take place, since they knew best what their own priorities were.

Dr PAVLOV (Russian Federation) expressed support for the new principle of strategic budgeting, the action taken by the Director-General so far, and the proposal to reallocate 5% of the regular budget to higher-priority activities. The regrouping of programme activities under only 19 programme headings would increase the effectiveness of WHO's operations. The designation of certain programmes as being of lower priority did not mean that they should be abandoned altogether: activities such as the prevention of noncommunicable diseases and the compilation of health statistics were still important. However, since WHO's budget had not increased in real terms, those activities should be subject to more stringent financial conditions.

The priorities of WHO's European Region were perhaps rather different from those of other regions, since it had a number of newly independent States, with economies in transition, which needed to reform their national health systems and therefore required considerable assistance from WHO. His country supported the significant increase in the resources allocated to national health policies and programmes development and management, which corresponded to the needs of countries in the Region.

He supported the Director-General's emphasis on the need for thorough planning of budgetary reallocations, an evaluation of the real needs of countries and a study of possible sources of extrabudgetary funding. That strategic approach should be maintained in the preparation of the next programme budget.

Finally, he endorsed the remarks made by the delegate of Spain about the need to preserve the current official languages of the Organization, of which Russian was one, in order to avoid discrimination against certain Member States.

Dr CHÁVEZ PEÓN (Mexico) said that many countries of the Region of the Americas were concerned at what appeared to be a deliberate attempt to reduce the use of the Spanish language in WHO documentation, which was the main means of communication between the Organization and many of its Member States.

The proposed programme budget rightly emphasized the importance of reproductive health and maternal and child health at both global and regional levels. He hoped that those areas would continue to receive the support they deserved in future programme budgets.

Dr VIOLAKI-PARASKEVA (Greece) expressed her support for the proposed reallocation of resources, but warned that the Organization's activities must continue to be guided by the Ninth General Programme of Work. She had been surprised to note the reduction in the budget allocation for human resources for health in the African Region; adequate human resources were surely essential for sustainable health development.

Dr PICO (Argentina) agreed with the delegates of Spain and Mexico that Spanish was an important official language of the Organization, and hoped that paragraph 17 of document A48/17 would be amended.

Dr DURHAM (New Zealand) expressed her overall support for the reallocation of WHO resources. However, some of the proposed reductions might limit the Organization's capacity to act in high-priority areas. For example, the proposed reduction in the area of noncommunicable disease control (document A48/17, paragraph 17) might adversely affect primary health care activities, particularly in respect of education concerning prevailing health problems and the methods of preventing and controlling them, which was one of the eight essential elements of primary health care outlined in the Alma-Ata Declaration. Noncommunicable diseases were becoming a major problem in the developing world: according to *The world health report 1995*, 58% of world cancer deaths occurred in developing countries (document A48/3, paragraph 40) and it had been estimated that 100 million people throughout the world would suffer from diabetes mellitus by the end of the century (document A48/3, paragraph 42). Those considerations should be taken into account in the preparation of WHO's detailed plans of action for the next biennium, in which the Executive Board and Member States should be fully involved. For future programme budgets, all priorities should be given both a current and a future orientation.

Dr AL-JABER (Qatar) said he fully supported the proposed programme budget for 1996-1997 and the priorities to be taken into account in the reallocation of US$ 41.2 million from the regular budget. Full use should be made of the WHO worldwide management information system for securing accurate information about the priorities established when preparing future programme budgets.

Mrs HERZOG (Israel) said that, given the crucial role of training in responding to countries' health needs, it was encouraging to hear that the development of human resources through WHO fellowships had been successful in some countries. However, difficulties were being experienced by many others, and indeed at WHO headquarters and the regional offices; steps must be taken at all levels to ensure the appropriate use of the financial resources available for training. People should be trained in fields that were a priority in the country concerned and should, to the extent possible, be trained in their own or a neighbouring country. Further, provision should be made for those trained abroad to return to their own countries to work for at least three to five years in the fields in which they had been trained; and the use of funds for training should be evaluated.

Dr SAMBA (Regional Director for Africa) said that the countries of the African Region supported the principle of establishing priorities and shifting allocations accordingly, and that the process had been initiated in close consultation with those countries. However, in a continent which comprised most of the world's least developed and poorest countries, and in which virtually everything was a priority, the process would undoubtedly take longer than in the developed world.

Human resources were a top priority in Africa where, in contrast to other regions, there had to be a WHO country office in all countries to provide assistance not just to ministries of health, but to a number of other ministries in fields with health implications. Emphasis was now being placed on training local personnel within the Region, starting with WHO fellowships, rather than providing for training abroad, which could be up to 10 times as expensive, increased the risk of a "brain drain", and was not always appropriate to local conditions; it was also important to use local institutions. Cases of misuse of fellowships had been identified, had been discussed with countries, and were now being corrected.

Mr LARSEN (Regional Office for Europe), responding to comments concerning the European Region, explained to the United States delegate that the reference in paragraph 22 of document A48/17 to "compelling reasons why a mathematical *pro rata* shift would not be appropriate now" did not imply any unwillingness to reallocate resources. Indeed, it would be seen from paragraph 22(d) and paragraph 23 that a total shift of 5.9% would be implemented in the European Region. The Regional Director's argument was, rather, that a uniform and across-the-board 5% shift was not necessarily the most appropriate way of reallocating resources, the reasons being given in paragraph 22, subparagraphs (a) to (d).

Replying to the delegate of Germany, he said that the question of regional regular budget allocations would be on the agenda of the forthcoming session of the Executive Board, partly in response to a resolution adopted by the Regional Committee for Europe. The Regional Director was equally concerned about cost and exchange rate increases faced in the next biennium, as set out in document A48/17 Add.1.

Dr HAN (Regional Director for the Western Pacific) regretted that the wording of paragraph 25 of document A48/17 might have conveyed a negative impression. He had intended it to be factual. He had wished to comply fully with the Director-General's directives concerning the 5% shift in resources on the basis of the Executive Board's recommendations, and had indeed done so and would continue to do so in the future. He had not felt it appropriate to reallocate resources without full consultation with countries. However, the convening of a special session of the Regional Committee would have taken time and entailed considerable expenditure. He had therefore reviewed the programme budget again and had proposed shifts involving 20 of the 35 countries and areas in the Region. The proposal, as presented to the Health Assembly, had the concurrence of those countries and areas. During the development of the 1994-1995 programme budget, the Western Pacific had been the only region to comply with the Director-General's directive to allocate 5% of the budget in real terms to designated priority areas; in fact, the allocation had amounted to 7.7% of the total regional budget. For the 1996-1997 financial period, 61% of the proposed total budget for the Region had already been allocated to priority areas before the Executive Board's review; in compliance with the Board's recommendations for a 5% shift, that figure had now risen to 66%.

Dr CHOLLAT-TRAQUET (Cabinet of the Director-General) said that the many comments and the wide range of priorities proposed by speakers gave an idea of the difficulty of refocusing the limited resources available on the small number of priorities recommended by the Executive Board. The various committees responsible for selecting priorities would have to bear in mind the need to cater for the very great and pressing needs of many countries, as Dr Samba had said, within the limits of a budget equivalent to that of a university hospital in a developed country.

In reply to the delegate of Germany's question about paragraph 22 of the Introduction to the proposed programme budget (document PB/96-97), she said that the proposed new division would regroup existing services; not only would that entail no additional costs, but it was expected to lead to economies and give wider scope to activities, bring together the management of regular and extrabudgetary resources and reform staff training.

Mr AITKEN (Assistant Director-General) reassured the delegate of Germany, with regard to the relative share of the budget allotted to the European Region, that there had been no shift in allocations between the regions in real terms. The Executive Board would be examining relative regional office and headquarters allocations at its forthcoming session. Since, however, the impact of exchange rate changes and inflation differed between regions, as the delegate of Côte d'Ivoire had pointed out, there might be small upward or downward shifts in the final figure. Reductions would have to be made, but a differential would be maintained between areas on which exchange rates or inflation had a greater or lesser impact.

Referring to paragraph 17 of document A48/17 and to the concern expressed about documentation in the Spanish and Russian languages, he said that strongly-worded comments in the Spanish press about the declining use of the Spanish language in the United Nations system had indeed been followed by a letter to WHO from the Spanish Government. The suggestions concerning the production of the Journal of the Health Assembly and the programme of work of the Executive Board in English and French only would not be pursued. With regard to annexes to documents, WHO would continue its long-standing practice of issuing, for example, statistical annexes in English and French, but there would be no further changes to its existing procedures in regard to other documents. He hoped that his response would allay the concern of the delegates of the Russian Federation and Spain, whom he wished to reassure of WHO's full commitment to multilingualism. On the other hand, the proposed reductions in the permanent staff concerned with reproducing documents in the various languages would be maintained, since substantial savings could be made by employing temporary staff for that purpose. Every effort was being made to mitigate the consequences for the permanent staff concerned, whose difficulties were appreciated. The proposed changes would not affect WHO's capacity to produce documentation in the necessary languages.

Dr SAMBA (Regional Director for Africa) said that an important development in the African Region had been the decision to shift resources from the Region to the countries, which was where WHO was most needed and where visibility should be highest. Reports would be submitted on the effects of that decision, although the impact would not be immediate. The large number of country offices raised the problem of staffing; personnel transferred from the Regional Office were not necessarily appropriate for country offices. Certain activities in the Regional Office were being subcontracted, which would lead to greater efficiency and lower costs, all savings going to the countries.

In reply to a question by Dr AL-JABER (Qatar), the CHAIRMAN said that she was informed that the Assistant Director-General's comments concerning the Russian and Spanish languages applied to all the official languages of the Organization.

The meeting rose at 12:30.

FOURTH MEETING

Friday, 5 May 1995, at 9:00

Chairman: Dr Fatma H. MRISHO (United Republic of Tanzania)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

GENERAL REVIEW:[1] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58) (continued)

Appropriation section 1: Governing bodies

Dr KANKIENZA (representative of the Executive Board), said that the cost of documents and other Executive Board and Health Assembly services had been included in the section under review in order better to reflect the actual cost of the governing bodies. The Board had noted the joint recommendation of the Programme Development Committee and the Administration, Budget and Finance Committee that savings should be made in that area, and had studied a number of measures to that end, in particular reductions in the duration of the Health Assembly every other year and in the volume of documentation produced for meetings of the governing bodies. Consideration had also been given to the possibility of making savings in relation to the regional committees. The Board had concluded that the area was one from which the Director-General should endeavour to free funds for allocation to priority areas, and indeed, as indicated in document A48/17, the Director-General had proposed a real reduction of US$ 1.1 million.

Appropriation section 2: Health policy and management

2.1 General programme development and management

Dr KANKIENZA (representative of the Executive Board) said that during the review of the section by a subgroup of the Board, a number of members had emphasized its importance to the success of the WHO response to global change and of the organizational reforms. But despite the interest of the Board and the Health Assembly in ensuring the success of those reforms, no additional funds had been allocated for their follow-up and implementation and the Board had requested the Director-General to examine the heading for further possible reductions. The Board therefore wished to encourage Member States to follow the example of the few who had made voluntary donations in the area.

2.2 Public policy and health

Professor BERTAN (representative of the Executive Board) said that the Board had welcomed the creation of the new heading, which brought together a number of important policy areas. Board members had emphasized the importance of ethics in the work of the Organization and welcomed the interest of the Director-General in maintaining high visibility for that area. They had expressed their support for the work of the Task Force on Health in Development and recommended that it should receive increased funding. As noted in paragraph 16 of document A48/17, the Director-General had made a proposal to that effect.

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[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

For the first time, the report of ACHR had been formally presented to the Executive Board. Board members had welcomed the return to annual meetings and ACHR's willingness to mobilize the scientific community in the further development of WHO's health strategy. ACHR served a very important function in linking WHO's intramural research with the broader resources of the world scientific community and helping WHO to maintain the focus and quality of its own scientific inquiry in accordance with the guidelines provided by its governing bodies. The Board had noted that ACHR's interaction with a number of WHO's major research-oriented programmes had been very productive.

The Board had recognized the strategic importance of health activities in sustainable socioeconomic development and of the role of women in health and development. Discussions had also focused on WHO's role and involvement in health legislation, human rights and ethics.

2.3 National health policies and programmes development and management

Emergency and humanitarian action (Resolutions WHA46.6 and EB95.R17; Document A48/5[1])

Health and medical services in times of armed conflict (Resolution WHA46.39; Document A48/6)

Professor BERTAN (representative of the Executive Board) said that the Board had fully endorsed the recommendations of the Task Force on Emergency and Humanitarian Action and the proposed new strategy for WHO action in that area. The strategy rightly focused on WHO's normative and technical guidance functions, especially in regard to complex emergencies, on partnership, and on early warning and coordination, rather than on operational response activities requiring extensive logistic support and staff in the field.

The general consensus had been that WHO had a limited but clearly defined area of competence. Its role in coordinating health and health-related measures and in the provision of relief and rehabilitation in emergencies had been reaffirmed in resolution WHA46.6. Thus, WHO should focus on areas in which it had a clear comparative advantage, and should collaborate with both United Nations and nongovernmental organizations. A "partnership approach" in relations with concerned governments, bilateral donor agencies, other organizations of the United Nations system and nongovernmental bodies would ensure complementarity of action.

WHO's response to the challenges of emergency and humanitarian action and health and medical services in times of armed conflict were clearly set out in documents A48/5 and A48/6.

The Board had also examined the serious violations of basic human rights perpetrated against health and medical personnel, and against property in areas affected by armed conflict.

She hoped that the draft resolution recommended by the Board in resolution EB95.R17, on emergency and humanitarian action, would be adopted by consensus.

Dr LARIVIÈRE (Canada) endorsed the proposed new strategy on emergency and humanitarian action, especially since it emphasized the normative and technical guidance functions of WHO: preparedness, internal training of WHO staff, support to national preparedness programmes, coordination of activities internally and with governments, assessment of activities, and collaboration with governments and other agencies in complex emergencies. He also endorsed the orientation of the strategy which fostered partnership, addressed emergencies within a development continuum, focused on early warning and coordination, and advocated respect for and protection of health personnel and health institutions in conflict situations.

Canada strongly supported the continuing involvement of the United Nations Department of Humanitarian Affairs in the overall management of international emergencies and situations requiring humanitarian responses.

He endorsed the proposed WHO mandate for emergency and humanitarian action contained in the Annex to document A48/5, but questioned the statement in the third paragraph of section 2 that one of

[1] Document WHA48/1995/REC/1, Annex 1.

WHO's objectives was "to provide, where appropriate, initial relief assistance in the humanitarian health field in the aftermath of disasters". To be fully effective, the deployment of that kind of rapid relief assistance would require a new competence within WHO, probably including standby personnel, equipment and resources. WHO was perhaps not the most appropriate organization to provide that level of emergency response. What was the precise scope of the operations envisaged?

Furthermore, there should be only one WHO strategy, which should be implemented in a consistent manner at global level in all regions and countries.

It was important for WHO to secure systematically the funds needed for effective emergency management through consolidated appeals, since there were very few purely health-related emergencies requiring direct fund-raising by WHO. The Organization's consolidated appeals on behalf of Member States had so far met with little success in obtaining resources, possibly because its strategy in the past had not been as clear or well understood as it would be in the future. He urged all countries that did respond to consolidated appeals to pay particular attention to the health needs of the countries concerned.

He expressed strong support for the draft resolution contained in resolution EB95.R17.

Professor LEOWSKI (Poland), commending document A48/5, said that emergency and humanitarian action was of the utmost importance and urgency. It was also an area subject to rapid change, and rapid reactions to change were therefore necessary.

Stressing the need to overcome bureaucracy in dealing with emergencies, he cited the example of tuberculosis, a chronic disease which required a long-term programme. In some areas, health system delivery had collapsed completely, leaving large numbers of sputum-positive cases untreated in the community. The only way to continue giving protection to the rest of the community was to provide short-term or emergency relief. The long-term effects of neglect would endure for decades, leading to multidrug-resistant cases which would spread the infection and be very costly to treat. He therefore supported the draft resolution contained in resolution EB95.R17.

Dr VAN ETTEN (Netherlands) also welcomed document A48/5 on emergency and humanitarian action and endorsed the proposed new strategy, which clarified WHO's mandate. The eight key elements of the strategy set out in paragraph 25 of the report provided a consistent and integrated framework for activities in that field. He strongly supported the emphasis given to coordination, as well as to normative and technical guidance functions. Over the past few years the Netherlands had expressed some concern about the extent of WHO's involvement in the operational aspects of emergency and humanitarian action; the new strategy gave a much clearer definition of the Organization's role in that regard.

He hoped that the proposed revision of *Management of nutritional emergencies in large populations*, published by WHO in 1978, would be undertaken as soon as possible.

He supported the draft resolution recommended by the Board in resolution EB95.R17, but proposed that in paragraph 6 the words "health aspects" should be amended to read "health and nutrition aspects".

Dr MILAN (Philippines) said that increasing disasters and other emergency situations called for high-priority attention and action not only by WHO but also by its Member States, which suffered because of the health risks to their populations and also because of the adverse impact on their overall socioeconomic development. Disaster brought with it a greater need for health services, yet at the same time reduced the capability to deliver such services, widening the gap between needs and resources, and a concerted and timely response by all sectors concerned was crucial. WHO's reassessment of its role in emergency and humanitarian action, and the restructuring to facilitate its response, were thus very timely. She was particularly heartened to note the new procedures aimed at harmonizing and expediting international response, the "development continuum" approach designed to ensure consistency of short-term interventions with long-term goals, and the continued advocacy of respect for and protection of health personnel and infrastructure in conflict situations. Protection of health personnel was of great importance, since they were the backbone of response capability not only during emergencies but subsequently, during rehabilitation and reconstruction. The most noteworthy aspect of the new initiatives was the practical emphasis on WHO's advantage, in terms of expertise and technology, in defining its mandate and role among the many agencies and sectors involved in emergency and humanitarian action.

The Philippines, as one of the most disaster-prone countries in the world, had a particular interest in the question of relief supply management, referred to in paragraph 11 of the report (document A48/5).

The Government of the Philippines was grateful to WHO for supporting its programme entitled "Stop disasters, epidemics and trauma for health (STOP DEATH)", which aimed at developing an integrated and flexible preparedness and response system.

In conclusion, she supported the draft resolution recommended by the Board in resolution EB95.R17.

Mr DEBRUS (Germany) appreciated WHO's efforts to clarify its role in emergency prevention and management and to make organizational improvements. With so many multilateral, national, governmental and nongovernmental organizations involved in the area of humanitarian assistance, effective coordination of activities was of particular importance. He was therefore glad to note that document A48/5 emphasized the need for coordination and cooperation with other United Nations organizations, notably the United Nations Department of Humanitarian Affairs established for that purpose, and urged that coordination should be further improved.

Turning to the report on health and medical services in times of armed conflict (document A48/6), he said the proliferation of emergency situations resulting from armed conflicts in recent years made it ever more important to protect persons engaged in humanitarian action from attack. The protection of medical personnel should be dealt with in the context of humanitarian legislation currently being developed, although care should be taken to ensure that any legal provisions introduced did not result in different levels of protection for different categories of personnel engaged in humanitarian activities. As a matter of principle, reference should be made to the Convention on the Safety of United Nations and Associated Personnel, adopted by the United Nations General Assembly on 9 December 1994. He hoped that all countries would become signatories to that Convention, as Germany had done on 15 December 1994. All future efforts undertaken to protect health personnel in times of armed conflict would have to conform to the provisions of that Convention.

Dr JEANFRANCOIS (France) joined previous speakers in congratulating WHO on its achievements in emergency and humanitarian action. In proposing a move towards a more proactive policy for tackling emergencies, the Organization had shown its ability to adapt to new situations, which were unfortunately likely to occur with increasing frequency.

The effectiveness and credibility of the Organization's action depended on its capacity for speedy intervention. That implied the setting-up of a rapid response system at headquarters, regional and country level, since the presence of experts able to take part immediately in emergency assistance was a crucial factor. It was also essential for WHO to work in partnership or in coordination with other bodies on the spot, with other United Nations and nongovernmental organizations, and with donors. That raised the problem not only of creating adequate structures and strategies, but also of ensuring that adequate resources were made available. The Organization's action in that field should therefore be recognized as having high priority, and the necessary funds should be provided for it; she supported the draft resolution.

Mr HALIM (Bangladesh) agreed that the dramatic and continuing rise in both natural and man-made disasters called for a strengthened and more proactive role for WHO in helping to mitigate their impact. He commended WHO's activities as a member of the Interagency Standing Committee, as well as its work in dealing with emergency situations through its offices at country level.

The concern of the international community regarding emergency preparedness and response had been reflected in the United Nations International Decade for Natural Disaster Reduction, as well as in the convening of the World Conference on Natural Disaster Reduction in Yokohama, Japan in 1994. As a disaster-prone country, Bangladesh attached high priority to that topic, and was in the process of setting up a centre for emergency preparedness and response. The cooperation received from WHO and donor countries in that effort was greatly appreciated.

Turning to the draft resolution contained in resolution EB95.R17, which he hoped would be adopted by consensus, he proposed the insertion in the preamble, after the fourth paragraph, of the following two new paragraphs:

> Recognizing further that the international community has a responsibility to supplement national efforts in disaster management, especially through mobilization of humanitarian assistance;

Reiterating the special needs of the disaster-prone countries,

He further proposed the insertion of a new operative subparagraph 7.A.4 reading:

4. to intensify support for the emergency and humanitarian action programmes in disaster-prone countries,

subparagraphs 7.A.4, 5 and 6 to be renumbered accordingly.

Mrs GU Keping (China), commending document A48/5, said that with the escalating number of people affected by natural and man-made disasters, emergency and humanitarian action was a matter of concern to the whole international community. As the agency with the relevant scientific and technical expertise, WHO had in recent years been playing a greater role in that area. She appreciated the highly productive work accomplished, and endorsed in principle the recommendations made by the Task Force on Emergency and Humanitarian Action and the proposed new strategy.

Regarding the future orientation of WHO's work in that field, emphasis should be given to helping Member States, especially developing countries, to improve their emergency preparedness by establishing early warning systems and by training staff in emergency health management. Links between WHO headquarters and regional and country offices should be strengthened, and there should be a clear division of responsibilities to ensure quick and effective response. Partnership between organizations of the United Nations system and nongovernmental organizations should be enhanced to avoid duplication of effort and waste of resources. Finally, training courses in emergency health management should be organized not only on a global but also on a regional basis.

Dr KHOJA (Saudi Arabia) commended the two reports before the Committee (documents A48/5 and A48/6). Emergency and disaster situations were seen by most countries of the world as being of prime importance. Saudi Arabia, as a supporter of human rights and a believer in international justice, had helped to provide disaster relief for countries in need. It had contributed medical equipment and health care to United Nations peace-keeping forces, and had set up bodies to supervise disaster relief operations in Somalia and in Bosnia and Herzegovina. In addition, it had held two symposiums on disaster and emergency situations in the course of the past two years.

In view of the importance of WHO's role in emergencies and disasters, and in the light of the strategy set out in paragraph 25 of document A48/5, he approved the setting-up of the Task Force on Emergency and Humanitarian Action, and recommended the preparation of a plan of action to ensure that WHO's intervention was effective and that optimum use was made of available resources. WHO should also assist countries in establishing national emergency and disaster relief programmes, and monitor their effectiveness. The Organization should draw up strict rules for the protection of medical and health centres in times of armed conflict. Health activities such as those referred to in paragraph 18 should be used for promoting peace.

In addition to the initiatives set out in paragraphs 3 to 6 of the report, WHO's role should include the training of national personnel in emergency relief, especially in countries subject to recurring health catastrophes. The Organization should also encourage self-help and self-reliance in Member States. He noted from paragraph 9 of the report that a course on emergency management for the health sector was to be held in Geneva in June 1995, and suggested that Saudi Arabia should be invited to nominate trainees and expert advisers to participate in the course. Emphasis should be given to research in the field of emergency and humanitarian action, notably in regard to the acquisition of technical expertise, and the need for coordination, supervision and monitoring.

WHO should increase the number of its scientific publications on emergency and disaster relief, and should encourage more experts to contribute material on the subject. In addition, it should encourage the designation of international days for emergency and humanitarian action.

In conclusion, the Organization's programme should not be confined to dealing with the immediate effects of disasters, but should also take into account their medium- and long-term effects, whether physical, environmental, economic or developmental. For example, children were often affected mentally and psychologically by disasters, and their growth inhibited as a result.

Dr PAVLOV (Russian Federation) joined previous speakers in supporting the draft resolution recommended in resolution EB95.R17. Hitherto, WHO's principal role in the area of emergency and humanitarian action had been to provide medical supplies, at both country and regional level. However, the report submitted to the Executive Board had asked for WHO's mandate to be extended; the Health Assembly should endorse that request. Increased assistance was needed in the training of nationals to deal with emergencies, as also were improvements in coordination of activities, both between international organizations and between WHO headquarters and regional offices. Closer cooperation with countries was also needed, and experience acquired by Member States in dealing with emergency situations should be disseminated. In developing such activities, WHO would need additional resources, and would therefore have to seek new potential donors.

Dr ONO (Japan) commended document A48/5 and congratulated members of the Task Force on Emergency and Humanitarian Action on the successful outcome of their work.

He was pleased to note that the Task Force had discussed such crucial questions as the mandate of WHO and the role of headquarters, regional offices and country offices in emergency and humanitarian action. WHO should not be expected to meet every possible emergency health need: as an agency with scientific and technical expertise in the field of medicine and public health, it should strengthen national capabilities in countries by coordinating and monitoring health policies, rather than by providing logistic support and staff.

With regard to the proposed new strategy set out in paragraph 25 of the document, he stressed that the partnership approach would be crucial to success. The prompt collection and dissemination of emergency health information was essential for inducing partners to collaborate. He was pleased to see that training was also included as one of the key elements of the strategy.

In conclusion, he fully supported the draft resolution contained in resolution EB95.R17.

Dr ABU BAKAR Dato' SULEIMAN (Malaysia) expressed his support for the new WHO strategy for emergency and humanitarian action described in document A48/5 and for the draft resolution proposed by the Executive Board. He asked for clarification of two points: what was meant by "complex emergencies" in paragraph 25(4) of document A48/5, and what was the function of the "regional and interregional emergency preparedness centres" referred to in paragraph 7.A.6 of the draft resolution?

He suggested the preparation of a list of organizations with special expertise and capabilities, from whom countries could request assistance at short notice in case of major disaster.

Dr KEY (United Kingdom of Great Britain and Northern Ireland) also expressed her support for the new strategy. She commended WHO's strenuous efforts to improve its emergency response capacity, in view of the recent unprecedented increase in demand for emergency assistance throughout the world. She had welcomed the formation of the internal Task Force on Emergency and Humanitarian Action, and noted with concern the suggestion that it was to be disbanded.

It was essential that WHO and the other United Nations humanitarian organizations should continue to work closely with the United Nations Department of Humanitarian Affairs, since that was the only way to strengthen the United Nations humanitarian action as a whole. The United Kingdom had established particularly good working relations with WHO in its emergency response in former Yugoslavia.

With particular reference to document A48/5, donor countries should be urged to ensure that in response to United Nations consolidated appeals they make other donations besides food. She particularly commended WHO's work on emergency preparedness, with its emphasis on the improvement of early warning mechanisms to mitigate the effects of epidemics, and welcomed WHO's participation in bodies such as the Interagency Standing Committee of the United Nations Department of Humanitarian Affairs.

Health and medical services in times of armed conflict (document A48/6) were a subject of increasing concern, particularly given the frequent disregard of the rules of war and international humanitarian law, and for the safety of those engaged in humanitarian work. The United Kingdom welcomed and supported WHO's efforts, as set out in paragraph 18 of the report.

Finally, she expressed strong support for the draft resolution proposed by the Executive Board, with the amendment proposed by the Netherlands.

Dr SALMON (United States of America) agreed in principle with the eight key elements of the new WHO strategy for emergency and humanitarian action. Her country attached great importance to coordination within the United Nations system, and she considered that the draft resolution proposed by the Executive Board provided an excellent framework within which WHO could enhance its capabilities and operate effectively with its partners, under the overall guidance of the United Nations Department of Humanitarian Affairs or other designated lead organizations.

With regard to section 3 of the Annex to document A48/5, she asked for information on WHO's intended approach, including the practical details of coordination with the United Nations Department of Humanitarian Affairs, the Office of the United Nations High Commissioner for Refugees and other agencies. She believed that WHO could most effectively contribute in a consultative role, rather than by establishing its own field teams or involving itself in logistics. She also wondered whether WHO's proposed provision of "initial relief assistance in the humanitarian health field in the aftermath of disasters" (mentioned in section 2 of the annex) would not duplicate the efforts of other agencies. On the other hand, she welcomed the Director-General's emphasis on the maintenance and restoration of health infrastructure and health services in emergency situations.

In conclusion, she noted that, given WHO's financial situation, emergency and humanitarian relief activities would have to be financed largely from extrabudgetary resources.

Mr DENGO BENAVIDES (Costa Rica) expressed his support for the draft resolution proposed by the Board, which reflected the need for disaster preparedness at all levels. It was essential for the United Nations, the specialized agencies and nongovernmental organizations to coordinate such activities.

His country's policy of sustainable development included elements of disaster prevention, as reflected in the draft resolution. The strengthening of WHO activities would be of great benefit to Member States.

Dr CICOGNA (Italy) expressed his support for the eight key elements of the new strategy, which formed a realistic basis for WHO's emergency and humanitarian action. Given the Organization's current financial constraints, it should concentrate on areas where its capacity had been proved and where it could maintain a high technical standard. He noted with satisfaction that the new strategy paid particular attention to cooperation with the network of WHO collaborating centres and that there was provision in the proposed programme budget for including emergency preparedness and prevention in training curricula.

Dr VARGA (Hungary) said that a considerable humanitarian and social problem was posed by the rapidly increasing immigrant population in her country. Moreover, the immigrants brought with them communicable diseases, such as tuberculosis and cholera, and had a rising prevalence of drug abuse. The Hungarian economy was in depression, and the authorities were unable to find the financial and human resources needed to deal with the immigrants' health problems. Hungary urgently needed the help of WHO and other countries and agencies in order to deal with the problems caused by immigration, which was largely due to the civil war in the former Yugoslavia and the economic problems of neighbouring countries. Her country proposed that a regional project should be organized to deal with the situation.

Mrs HERZOG (Israel), expressing her overall support for the new strategy and the draft resolution recommended by the Board, proposed that the words "regional and country" in subparagraph 7.A.3 of that draft should be amended to read "regional, bilateral and country". A joint preparedness programme developed by two neighbouring countries could be beneficial to both.

Professor ORDÓÑEZ (Cuba) said that document A48/5 was a useful report on WHO's emergency and humanitarian action in the various regions and countries, on the contributions of donors, and on the part played by various other agencies. It also described the recommendations of the Task Force and WHO's new strategy, which was fully consistent with his country's own policy. However, he was concerned about meddlesome and interventionist acts which were sometimes perpetrated in the name of humanitarian assistance, although his country was most grateful for the humanitarian relief WHO had provided pursuant to Health Assembly resolution WHA46.28. His country would continue to display its solidarity with the international community in natural and other disasters such as had befallen Chile, Honduras, Islamic Republic of Iran, Nicaragua, Peru and Ukraine.

Mrs PRADHAN (India) expressed her support for the new strategy. Natural disasters were common in her country, as in many other developing countries, and time was of the essence in relief work. Although some resources were provided by the Director-General's and the Regional Directors' Development Programme, extrabudgetary resources would be required to support disaster planning and management in the health sector at country level. She hoped to see coordinated international action to strengthen national capabilities to meet the health and nutritional needs of disaster victims.

Dr BIRUTA (Rwanda) expressed his approval of the reports before the Committee and thanked WHO, Member States and other agencies for their contribution to emergency relief in Rwanda over the past year. WHO had a vital role to play in helping Member States to set up the procedures required to deal with emergency situations and restore normality. Such rehabilitation, in particular, was often beyond the capacity of countries in crisis, and intensive cooperation programmes with outside agencies were often required.

Dr ABELA-HYZLER (Malta) paid tribute to the efforts of WHO Member States in emergency and humanitarian assistance, particularly in the European Region. He agreed with the delegate of China that WHO should concentrate on strengthening country preparedness for natural disasters. It might be useful to organize a simulated emergency, perhaps on a regional basis, which would show whether national emergency plans worked. The Organization also had a role in helping countries, early in an emergency, to plan for the rehabilitation stage. The Regional Office for Europe had undertaken some very effective work in that area. He supported the draft resolution recommended by the Executive Board, with the amendment proposed by the Netherlands.

Dr TIERNEY (Ireland) expressed his support for WHO's new strategy and commended the Organization for its activities in disaster and emergency relief, particularly during the recent grave and complex events in Rwanda. WHO should participate fully in interagency coordination mechanisms and cooperation in the field with other agencies, particularly nongovernmental organizations.

Dr LARIVIÈRE (Canada) reminded Committee members that the United Nations Convention on the Safety of United Nations and Associated Personnel, adopted in December 1994, would enter into force as soon as the requisite number of Member States had ratified it. Canada had signed within a few days of the adoption. Under the Convention, certain acts of violence against health personnel and establishments would constitute a crime under international law, which would make it easier to prevent and punish such acts. He called upon Member States which were considering ratifying the Convention to do so as soon as possible, and expressed his support for the Director-General's efforts to prevent acts of violence against health personnel, who were increasingly the target of deliberate attacks.

Dr ATTAS (United Republic of Tanzania) expressed his wholehearted support for the new WHO strategy. His country had been directly affected by the tragic events in Rwanda and Burundi, taking in thousands of refugees at considerable cost to itself. He thanked the international community for its support and endorsed the full participation of WHO in emergency action.

Dr SAMAYOA (Honduras) said that the nature of disasters varied from country to country. For example, his own country was subject to regular large-scale flooding, and the best and least expensive way to combat that was prevention. Honduras would welcome more international assistance in that endeavour.

Dr COUPLAND (International Committee of the Red Cross), speaking at the invitation of the CHAIRMAN, referred to subparagraph 7.C.2 of the draft resolution recommended by the Executive Board, in resolution EB95.R17. As a surgeon working for the International Committee of the Red Cross (ICRC), he was particularly concerned at the medical and public health implications of the widespread use of landmines, which threatened civilians in at least 50 countries, both during and after periods of armed conflict. Over the past ten years, ICRC hospitals had treated more than 12 000 mine-injured patients. Landmines were designed to inflict horrific injuries: for example, a foot or leg coming into contact with a buried landmine would be blown off, while earth and pieces of shoe would be driven up into the other leg, the arms and the genitals. Mine-injured patients presented special surgical problems and used more hospital resources than

other injured people. In particular, they required more blood transfusions: the need to screen blood supplies for contamination with malaria parasites, hepatitis virus and HIV was just one example of the public health implications of mine injuries. The countries affected by landmines were those going through or recovering from wars, which were the least likely to have enough resources for all patients in need.

That was not all. Injured people who survived would require an artificial limb, to enable them to walk again and work to support their families. They were often divorced by their spouses. The presence of mines might prevent access to clean drinking-water and the cultivation of agricultural land, leading to intestinal disease or famine. The social impact of many thousands of young amputees in a society with no welfare system was immeasurable. The presence of mines on roads disrupted a country's recovering economy and stopped aid agencies reaching vulnerable populations. In short the International Committee of the Red Cross saw the widespread use of mines as one of the most serious preventable health problems facing the world.

Mrs DOSWALD-BECK (International Committee of the Red Cross), speaking at the invitation of the CHAIRMAN, said that current preventive efforts by the international community - a United Nations fund to help mine clearance, a conference to review the 1980 convention on certain conventional weapons that was to be held in Vienna in September 1995, and the moratorium instituted by some countries on the export of antipersonnel landmines - would be largely inadequate to deal with the problem. Mine-clearance was difficult, expensive and dangerous. A recent report of the United Nations Secretary-General had indicated that there were approximately 110 million mines scattered in more than 60 countries in the world. At the present rate, it would take 1100 years to clear them, at a cost of US$ 33 thousand million - always assuming that no more mines were laid; in fact US$ 70 million had been spent on clearing 100 000 mines in 1993, during which year another 2 million had been laid.

Further restrictions on the use of landmines were unlikely to have an appreciable effect on the situation, for as long as landmines were available they would continue to cause the casualties and adverse effects just described. It was likely that the Vienna review conference would adopt only limited amendments to the convention regulating their use; ICRC's briefing and position paper, available to delegates, described the amendments likely to be adopted and its views thereon. ICRC was convinced that the total prohibition of the use, production, stockpiling and transfer of anti-personnel mines was indispensable. The limited military utility of antipersonnel landmines could not justify their catastrophic consequences. Export moratoriums, limited in time and effect, would not substantially help the problem.

Current negotiations on the international community's response to landmines, while acknowledging humanitarian concern, primarily took into account military utility, were inevitably coloured by commercial interests, and did not consider public health effects. It was therefore of great importance for WHO to take the matter up, advocate a ban on antipersonnel landmines, and establish an effective programme to deal with the public health damage caused by such weapons.

Professor BERTAN (representative of the Executive Board) said that attention had been drawn in the Board to the importance of the partnership approach towards other United Nations bodies; fund-raising could be done regionally or locally by contacting donor agencies. Furthermore, the Board had recommended that WHO should play not only a normative but also an operational role.

Dr SAMBA (Regional Director for Africa) said that emergencies were a problem faced almost daily in the African Region. Of the 46 countries in the Region, 36 were in the throes of some form of emergency and some of the remainder threatened with such situations. Commenting on a chart and three maps projected on a screen, he said that the chart, representing a "disaster severity index", showed the extreme severity of disasters in Africa as compared with the rest of the world. A map showed areas in Africa affected by cholera, yellow fever and plague epidemics in January 1995. A second map, with the heading "Conflict, instability and transitions", showed the results of such situations, as at January 1995, in terms of internal or external displacements of people. A final map illustrated the extremely serious problem of landmines, of which there were over 10 million in some countries.

In response to that situation, WHO was training its personnel in the country offices and preparing them to train nationals in order to ensure effective collaboration with national authorities and United Nations and other multilateral and bilateral agencies, including nongovernmental organizations. Although no two emergencies were alike, he endorsed the idea, put forward by Malta, of a form of peace-time dress rehearsal

at the regional level for collaboration in an emergency. Trial runs of that kind would impress on WHO partners the need for cooperation and complementarity. Furthermore, a small unit had been established at the Regional Office to work with headquarters in contacting partners in support of countries facing emergencies, in which time was of the essence. WHO was ideally placed to assist in such situations through its presence, in the form of the country offices, before, during and after an emergency. It was thus well qualified, for instance, to play a "proactive", preventive role in certain predictable types of emergency, and to participate in reconstruction and rehabilitation after the event.

Emergency action was a drain on resources, and he therefore appealed for increased extrabudgetary funding in addition to regular budget allocations. To his knowledge, the increasingly important training centre in Addis Ababa received funding from Italy; further support from other countries or agencies would be greatly welcome.

WHO's emergency work did not, perhaps regrettably, enjoy media visibility, and yet the Organization was deeply engaged in often dangerous emergency action in the field, as could be seen from the loss of five WHO staff members during the recent conflict in Rwanda. In tribute to those five victims he hoped the Health Assembly would confirm and increase its support for WHO's emergency and humanitarian action.

Dr UTON RAFEI (Regional Director for South-East Asia), endorsing Dr Samba's comments, said that at its forty-fourth session the Regional Committee for South-East Asia had considered the subject of emergency preparedness and response and had adopted resolution SEA/RC44/R5, requesting the Regional Director to support the Member States in their efforts to improve their capability for formulating national health plans for emergency preparedness, human resource development, training and research. Since then, many countries had developed national plans for emergency preparedness and humanitarian action. Particularly relevant to the South-East Asia Region were health emergencies arising out of natural and technological disasters. The activities undertaken thus far in the Region were consistent with the new strategies and aimed primarily at long-term national capacity-building. The Regional Office had taken steps to strengthen its role in emergency and humanitarian action. The intercountry programme for the biennium 1996-1997 would address the formulation of national plans and programmes for health emergency preparedness and relief operations, improvement of the infrastructural and disaster management capability of countries, the Regional Office and the WHO Representatives' offices, development of human resources through large-scale training activities, and promotion of interagency cooperation. A post of technical officer for emergency and humanitarian action had been established at the Regional Office to strengthen its capacity for implementing those activities, and the position had been filled in April 1995.

Dr JARDEL (Assistant Director-General) said that every effort would be made to take account of the speakers' suggestions and comments during the preparation of the plan of action for the programme budget for the financial period 1996-1997. Regarding WHO's role in emergency and humanitarian action, while great importance was attached to its normative function as public health adviser in emergency situations, that priority did not preclude its immediate presence in the field, which was crucial to its credibility. It could very well fulfil that normative function through action in the field without engaging in the logistic aspects.

WHO's presence was, moreover, essential for coordination with other partners. Emphasis was also being placed on internal coordination, mechanisms having been introduced to improve coordination between headquarters, the regional offices and the WHO Representatives' offices, and also at headquarters itself, with encouraging results. Furthermore, of all the agencies in the United Nations system, WHO was perhaps the most fully committed to interagency coordination by the United Nations Department of Humanitarian Affairs, through the Interagency Standing Committee.

The programme budget gave considerable importance to training, a subject raised by many speakers. The Organization was not in a position to develop training activities on a very wide scale, but directed its efforts more towards the use of national collaborating centres and national, regional and interregional centres, like the Addis Ababa centre mentioned by the Regional Director for Africa; in that connection, while Italy was indeed the major contributor to that centre, Finland also provided personnel. Regarding emergency information or early warning systems, WHO was developing such systems and was ideally placed to enable its representatives to play a key role in early warning.

Despite the importance assumed by relief operations, emergency preparedness activities were still a priority, with the Organization participating closely in activities under the International Decade for Natural

Disaster Reduction. It was particularly concerned with strengthening national capacity to respond to emergencies and with ensuring a continuum between emergency relief and development. The two divisions responsible for emergency relief and international cooperation were working in close association to that effect. Another important area, for which funds were regrettably inadequate, was the evaluation of emergency operations. For maximum effect, independent evaluations should be carried out, as had been done in the European Region for activities in the former Yugoslavia. Other crucial areas were research and publications. Emphasis had been placed in all technical discussions on publishing clear, readable and accessible technical documents so that technical information could be available immediately in emergencies.

In answer to the delegate of Malaysia, "complex emergencies" were multisectoral crises that could not be dealt with by the governments alone but demanded a coordinated response by humanitarian agencies, nongovernmental organizations and bilateral partners. Often erupting into open conflict, they had a deep-seated political dimension that required a political response by the United Nations system through the Secretary-General and the Security Council. A situation was deemed a complex emergency when the United Nations defined it as such.

The CHAIRMAN drew the Committee's attention to the draft resolution recommended by the Executive Board in its resolution EB95.R17, and to the amendments proposed by Bangladesh, Israel and the Netherlands.

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

Intensified cooperation with countries in greatest need (Resolutions WHA43.17, WHA44.24, WHA46.30 and EB95.R8; Document A48/7)

Professor BERTAN (representative of the Executive Board) noted that the WHO initiative for intensified cooperation, on which the Director-General had reported to the ninety-fifth session of the Board, had been introduced at the end of 1988 in response to the stagnation or deterioration of the health status of the world's poorest people. Resolutions WHA43.17, WHA44.24 and WHA46.30 endorsed the launching of the initiative, and the Director-General had been requested to report to the Forty-eighth Health Assembly on the implementation of resolution WHA46.30. The approach focused on strengthening the capacity and performance of the health sector in the poorest countries, in ways specific to the needs of each country. It had become increasingly apparent, however, that halting a decline in health services must include a strong, focused attack on all aspects of poverty and its consequences for health; furthermore, the health sector would have to assume new roles. The fundamental aim of intensified cooperation was to develop national health systems, rather than to make successive short-term improvements.

The Executive Board had noted that the approach was based on the needs of countries rather than of programmes, and that support had been found for only 26 of the 36 countries that had expressed an interest in the initiative. Proposals for the future included the promotion of policies, developed on the basis of experience in specific countries, for health development in countries in greatest need; development of new methods when necessary; strengthening WHO's country offices; and strengthening WHO's technical and budgetary support. The Board had noted that the initiative had been in operation for five years and represented both a new kind of partnership and a stronger, better-defined role for the Organization at the country level. Much had been accomplished of which WHO could be very proud. It had been proposed that criteria might be established for setting priorities, especially in view of the lack of financial and human resources in the Division of Intensified Cooperation with Countries to respond to the demands of all the countries that wished to benefit from the initiative. In order to pursue and strengthen cooperation with countries in greatest need, the Executive Board had therefore decided to submit to the Health Assembly the draft resolution contained in resolution EB95.R8.

Dr TIERNEY (Ireland) said that, like other States, Ireland was seriously concerned about the deteriorating conditions of health in the world's poorest countries and among the poorest people in all

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA48.2.

countries. In view of the wide diversity of political, economic and social circumstances, any approach to the problem should be based on the needs of individual countries, and strong leadership would be required from WHO in order to initiate an adequate, coordinated response to those needs. He strongly supported initiatives in which WHO worked within a planning framework with the governments of countries in greatest need. The work should be based on priorities determined by those governments, and carried out with advice from WHO and in close cooperation with donor countries, nongovernmental organizations and funding agencies. A district or region could be selected within a country, for example, and a programme for reform of the health care system be decided upon by the national government in conjunction with WHO; all interested parties could be invited to participate in the detailed planning and coordination. The programme should be long-term, sustainable, and transferrable to other regions and countries with suitable modifications. The initiative under discussion was a demonstration that such an approach could be successful.

Mrs GU Keping (China) also noted the profound political and socioeconomic changes that had taken place over the preceding few years and which had had adverse effects, especially in the least developed countries, not only hindering the development of medical and health services, but also damaging the existing services and reversing many of the gains they had made in their efforts to improve the health of their people. Those countries needed support from the international community, including WHO. The programme for intensified cooperation with countries in greatest need had had a positive effect, and she endorsed the future activities recommended in the report. She noted, however, that of the 36 countries that had made formal requests to WHO for assistance within that programme, only 26 had received it. More countries would probably ask for such cooperation, and WHO should be able to respond fully to such requests. The emphasis should be on helping countries to help themselves, for instance, in establishing sustainable health systems based on primary health care, strengthening and improving health financing systems at all levels, enhancing health manpower training, and transferring appropriate technology. Intercountry exchange of experience should be intensified, and approaches that benefited health development should be popularized. She fully endorsed WHO's plan to convene an international meeting for that purpose in 1996; exchange of experience could also be promoted by, for instance, visits between neighbouring countries, publications and communications. At the international level, WHO should strengthen its partnership with other United Nations bodies and with multilateral and bilateral donor agencies in order to encourage recognition of the high priority that should be accorded to health when assistance was provided.

Dr GIBRIL (Sierra Leone) said that his country had been part of the network for intensified cooperation for the previous two years, during a time when radical changes were being made in the structure and functioning of the health care delivery system, including the development of a new health policy, a national health action plan, donor coordination, and new systems for managing human resources and finances. WHO through its intensified cooperation with countries had provided support in a number of areas. In order to strengthen health management, a problem-solving approach had been adopted to improve managerial capacity at the district level, involving preparation of projects, establishing a national network of "facilitators", training such people and holding a series of workshops on management. In the area of health care financing, papers had been prepared on the system used currently, a national seminar had been held on the subject, a project proposal had been written and guidelines had been prepared. Cooperation in the field of health legislation had involved assessment of needs and review and implementation of an effective system. Aid mobilization had been supported by assistance in the negotiation process.

He recalled the emphasis placed at earlier meetings of the Committee on WHO's focusing on what it did well, and hoped, by describing the kinds of assistance that could be effectively provided at country level, to allay the fears that some might have. He strongly supported the draft resolution recommended by the Executive Board.

Mrs RODRÍGUEZ de FANKHAUSER (Guatemala) noted that in *The world health report 1995*, and in the Director-General's address to the Health Assembly, poverty was identified as the main cause of ill-health. Poverty was extending all over the globe, and WHO should try to respond to new and old challenges, using the strategy of health for all as a means of reducing disparities between and within countries. Health problems might be similar in various regions but there were no universal remedies; the characteristics of each country had to be taken into account. Technical cooperation required an integrated approach, including

assistance to countries or localities in managing and administering the aid received from organizations or countries.

Guatemala was one of the 26 countries that had benefited from intensified cooperation since 1992, at which time two main strategies had been identified: implementation of health policies in order to improve the distribution of funds at all levels, which implied decentralization, the development of local health systems and a stable financial system; and development of health care for vulnerable populations and groups, using an integrated, humane approach. Repatriates and displaced persons from Mexico were included in that approach.

One of the areas covered by the strategy for 1995 was support to the process of reform of the health services by developing local institutional capacity, especially in administration and management, through the training in particular of health professionals. Local offices had been created and staffed by qualified national personnel, with enhanced management capacity. Another area of concern was the large migrant population in Guatemala, where people from the high plateaux came down to the coast each year for the coffee, sugar and cotton harvests. Ways were being studied to increase the social security coverage of those migrants, and pilot studies were being conducted to provide better sanitation on the plantations where they worked and to improve their health status.

Intensified cooperation was a new, positive activity which had already shown its worth; countries had learned to use a more specific type of assistance. Although she agreed in general with the draft resolution, she would have liked the text to be more emphatic.

Dr VAN ETTEN (Netherlands), noting that the programme for intensified cooperation provided an important mechanism for strengthening health systems at the national level, inquired to what extent it was cooperating with programmes coordinated by the Division of Strengthening of Health Services. He also asked what criteria were used in allocating financial and technical resources; document A48/7 mentioned none, but subparagraph 3(1) of the draft resolution recommended in resolution EB95.R8 made reference to criteria such as income and health status. Were those some of the criteria adopted by WHO?

He proposed two amendments to the draft resolution: in subparagraph 2(2), the insertion of the words "in addition on" after the words "expertise and"; and in subparagraph 3(1) the addition of the words "and willingness of governments" after "national capacity".

Mr TOMO (Mozambique) said that his country was one of those that had benefited from the programme for intensified cooperation since 1990. It had been at peace since 1992, and the Government formed in December 1994 had adopted a programme of national reconstruction in which health was a priority. It was difficult to rebuild a country after 15 years of war, especially since the proportion of the population not covered by the national health service had risen from 40% before the war to about 60% by the end of it. Within the framework of government-donor coordination, great efforts were being made to determine what were the most urgent among the many priorities in the national reconstruction programme. His country's needs were clearly defined; it now required the financial means to deploy the necessary material and human resources in order to transform the constantly growing demands into reality. He fully supported the draft resolution.

Dr YAO SIK CHI (Malaysia) noted with concern the deteriorating health of people in the least developed countries. Measures to alleviate poverty and its effects on health were crucial to progress, health for all and socioeconomic development. Malaysia supported the efforts of Member States to strengthen health development and commended WHO's reorientation of its structure and function at all levels towards intensified cooperation with countries in greatest need. He expressed his support for the draft resolution recommended by the Executive Board.

The meeting rose at 12:30.

FIFTH MEETING

Saturday, 6 May 1995, at 9:00

Chairman: Dr E. NUKURO (Solomon Islands)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

GENERAL REVIEW:[1] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC.7 and EB95/58)

Appropriation section 2: Health policy and management (continued)

2.3 National health policies and programmes development and management (continued)

Intensified cooperation with countries in greatest need (Resolutions WHA43.17, WHA44.24, WHA46.30 and EB95.R8; Document A48/7) (continued)

Dr KEY (United Kingdom of Great Britain and Northern Ireland), welcoming the Director-General's report (document A48/7), said that since the launching of WHO's intensified cooperation initiative the United Kingdom had followed with interest the activities but had not so far been a major donor of voluntary or extrabudgetary contributions. In fact, the increasing reliance of the programme on extrabudgetary funds was a matter of concern; the percentage of funding from the regular budget had fallen from some 50% in 1990 to less than 25%.

The initiative, with its focus on national capacity building, improved horizontal and vertical integration of WHO activities, and coordination with other agencies involved, was well suited to respond to the most vital needs of the least developed countries. She commended its success in having, with limited staff and resources, established programmes in 27 countries. However, new requests were being made by many of the remaining eligible countries, and she feared that it would not be possible to respond to them given the current and proposed level of WHO funding.

The approach described in document A48/7 made no reference to the essential donor coordination mechanisms that WHO would need to establish by working together with governments. The multiplicity of donors, all with very different policies and approaches, meant that enormous demands were made on ministries of health, planning and finance in the countries concerned. WHO should take the lead in producing a guide for such countries on how to establish and institutionalize effective donor coordination mechanisms.

The initiative was somewhat isolated within the Organization; intensified cooperation activities should be an integral part of the work of other departments and divisions, and should be integrated with all other action programmes at country, regional and headquarters level. Unfortunately, the barriers that existed between programmes and between units tended to lead to duplication of effort, particularly at country level, and consequent waste of scarce resources.

She supported the draft resolution recommended in resolution EB95.R8 but proposed that in subparagraph 1(3) the words "to establish and institutionalize effective systems to" should be inserted before "coordinate". In subparagraph 3(1), she proposed that the word "more" should be inserted before "countries", and that the words "and strengthening the WHO country offices in those countries, so that the staff have the

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

technical competence and expertise to provide the necessary advice and leadership to the national government" should be added at the end of the subparagraph.

Dr SHRESTHA (Nepal), commending the report, said Nepal was one of the 26 countries in the world and the five countries in the South-East Asia Region benefiting from intensified cooperation with WHO. It had received support in such areas as health economics and financing, health sector review, accelerated development of management information systems, development of human resources for health, strengthening of district level health management systems, and strengthening of national capacity for external aid management. He endorsed the Director-General's four proposals for increasing the Organization's capacity for intensified cooperation set out in paragraphs 16-19 of document A48/7, and supported the draft resolution recommended in resolution EB95.R8.

Mrs OULTON (Canada) congratulated the Director-General on his efforts to intensify cooperation with countries in greatest need. Canada supported the basic principles of intensified cooperation, and the emphasis laid on integrated policies and national execution. It was crucial that national authorities benefiting from intensified cooperation should play an active role as full partners with WHO. The proposals for the future contained in section IV of document A48/7 were very encouraging, and the report showed that WHO's original vision of intensified cooperation was still very much alive. She supported optimum use of all WHO's resources at country level, and favoured close linkage between intensified cooperation activities and those funded through country allocations under the regular budget.

While she supported the draft resolution contained in resolution EB95.R8, it should be clearly understood that the "country-specific WHO response" referred to in subparagraph 3(1) implied, first and foremost, a response to collective policies, objectives and priorities, which could then be adapted to specific local circumstances through a country-focused approach placing health development in the context of overall national development.

Dr GOMES (Guinea-Bissau) said that as one of the beneficiaries of intensified cooperation, Guinea-Bissau appreciated the initiative as a clear expression of the Organization's solidarity with the countries in greatest need. However, the programme's first concern should be to identify the real obstacles to the development of health systems in countries. In Guinea-Bissau, the initiative continued to have a very positive impact, particularly in strengthening management capabilities at central and intermediate level, in coordinating health activities, and in ensuring a more rational use of available resources. Accordingly, he supported the resolution contained in resolution EB95.R8.

Mrs VOGEL (United States of America) welcomed WHO's continued recognition of the relation between poverty and ill-health. A holistic approach, linking economic, environmental and social factors to health, produced information that could be useful for all countries, not only those in greatest need. She hoped that efforts to ensure congruence with countries' national plans would be a major component of intensified cooperation. She emphasized the importance of rationalizing the selection of countries and of giving priority to activities at the country level. In that context it was encouraging to hear the experiences of beneficiaries of intensified cooperation. In seconding personnel to strengthen the capacity of WHO country offices, a sharing arrangement between contiguous countries might be considered, in order to make the best use of scarce resources. She noted the proposal to convene a meeting in 1996 to share the Organization's policy guidelines with representatives of the poorest countries, as well as with the multilateral, bilateral and nongovernmental organizations which were giving them support, and hoped that consensus could be reached at that meeting on priority health topics for contiguous countries.

She endorsed the proposal to strengthen the technical and managerial capacities of headquarters and of regional and country offices, although emphasis should be on strengthening capacities at regional and country rather than headquarters level. That would appear to be the conclusion reached in document A48/7, but she would welcome clarification.

Dr SINGAY (Bhutan) commended the intensified cooperation initiative, which was well focused and effective. Bhutan had so far benefited from assistance in formulating a five-year plan for its health sector, in capacity-building, and in the strengthening of training institutions. Help had also been given to improve

the patient referral system and to ensure effective and prompt responses from district to peripheral health services by improving telephone and radio communications. Further areas of cooperation were now under discussion. Intensified cooperation should give more emphasis to country-specificity and country-relevance in its approach, and efforts should be made to improve communications between headquarters, regional offices and countries, so that the enthusiasm and momentum generated at country level could be sustained. He supported the draft resolution contained in resolution EB95.R8.

Dr KATEMA (Zambia) said Zambia too had benefited from intensified cooperation, and he therefore supported the resolution recommended by the Executive Board in resolution EB95.R8, with the amendments proposed by the delegate of the United Kingdom.

Dr TOURÉ (Guinea) said it was clear from the Director-General's report (document A48/7) that poverty was the major cause of ill-health; the poorest countries bore the heaviest burden of ill-health. While the analysis given in the report was excellent, attention should be focused on the action needed to remedy the situation. The integrated approach of intensified cooperation with countries should be encouraged, strengthened, and if possible expanded, and he commended the efforts thus far. Intensified cooperation not only enabled WHO to reduce inequalities but also enabled the countries concerned to develop the capacity to bring their own process of health development to a successful conclusion. He shared the views expressed by previous speakers, and strongly supported the draft resolution under consideration.

Mr CHAE Thae Sop (Democratic People's Republic of Korea) commended WHO for its efforts to strengthen cooperation with countries in greatest need. As indicated in the report, the health status of the least developed countries was continuing to deteriorate, despite continued efforts by WHO to support their health services. If inequalities in the field of public health were to be eliminated, WHO's collaboration with such countries must be strengthened. The international community should focus attention on the plight of countries in greatest need, and should do all it could to mobilize additional funds to assist their health development and to tackle urgent health problems. He supported the draft resolution before the Committee.

Dr GEORGE (Gambia), commending the Director-General's report, recognized the decline in the health status of the least developed countries following the decline in their economic performance; poverty was the root cause of the problems such countries faced. He hoped that WHO and its partners would continue to implement a multisectoral strategy, which was a realistic approach to the solution of those problems. Specifically, support should be given to improving and strengthening mechanisms and capacities at district level, and to coordinating, monitoring and evaluating health intervention programmes to ensure that they had the maximum impact. WHO should coordinate its intensified cooperation activities with those of other agencies at country level. Synchronization of efforts would do much to help communities build up the skills and capacities they needed to manage and implement community-based projects such as the Bamako Initiative.

Most, if not all, of the least developed countries needed to benefit from WHO's intensified cooperation. In view of the current shortage of funds, he urged the Organization to intensify its alliance with nongovernmental organizations, so that it could play a proactive role in deciding how the extensive health sector resources available to them were spent. WHO country offices could play a significant role in that connection. He welcomed the Director-General's proposals for the future, set out in section IV of document A48/7, and stressed that it was important for countries to be provided with information, through country offices, as to how they could best benefit from intensified cooperation. He supported the draft resolution contained in resolution EB95.R8, with the amendments proposed by the delegate of the United Kingdom.

Dr PAVLOV (Russian Federation) said that the current far-reaching changes in the world could not fail to affect health and health systems in many countries. The most vulnerable groups in society were the worst affected, finding it ever more difficult to obtain medical and preventive care. The growing commercialization of health care, resulting from the need to cut costs while maintaining a basic level of services, reduced equity of access even further. He therefore welcomed WHO's activities in the field of intensified cooperation with the countries and peoples in greatest need. With its wealth of experience, WHO was in a position to provide technical support, information and expertise to poor or crisis-stricken countries. He therefore supported the draft resolution proposed by the Executive Board in resolution EB95.R8.

Ms NESBITT (Australia) noted that intensified cooperation was a country-specific approach recognizing the differences in health problems and in the resources needed. She welcomed the increased emphasis on policy development and the strengthening of WHO country offices described in paragraph 3 of the Director-General's report (document A48/7). Nevertheless, resources remained limited, and WHO's policy of action at country level had committed it to re-examining the way its resources were allocated in order to use funds in a more focused but flexible way through links with country-specific strategies (paragraph 20). She therefore had some reservations about the proposal in paragraph 16 to convene a meeting with representatives of the poorest countries and various donor agencies to publicize WHO's policy guidelines, an aim which, she felt, might be more effectively achieved at country level.

Mrs MILEN (Finland) expressed her support for WHO's concept of intensified cooperation, which emphasized national health development and promoted intersectoral, integrated and coordinated action. WHO should strengthen such approaches in all countries in order to take the leading role in health development. As the health gap between nations widened, the need to support the poorest countries increased. Activities should therefore be expanded to cover more countries, as proposed in paragraph 15 of document A48/7, with a corresponding increase in financial and technical resources at both country and headquarters levels. Immediate action would, however, be needed to strengthen the coordination of WHO's intensified cooperation with countries at all levels. She supported the proposed draft resolution in principle, but it should be amended to reflect her concern and that expressed by the delegate of the United Kingdom.

Dr DO NASCIMENTO ALVES (Brazil) said that WHO should rationalize its intensified cooperation by identifying groups of countries with similar ethnic structures, languages, geographical features and technical capacities. It was also essential to establish clear, viable and useful objectives for action. WHO would need to mobilize international sources of funding if such cooperation was to succeed: perhaps an international health fund could be set up, financed by a levy on world financial transactions. Brazil had established a number of cooperation programmes with Portuguese-speaking African countries in such areas as epidemic diseases, AIDS and mental health, in accordance with WHO guidelines. He supported the draft resolution.

Mr BAYARSAIKHAN (Mongolia) said that over the past five years 26 countries had benefited from intensified cooperation, enabling them to improve their national capacity for sustaining an effective health system, to improve cost-effectiveness and to make the best use of scarce resources. The success of the country-specific approach was demonstrated by the number of countries waiting to take advantage of the initiative. In Mongolia, intensified cooperation had contributed to the introduction of a universal health insurance system, the strengthening of health management, the coordination of aid in the health sector and the improvement of rural health services. He supported the draft resolution, with the amendments proposed.

Professor LEOWSKI (Poland) welcomed the proposed extension of intensified cooperation with countries and peoples in greatest need to 40 countries over the next biennium. However, in another clearly identifiable group of countries - those with economies in transition - a marked deterioration in basic health indicators had been seen in the very recent past. In the interest of equity and solidarity, WHO might consider extending such intensified cooperation to those countries, which would certainly require it if their health status was not to deteriorate further. Moreover, they were in a good position to make the best use of WHO assistance. He expressed his support for the draft resolution under discussion.

Dr KHOJA (Saudi Arabia) suggested, first, that a database should be established on international cooperation with countries in greatest need. Secondly, WHO should consider carrying out research on common problems associated with technical cooperation in sectors other than health, and training for decision-makers in those sectors, in order to improve the planning and cost-effectiveness of health systems. For example, in 1987 the Gulf Cooperation Council had undertaken research on children's health, which had provided a great deal of valuable information. Thirdly, it was essential to provide training for health leaders to help them to appreciate the importance of technical cooperation and to apply their expertise to best advantage. He endorsed the draft resolution under consideration.

Dr KORTE (Germany) welcomed the country-specific approach taken in intensified cooperation and the emphasis on the poorest countries, which was fully consistent with his own Government's policy. In particular, he welcomed the efforts to help countries to strengthen their own planning and health management capabilities.

His Government's policy was to support countries primarily through bilateral mechanisms and funding. Nevertheless, there was still scope for collaboration between WHO and bilateral programmes to improve the coordination of donor support. He requested more information about the collaboration mechanisms introduced for the strengthening of health services.

He welcomed recent moves by WHO and the World Bank to work more closely together. Those initiatives could be taken even further, e.g. by means of bilateral programmes. He endorsed the draft resolution, with the amendments proposed by the Netherlands and the United Kingdom.

Dr VIOLAKI-PARASKEVA (Greece) endorsed the draft resolution, with the amendment proposed by the United Kingdom, and proposed that in subparagraph 3(2) the words "and strengthen technical and managerial capacities" should be inserted after the word "Organization".

Professor GRANGAUD (Algeria) said that the draft resolution, which he supported, rightly emphasized that Member States were responsible for defining their own national priorities. In future, intensified cooperation should take the form of a basic package, agreed by consensus, and offered to every country. It was necessary to examine more thoroughly the methodology of all proposed health system reforms. On some occasions in the past, such reforms had led to a deterioration in the health status of the poorest groups in society.

Mrs HERZOG (Israel) proposed that in subparagraph 3(4) of the draft resolution the words "including human resources from countries that have emerged successfully from the state of a developing country to a developed one", should be inserted after the words "external resources".

Dr MOREAU (France) said that intensified cooperation activities were in the best WHO tradition of equity, international solidarity and the fight against poverty. However, evaluation was essential if lessons were to be learned from the experiences of the 26 countries which had benefited so far. It was also essential to establish real coordination between donors in order to avoid duplication. He endorsed the draft resolution recommended by the Executive Board.

Dr NICKNAM (Islamic Republic of Iran) also endorsed the draft resolution. In particular, paragraph 2 rightly emphasized that all Member States were responsible for the planning and implementation of their own health development policies, with appropriate financial and technical assistance from donors.

Dr ANTELO PÉREZ (Cuba) said that the initiative was very much in keeping with the Director-General's appeal for equity and solidarity. The fact that 26 countries were benefiting from it and that an additional 14 wished to participate in it demonstrated its importance. He supported the draft resolution.

The experience gained and the growing number of requests showed that intensified cooperation was an effective approach, focusing as it did on country-specific needs, on reducing disparities between and within countries, on capacity-building, including the capacity to manage the support provided by donors, and on coordinating and directing activities by countries so as to increase their effectiveness and sustainability. The "top-down" approach adopted enabled the Organization's resources to be used in a cost-effective manner. WHO's capacity to provide effective support to countries should be strengthened by a more flexible and broader approach to intensified cooperation so as to increase its viability, more resources being made available for countries, especially those in greatest need, and by coordination of intensified cooperation with countries and ensuring direct reporting to the Director-General. He was grateful for the visit to Cuba by a representative of the programme and reiterated his country's commitment to further collaboration.

Dr ASHLEY-DEJO (Nigeria) said that, despite the relatively large number of health professionals in Nigeria and his country's national policy based on primary health care, it was difficult, with a population of

some 100 million, to provide minimum services to all 3000 districts equitably. His Government appreciated the support provided by the WHO country office to Nigeria's national programmes.

Although Nigeria was not listed as one of the countries in greatest need in Africa, it would like WHO to use its good offices to assist in streamlining and coordinating the activities of the various multilateral and bilateral donor agencies, which were lacking in focus and consequently in effectiveness. Thus two different systems of supplying drugs to districts, both supported by WHO, were in operation; the essential drugs system supported by the World Bank, and the Bamako Initiative system promoted by UNICEF and the British Overseas Development Agency. Nigeria fully supported the draft resolution, with its emphasis on the collaborative and coordinating role of WHO.

Dr DOSSOU-TOGBE (Benin) said that, despite the emphasis in the Declaration of Alma-Ata on participation by every individual in the planning, delivery and evaluation of health care, the focus on community involvement in health development in the Technical Discussions at the Forty-seventh World Health Assembly, the consensus at that Health Assembly on the respective roles of the community, the health sector and other sectors, and the abundant and authoritative literature on participation, the fact must be faced that participation was still something of a dead letter in international and bilateral cooperation and in national programmes, with a resulting lack of interest by beneficiaries, who failed to identify themselves with programmes or projects. He therefore urged the Committee to place particular emphasis, in the draft resolution, on enhanced participation in the intensified cooperation initiative. He was prepared to join in efforts, for example in a drafting group, to that end.

Dr AL-JABER (Qatar) advocated full, comprehensive cooperation under the initiative with all 40 countries referred to in the report. He hoped that WHO would receive the necessary financial resources so that intensified cooperation could be implemented as soon as possible, and stressed the role of nongovernmental organizations in assisting in that endeavour. A portion of the 5% of resources reallocated to priority areas might perhaps be set aside for intensifying cooperation with countries in greatest need in the coming period.

Dr MANSOUR (Egypt) endorsed the suggestion by the delegate of Saudi Arabia that a database on intensified cooperation with countries in greatest need should be established. It was necessary to strengthen those countries' capabilities for making optimum use of available resources in evaluation and planning and in maximizing impact, and for supporting programmes and activities on a sustainable basis. Emphasis should be placed on strengthening technical cooperation between the countries concerned. Egypt supported the draft resolution recommended by the Executive Board.

Dr DY (Cambodia) supported the draft resolution. The combination of poverty and low health status made it necessary for WHO to intensify cooperation with countries in greatest need so that at least the minimum needs of the populations of those countries could be met.

Dr BASLY (Tunisia) expressed gratitude for the support received by the health sector in Tunisia and, in general, for WHO's efforts, as reflected in the report by the Director-General (document A48/7), to improve the health status of the world's poorest people and close the gap between the advanced and the developing countries through intensified cooperation with countries and peoples in greatest need. The health situation was particularly unsatisfactory in Africa, and he hoped that WHO would attain all its objectives as soon as possible.

International cooperation should be based on a multidisciplinary, comprehensive approach, with special programmes for countries in greatest need, and should provide for an appropriate legal and administrative framework to sustain programmes and cooperation; qualified personnel at all levels dealing with both primary health care and emergency measures, and ensuring effective coordination between all partners; and optimum use of available resources to help countries overcome bureaucratic obstacles to immediate action, which could be essential in certain situations. WHO had a leading role to play in that field.

In many cases a regional approach to intensified cooperation, especially in the countries of the South, would have a greater impact than an individual country approach. Activities should accordingly be horizontal in character, with emphasis on South-South cooperation and technical cooperation among developing countries

(TCDC), which could be mutually beneficial to countries with similar socioeconomic conditions; likewise, the experience of economically more developed countries would benefit those that were less developed.

Dr SAMBA (Regional Director for Africa) said that most of the 46 countries in the African Region were eligible for support under the initiative, which was much appreciated in Africa. Since he had taken office, he had sought very close coordination of emergency and humanitarian action and intensified cooperation with countries, the former for acute emergencies and the latter for chronic emergencies and rehabilitation. His objective was to ensure continuity in action and expansion of the initiative to other countries. Twelve countries in Africa were currently benefiting from intensified cooperation, but others were requesting support.

Given the Region's limited capacity, the process was to be accelerated by strengthening country office capacity through training and human resource mobilization, and by strengthening the Regional Office's capacity to support countries more effectively. Intensified cooperation in Africa was country-driven, with emphasis on collaboration at the country level.

Dr HUSAIN (Regional Office for South-East Asia) said that the Region was a major participant in the initiative. Participating countries received appropriate, timely and catalytic support for national health policy formulation and health system reforms, including financing and health insurance, in addition to support for the strengthening of long-term major country programmes such as human resources development and health planning and management. Experience in the Region in the past three to four years had confirmed that the initiative was more effective and potentially more sustainable when delivered in a coherent and integrated manner with technical back-up by the Regional Office and headquarters and when incorporated into the mainstream of WHO country-level cooperation. The new focus on poverty alleviation opened up new vistas for intensified technical cooperation. He was hopeful that the further strengthening of the initiative would be of continuing benefit to the countries in greatest need.

Dr JARDEL (Assistant Director-General), replying to comments and questions, noted that the statements of the Regional Directors had shown that the initiative for intensified cooperation with countries was one that involved the Organization as a whole and not just headquarters. Regarding the question of criteria for deciding to support countries, action was taken not only on the basis of national statistics but in response to requests from individual countries, either because they were among the poorest, as were the least developed countries, or because they were experiencing temporary crises resulting in a decline in the health status of their populations which called for a phase of national recovery or a specific plan to counteract poverty. The strategy therefore hinged on a clear expression of the will of the country concerned to participate in the initiative and also, of course, the Organization's material capacity to respond.

Regarding the links between the initiative for intensified cooperation with countries and the programme for strengthening of health services, the main responsibility of the latter at headquarters was to develop norms and standards for the organization of health systems based on primary health care. The initiative for intensified cooperation with countries was not a programme in the traditional sense, but a division at headquarters facilitated such cooperation at all levels: headquarters, regional offices and country offices. One of its main functions was to ensure that WHO recognized the specific needs of countries and responded to them adequately and sustainably. In reply to the comments of the delegate of Canada, he said that the Organization's response to country-specific needs also took into account the orientations of programmes and the global and regional priorities of WHO. The initiative for intensified cooperation with countries and the programme for strengthening of health services cooperated closely. For example, the former used manuals for training district managers that had been prepared by the latter; both participated actively in a special group on economics established by the initiative, which participated in studies undertaken by the programme on decentralization, especially in several of the countries that were participating in the initiative; and in fact several members of the staff of the programme for strengthening of health services had participated directly in activities in those countries. There was thus close cooperation and cross-fertilization.

A question that had been raised, in particular by the delegates of Bhutan, Finland, the United Kingdom, and the United States of America, concerned the strengthening of WHO capacity to undertake the initiative. The intention was first to strengthen capacity at the country level, with the support of the regional offices; in fact, the Director-General, in reallocating 5% of the budget, proposed to assign three posts to the initiative,

which would be based in the regions in order to serve the countries in greatest need. The financial implications of directing the efforts of the three levels of WHO towards the specific needs of countries and the demand for extension of the initiative were, however, problematic. The balance between the regular budget and extrabudgetary funds, which currently predominated, must be monitored continually. Although WHO was proud of the initiative, it did not consider that it owned the approach and was pleased to note that its principles were reflected in bilateral cooperative efforts, as had been noted by the delegate of Brazil.

The CHAIRMAN drew the Committee's attention to the draft resolution contained in resolution EB95.R8, entitled "Intensified cooperation with countries in greatest need", and the amendments to that resolution proposed by a number of delegations.

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

2.4 Biomedical and health information and trends

Professor BERTAN (representative of the Executive Board) said that the programme budget heading under discussion comprised activities relating to assessment of the health situation and trends, including *The world health report 1995*, as well as those relating to health and biomedical information support; both components had been reviewed and evaluated by the Executive Board. The first, assessment of the health situation and trends, concerned constitutional tasks of WHO. The Board had endorsed the future plans for the programme but had requested more emphasis on strengthening national systems for health information, so that countries could better monitor and evaluate their own health policies and their progress towards health for all. WHO should be able not only to examine trends in past performance but also to analyse future health trends and make projections on the basis of a study of data on mortality, morbidity, disability and health determinants. Analytical capability should be strengthened at the regional level in order to facilitate closer exchange with countries.

The second component of the programme heading, health and biomedical information, covered editing and publication of WHO books and periodicals, translation of technical documents and publications, graphic design, contractual printing, distribution, promotion and sales and library and health literature services. The Executive Board had concluded that, given the available resources, that part of the programme was of a high standard and played a key role in enabling WHO to fulfil its ethical and constitutional obligation to provide Member States with the best possible information about health, derived from its technical programmes. The Board had decided not to include publications among the areas from which resources should be transferred, despite a suggestion to that effect from the Administration, Budget and Finance Committee. The proposed budget already included substantial reductions in relation to the previous biennium. Furthermore, the Director-General had decided to transfer resources amounting to US$ 1.12 million to heading 3.1, Organization and management of health systems based on primary health care, in order to strengthen the promotion of primary health care by a reorientation of the focus of *World Health* magazine, as was outlined in document A48/17.

Dr CICOGNA (Italy) congratulated WHO for its efforts and work in health and biomedical information. He recognized the problems inherent in assessing the global health situation and trends, in making projections, and in monitoring implementation of the global strategy for health for all. He stressed the importance of disseminating data and statistics relating to health and of the enhancement of epidemiological surveillance. The assistance that the governing bodies received in the form of editing and translation of documents and preparation of records was of a high professional standard.

Dr RAI (Indonesia) suggested the addition to document PB/96-97, after paragraph 95, of a new paragraph reading:

'Biomedical and health information and trends' is composed of assessment of health situations and trends, world health reporting and biomedical information support.

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[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA48.3.

In section 3 of the text adopted by the Executive Board to guide the Director-General in the reallocation of resources, document A48/17 (paragraph 6), the proposed sources of savings were given as: "governing bodies, including documents and official records; procurement and overall staff costs; and administrative services"; there was no mention of the activities under programme budget heading 2.4. On the other hand, paragraph 17 of the same document did show heading 2.4 as one of the sources of funds for reallocation, mentioning that US$ 3.5 million "devoted to epidemiological surveillance and statistical services" would be used for "a new and active approach to epidemiological surveillance of communicable diseases". While he favoured a new approach, he considered that its implementation should be based on sound principles and be feasible. He therefore proposed that a number of epidemiological and statistical activities should be reviewed substantively and the findings used to update and regroup epidemiological surveillance in a broader context of public health action.

Dr ONO (Japan) said that global information networks were of great importance to the international community. One of the normative activities of WHO was to coordinate networks of health information. The Organization should also take the initiative of setting up a global network for medicine and public health by creating, for instance, a database on communicable diseases, standardizing the terms to be used in global information networks, and assisting countries to strengthen their health information systems. Global information networks should be promoted in both developed and developing countries.

Dr EMIROĞLU (Turkey) noted that programme budget heading 2.4 pointed to an important managerial constraint. Countries that had inadequate health information systems needed rapid assessment techniques in order to collect the necessary data, and the action-oriented strategy for the development of health systems should be promoted and applied through collaboration between WHO and Member States. The information, especially in developing countries, should be simple, easy to collect, and readily understandable. Data were often not transformed into useful information, so that the managers who should benefit from such information could not use it to plan, implement or monitor activities and did not share their knowledge with those who collected the data. Both providers and users should ensure that information was accurate, that it was interpreted correctly and that it was used properly.

Dr ABELA-HYZLER (Malta), underlining the importance and relevance of Health situation and trend assessment, observed that the activities highlighted in that field during the Executive Board meeting (as recorded on pages 124-127 of document EB95/1995/REC/2), were a further elaboration of the elements specified under heading 2.4 in Annex 1 of document A48/17, with which he was in full agreement.

With reference to Annex 3 of document A48/17, he suggested that the subject index should include the elements of the Biomedical and health information and trends programme, as set out on page 2 of Annex 1 and on pages 50-52 of the proposed programme budget (document PB/96-97).

Mrs VOGEL (United States of America) was concerned about a potential reduction in the overall resources for the area under discussion; for example, document PB/96-97 indicated an aggregate reduction of around US$ 20 million, some US$ 12 million of which was in the regular budget, though it was not clear how that would be affected by any funds gained from the 5% reallocation. Considering the importance of epidemiology and surveillance for monitoring the progress of health for all, planning the use of resources, coping with emerging diseases and other matters, she requested clarification on the level of funding that would indeed be provided.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) said that, like other countries whose delegates, elsewhere in the Health Assembly, had spoken of the difficulties flowing from the rapid spread of unconfirmed information, the United Kingdom attached particular importance to the collection and validation of data and the maintenance of sound statistical databases, which were of fundamental importance to planning and priority-setting. Collected data absolutely must be validated by reference to the country concerned before being put on the "information super-highway" for instant dissemination to the rest of the world.

Dr KHOJA (Saudi Arabia) said that, although WHO had to draw up a strategy for health planning, its role in the gathering and dissemination of information was perhaps even more important. Wide availability of information was vital for planning, for obtaining a global picture, and for comparing national data, statistics and health status. It was therefore essential that funds allocated to that activity should not be reduced; if anything, they should be increased.

Dr ABDELAAL (Egypt) said that the collection and dissemination of data was one of WHO's most important functions. He too therefore hoped to see an increase, not a decrease, in the funds made available for it.

Dr PICO (Argentina) underlined the importance of epidemiological surveillance as a major element in planning a health strategy. His country had made progress in developing drug monitoring, which was yielding excellent results. He therefore favoured maintaining the proposed budgetary allocations.

Mr CHAUDHRY (Pakistan) expressed support for the biomedical and health information programme, considering that WHO's main mission was to collect data. He felt there should be an increase, not a cut in the budget.

Dr AL-MUHAILAN (Kuwait) said that health and biomedical information was essential to Member countries. He was therefore in favour of maintaining not reducing financial support.

Dr AL-SHABANDAR (Iraq) said he was in favour of an increase in funds for biomedical health information and trends.

Dr VIOLAKI-PARASKEVA (Greece) expressed surprise at the budgetary decrease shown for heading 2.4 in Table 2 of document A48/17, given the importance for the topic. She was in favour of maintaining, not decreasing, the allocation to biomedical health information and trends.

Dr MUKHERJEE (India) said that at grass-roots level, particularly in a developing country such as India, the collection, compilation and dissemination of information was a complex matter, and that health information systems were of great importance for understanding the situation at national and global levels. It was vital to obtain information at the right time and have an opportunity to analyse the data and set in train the necessary interventions at the local, national or global level. He was therefore not in favour of making a cut in the budget.

Mr MOEINI-MEYBODI (Islamic Republic of Iran) also expressed support for an increase in the budget allocation.

Dr ABDULHADI (Libyan Arab Jamahiriya) said that biomedical and health information was a cornerstone of health planning. WHO had played a major role in that field and been of great service to Member States in obtaining accurate information. The importance accorded to heading 2.4 would affect the future validity of the Organization's other programmes. It should therefore receive appropriate support and financing.

Professor BERTAN (representative of the Executive Board) noted that the Board had stressed the importance of action-oriented health information system strategy development. It had also recognized that priority should be given to strengthening the capacity of countries' health information systems, including epidemiological surveillance systems.

Dr JARDEL (Assistant Director-General), responding to points raised during the discussion, said that the editorial amendments put forward by Indonesia and Malta would be taken into account in the final draft.

Concerning the delegate of Japan's call for greater WHO involvement in the global information network, on the initiative of the Regional Office for Europe WHO had started cooperating, within the scope of available resources, with the project on health questions set up by the Group of Seven. WHO would make

every endeavour to play its part in the project, particularly with regard to terminology and the databases on mortality and morbidity.

Regarding the comments of the United Kingdom, he assured the Committee that the validity of data disseminated by WHO and the inclusion of data for all countries in WHO publications were matters of grave concern to the Director-General. The Organization stood ready to discuss with countries how best to prevent political and diplomatic problems arising as a result of the over hasty publication, or non-publication, of data concerning them.

Many speakers had proposed an increase rather than a decrease in funding for the programme. However, before the Health Assembly could take a decision, the matter had to be considered in the broader context of resource transfers to high-priority programmes.

Referring to heading 2.4 in Table 4 of document A48/17, he pointed out that the programmes concerned had been subject to two waves of cuts. The first changes had been presented to the Executive Board and were set out in the programme budget for 1996-1997. As far as headquarters was concerned, the first cut concerned a transfer of resources for editing and translation, which had been moved to Appropriation section 1, Governing bodies. There were also some programme reductions, in particular in the publications, library and language services. The second reduction had resulted from the need to identify resources to be transferred to higher-priority programmes in order to implement the 5% shift requested by the Executive Board. It mainly concerned a transfer of resources for epidemiological surveillance and statistical services to heading 5.2, Control of other communicable diseases. The idea had been to bring together the epidemiological capacities in headings 2.4 and 5.2 in response to the call to strengthen epidemiological surveillance. It was not, therefore, a question of reducing WHO's capacities generally, but of a change in approach giving greater emphasis to the surveillance and control of communicable diseases, although some statistical services would have to be discontinued.

Appropriation section 3: Health services development

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

Dr KANKIENZA (representative of the Executive Board) said that the Board had reaffirmed primary health care as the pillar of health system development. While many programmes were involved in the implementation of primary health care, activities under heading 3.1 focused on improving the organization and management of health systems to support primary health care.

The Board had noted that many countries were currently engaged in restructuring and reforming their health systems. The principles of primary health care, particularly equity, should guide decisions on the changes to be introduced. Privatization should not mean withdrawal of government responsibility, but development of partnerships between all concerned in health development. Thus, ministries of health had to redefine their role.

Hospitals consumed over 60% of the government health budget in many poor countries. Improving the performance of hospitals and integrating their activities with community-level efforts were therefore a priority concern for countries working to improve the efficiency of health services.

The Board had expressed concern at the large reduction of allocations under the programme. The cuts were surprising in view of the appalling situation of primary health care and infrastructure in many developing countries. WHO had recently championed an integrated approach to the delivery of health care, involving sustainable infrastructure based on the district, but much remained to be done. It had been explained that the decrease was due to the transfer of resources to other programmes, particularly at the country level. A number of countries had also received funds from donor agencies to strengthen their district health systems.

Because of the importance of the programme, the Board had felt that allocations under heading 3.1 should be safeguarded. The Board had further recommended that WHO's capacity to promote and support integrated development and delivery of primary health care should receive increased resources on a priority basis.

Dr LEPPO (Finland) expressed his satisfaction at the steps taken towards shifting resources to areas being given high priority. He was gratified that the Director-General had been able to implement the Executive Board's recommendations throughout in the finalization of the proposed programme budget.

Dr KHOJA (Saudi Arabia) said that WHO should be proud of its achievements in promoting health systems based on primary health care. Support for that area should continue to increase. He endorsed the views set out under heading 3.1 in document PB/96-97. Human resources for health (heading 3.2) were closely linked to the primary health care system and he was therefore against any cut in funding in that area as well, especially in so far as it affected the Eastern Mediterranean Region.

Dr GEORGE (Gambia) noted that unfortunately, there appeared to be a reduction in funding under heading 3.1, which comprised vital activities. Strengthening capacity at district and community levels through health sector reforms and decentralization was essential to ensure "ownership" and sustainability of health and development programmes: assistance should be targeted to that area. Moreover, primary health care required integrated development. It was important to establish closer collaboration with UNICEF, especially in the development of training manuals for the Bamako Initiative, which covered topics ranging from community diagnosis to financing and drug supplies.

Dr PICO (Argentina) said that in his country primary health care was given priority in health policies. Profound changes were taking place in the health sector in order to enhance the humanitarianism, solidarity, efficiency and equity of care systems. Primary health care and education for health were essential components to be provided for in health planning. Primary health care strategy made it possible not only to improve health care models but also to develop sustained action to diminish the avoidable risks of illness and death, plan the activities of health establishments in programme areas, and extend care throughout the community. For that reason his delegation supported the reallocation of funds.

Dr JARDEL (Assistant Director-General), in reply to the delegate of Gambia, explained that the apparent reduction in funding under heading 3.1 in the proposed programme budget for 1996-1997 had been corrected by a reallocation of resources, as part of the 5% shift. Table 4 of document A48/17 showed that there was in fact increased funding under that heading. With regard to collaboration with UNICEF, work had begun on a common approach to district health services through the WHO/UNICEF Joint Committee on Health Policy.

3.2 Human resources for health (Resolution EB95.R6)

Dr KANKIENZA (representative of the Executive Board) said that the development of human resources for health had been the subject of a special review by a subgroup of the Executive Board in January 1995. Many of the subgroup's comments and recommendations had fitted naturally into the Board's discussion of the relevant part of the proposed programme budget for the financial period 1996-1997 and had been endorsed by the Board members.

On average, 70% of a country's recurrent health budget was spent on health staff. WHO was concentrating on the development of a range of guidelines and methodology which would allow Member States to achieve their own optimal results through appropriately trained and placed personnel. The health workforce must be considered as a whole rather than as a mosaic of specific professional categories. In that context it was recognized that studies of the work of health professionals should include consideration of medical education, including the training of general practitioners and medical specialists, to determine how they could best reflect the priorities of Member States. The Executive Board therefore recommended for adoption by the Health Assembly the draft resolution contained in resolution EB95.R6.

The Board had discussed the WHO fellowship programme at some length. While there had been pressure to make cuts, many members considered the programme to be a very important feature of national human resource development. Given its long experience in the matter, WHO was felt to be well placed to help in identifying training needs, and in selecting fields of study as well as candidates. It could continue to do so as a service for new donors with new modalities of funding.

The Executive Board subgroup had stressed that fellowships should be relevant to national health needs and the priority concerns of WHO, and that training should to the extent possible be carried out within the country, with the assistance of outside consultants if required. The Board had been informed that work had already begun on an evaluation of the fellowship programme to be submitted to it in January 1997.

Central to the educational development component of WHO's human resources development activities was concern with the relevance and efficacy of the learning process, with a focus on educational methodology, institutional change, and the link between education and practice. The proposed resolution had important implications for that component.

Activities relating to nursing centred on the implementation of resolution WHA45.5 on strengthening nursing and midwifery in support of strategies for health for all, in close collaboration between different parts of WHO and nongovernmental organizations and funding agencies.

Professor ORDÓÑEZ (Cuba) warmly supported the draft resolution contained in resolution EB95.R6. Radical change in medical education, with more emphasis on the community, was a fundamental strategy for achieving health for all by the year 2000. Medical education should, moreover, be adapted to health services, reversing the traditional trend whereby services were adapted to the teaching.

In 1980 a network of community-oriented educational institutions had been set up to change the way medicine was taught. That network was currently a nongovernmental organization cooperating with WHO.

Each country should train doctors for health promotion, not simply for prevention and treatment. A critical approach to health problems, based on independent thought rather than learning by rote, should be encouraged. Two or three years of practice in general, family or community medicine should precede specialized training. Primary health care should be recognized as a speciality; in Cuba, upon graduating after a period of comprehensive training, general practitioners served for a year in the community before embarking on a three-year internship associated with work as a family doctor. They were then considered as specialists in comprehensive general medicine, and received the same remuneration as other specialists.

In order to contribute to the attainment of health for all, medical training should ensure that undergraduate, postgraduate and continuing education produced the human resources necessary for the consolidation and development of primary health care.

Dr VIOLAKI-PARASKEVA (Greece) said that human resource development should be a major priority of WHO, as it was through the health workforce that programmes were implemented. The quality of training was therefore important. Unfortunately, in most developed countries the clinical approach to training led to extreme specialization. Medical training had to be adapted to the demands of primary health care: new models were needed for the provision of primary health care, in association with clinical care at the secondary and tertiary levels, which would enable general practitioners to play a major role in public health.

She supported the draft resolution contained in resolution EB95.R6, but proposed two amendments, namely: the addition, at the end of the fourth preambular paragraph, of the words "and in the attainment of health for all"; and the addition, at the end of subparagraph 1(4), of a call for the reform of basic education to take account of the contribution made by general practitioners to health services geared towards primary health care.

Dr MOREAU (France) remarked that human resources development was a major priority of the Organization. In countries such as his own, a clinical approach to medical education dominated, leading to extreme specialization. Training was dispensed through a highly structured establishment which was difficult to change and from which the general practitioner seemed to have all but disappeared. It had to be recognized that the necessary reforms would not come from within, but only as a result of outside pressure, such as was exerted by WHO. Medical training was becoming less and less adapted to realistic requirements in developed and developing countries alike: a reassessment of the role of the doctor and a definition of human resource priorities, as seen by countries and by communities, was necessary. His delegation supported the draft resolution contained in resolution EB95.R6.

Dr BRUMMER (Germany) observed that the draft resolution recommended by the Executive Board laid emphasis on training in general medicine. The latest amendments to the German regulations on the licensing of doctors also tended to give more consideration to primary medical requirements. The reform of

medical education and training currently being prepared in Germany focused more on the subjects needed to become a general practitioner.

The proposals on medical schools contained in the draft resolution would, however, be difficult to implement in Germany, where such bodies were autonomous and not subject to supervision by public authorities.

Dr ABDULHADI (Libyan Arab Jamahiriya) remarked that human resources development was one of the most important WHO activities. The essential purpose of training doctors was to prepare them for service in the community. However, universities, particularly in the developing world, continued to follow more traditional medical curricula. The efforts made by WHO to persuade those universities to change had not been successful. Doctors were therefore continuing to graduate without any knowledge of primary health care. Additional programmes should be added to courses, so as to orient the whole concept of medicine towards primary health care rather than clinical medicine. The Regional Office for the Eastern Mediterranean had, through the various health ministries, sought to promote training in primary health care, but that principle had not been formally accepted by the universities. WHO might examine other methods of persuading them to do so, perhaps by preparing a model curriculum or prototype for medical teaching, to be distributed worldwide.

Dr ADAMS (Australia) expressed his country's support for the draft resolution recommended by the Executive Board, but emphasized the need to strengthen the teaching of public health and population health at both undergraduate and postgraduate levels. He hoped that when the "desired profile of the future doctor", referred to in subparagraph 1(2) of the resolution, came to be defined, knowledge and skills in public health would be emphasized along with the need for doctors to work as equal partners in health teams.

Dr DRISSI (Morocco) said it was vital for WHO to give particular attention to general practitioners in the development of human resources because they played a large and important role in health teams. However, reform was needed in the teaching of medicine in order to achieve a better relation between training and medical practice so that doctors would be better able to respond to the priority health needs of populations. Morocco supported the draft resolution.

Dr ABUSALAB (Sudan) agreed on the need for a new orientation in medical education. The developing countries had been training technical staff without reference to the community aspects of their work, concentrating on the clinical rather than the health-for-all element. They had been sending large numbers of medical personnel for training in the developed countries - a very expensive exercise and in many cases a waste of resources. They lost the services of the medical personnel during training, and sometimes the trainee did not return home afterwards. For the cost of training one student abroad, Sudan could train 10 at home. His country had a great need of medical personnel in its regions, and had established 10 new universities and a council to train clinical specialists. The council supported research work, and organized short courses in subjects that were of special interest to Sudan, notably tropical diseases.

Dr BASHI ASTANEH (Islamic Republic of Iran) said that community-oriented medical education should be regarded as the basis for a review of the curricula of medical schools. Duty doctors and general practitioners with traditional qualifications should receive refresher courses, and there should be changes in medical education for other health professionals as well. Medical education and the health services in his country had been integrated in 1985, resulting in better health care delivery in the primary health care system. His country's extensive experience in that regard was available to be shared with any Member State that was interested.

Dr WAHEED (Maldives) expressed support for the draft resolution recommended in resolution EB95.R6. For developing countries like his own, human resources were a priority area. It was desirable for WHO not only to maintain present levels of spending on human resources for health, but to increase them.

Professor GUMBI (South Africa) said that over the past three years her country had been engaged in a review of a number of areas of medical education to make sure that the quality of health personnel

produced was relevant to South Africa's needs. While endorsing the draft resolution, she considered that there should be a review of medical curricula at both the undergraduate and the postgraduate level in consultation with the statutory councils, professional organizations and policy-makers to ensure that health personnel were competent and had received appropriate education. It was essential to move away from the traditional didactic system towards the more modern trend of developing critical thinking processes. That required a reorientation on the part of teachers and also the use of community-based and problem-based learning. Another fundamental requirement was correlation between theory and practice within the primary health care model, so that health professionals would acquire the compassionate and caring attitude that was all too often absent. Finally, an international support system was needed, and in that respect South Africa regarded WHO as the fundamental international coordinating organization for technical support and for ensuring the provision of cost-effective quality education within the system of multidisciplinary health care education.

Professor GRANGAUD (Algeria) said that his country now had one doctor for fewer than 1000 inhabitants, but those doctors found themselves somewhat at a loss when embarking upon active service at the end of their courses. Their training had given them a technicist model of patient care which completely neglected the socio-anthropological and economic aspects as well as that of communication with the patient. Health personnel already working in the field were having to be retrained in order to place more emphasis on primary health care, and training courses were being modified to take account of the health needs of the country. Algeria supported the draft resolution recommended by the Executive Board, which should permit the gap between the results of medical training and the real health situation to be closed, but it should take account of the observations made by the representatives of the Libyan Arab Jamahiriya and Australia.

Dr MUKHERJEE (India) said that the Medical Council of India had undertaken extensive consultations at the regional and national levels before drawing up a new medical curriculum which it was hoped would be introduced very soon in the country's 147 medical schools; new training mechanisms had also been introduced in some schools. India produced 14 000 medical graduates each year, so there was clearly a need to ensure that they understood the philosophy of primary health care; 500 000 registered medical practitioners were already working in India. He expressed his support in principle for the draft resolution, but proposed that in subparagraph 2(1) the words "and other primary health care providers" should be deleted, since such mention was made nowhere else in the text. All medical practitioners should be familiar with the concept of primary health care, and be offered a continuing programme of medical education to verse them in its philosophy and principles so that health for all could be achieved by the year 2000.

Dr THIERS (Belgium) said that the measures recommended by the Board in resolution EB95.R6 had been implemented in his country for 20 or 30 years. However, Belgian universities still adopted the technological approach rather than that of public health, epidemiology and sociology. The influence in that respect of the teaching staff and of the professional organizations was still preponderant. He proposed a minor amendment to the French text of the resolution: replacing the word "suffisants" by the word "adéquats" in the second preambular paragraph.

Dr KALAÇA (Turkey) emphasized the need for a community-oriented medical curriculum, and for communication between doctors and other members of the medical workforce that would enable them to practise medicine as a health team in order to provide better primary health care services. He paid tribute to the WHO Office of Publications for its user-friendly material on continuing education, and expressed support for the resolution recommended by the Executive Board.

Dr BAATH (Syrian Arab Republic), expressing his country's support for the draft resolution, said that the traditional role of the doctor had been to deal with patients not only from a physical but also from a psychological point of view. Medical education, however, had led to increasing specialization. As primary health care coverage was expanded in pursuit of the health-for-all strategy it occasionally became clear that shortcomings in that respect were due to a lack of practitioners who knew their country and its needs. Hospitals were full of specialists, but had too few general practitioners. The services required of a general practitioner were greater than those required of specialists, and there was a general lack of balance between

the education of the two. Although the Syrian Ministry of Health had initiated a family medicine programme and a public health programme, those initiatives alone could not achieve the desired objectives, and WHO had an important role to play in effecting changes within universities so that they catered for the needs of society and the community and met primary health care requirements. Units should be set up within the universities with a view to establishing general practice as a speciality: that would encourage general practitioners to play their proper role in society and in hospitals and regain people's regard, which had become low in comparison with that for specialists.

Dr ABU BAKAR Dato' SULEIMAN (Malaysia) expressed his country's full support for the resolution recommended by the Executive Board: medical schools had to be prepared to make changes in order to be more responsive to the needs of the community and the country. WHO was to be commended for the efforts to facilitate communication between health authorities, medical schools and professional associations on such changes; but the process must be accelerated if medical graduates were to be produced who were more committed to the promotion of health for all in their respective communities.

The meeting rose at 13:00.

SIXTH MEETING

Monday, 8 May 1995, at 9:10

Chairman: Dr Fatma H. MRISHO (United Republic of Tanzania)

1. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

GENERAL REVIEW:[1] Item 18.2 of the (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58) (continued)

Appropriation section 3: Health services development (continued)

3.2 Human resources for health (Resolution EB95.R6) (continued)

Dr LEPPO (Finland) noted that Table 4 of document A48/17 showed that the reallocations had led to a reduction of about US$ 7 million in the budget for heading 3.2, over and above a previous reduction of about US$ 12 million. While he appreciated that those changes reflected the recommendations of the Executive Board, a more detailed explanation should be provided of how such a large reduction had been made, so as to alleviate fears that it might endanger the core activities of the programme. He strongly supported the draft resolution recommended by the Board in its resolution EB95.R6, which amplified attempts to reorient the training of health personnel, but considered that amendments taking into account the comments of the delegates of Australia and the Libyan Arab Jamahiriya would reinforce its provisions.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland), noting that 8 May 1995 was the fiftieth anniversary of the end of the Second World War in Europe, expressed his hopes for continued peace and for the attainment of health for all in the spirit of solidarity that had characterized the work of WHO.

In full agreement with the remarks of the delegates of Australia, Finland and the Libyan Arab Jamahiriya, he proposed that the draft resolution recommended by the Board should be strengthened by amending the end of subparagraph 2(1) to read: "... working conditions that would allow general practitioners better to identify the health needs of the people they serve and thereby to enhance the quality, relevance, cost-effectiveness and equity of health care".

Dr PURRAN (Mauritius) said that many countries would never be able to generate the resources necessary to establish the faculties of medicine and institutes in which to train their own medical personnel in a manner adapted to their specific national needs. WHO should set up appropriate training facilities on a regional or subregional basis.

Dr GEORGE (Gambia) said that a sustainable health delivery system and a better health status necessarily rested upon an appropriate combination of human resources that reflected the health priorities of a country. In his part of the world, staff should be trained to address the problems of high infant and maternal mortality and morbidity and be deployed to areas in greatest need. Training must be followed up with the provision of the necessary equipment and supplies, and WHO should intensify its efforts to assist countries with the standardization of such material for various levels of care. The development of a minimal

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

package would be a step in that direction. Incentives and other sources of satisfaction should be created for personnel, who sometimes worked under very difficult circumstances. Those needs could be tackled during the reform of the health sector, with the assistance of WHO.

He noted that technical experts were currently a large component of aid to the least developed countries. That led to an imbalance which could be redressed only through intensive training of national staff. It was therefore important that WHO should increase its fellowships programme, especially for countries in which there were no suitable training institutions, and he hoped that reductions under heading 3.2 would not be made at the expense of fellowships. He supported the draft resolution, amended as proposed, and suggested the addition of the words "equipment and supplies" after "working conditions" in subparagraph 1(3).

Dr SANGALA (Malawi), noting that the terms "doctor", "medical practitioner" and "general practitioner" were all used in the resolution proposed by the Board, suggested that only the word "doctor" should be used, as "practitioners" played different roles in different countries.

The disease pattern in developed countries being different from that in the developing world, the guidelines for medical schools should be flexible enough to allow different approaches to medical education. In his country, as in most of the developing world, people suffered mostly from preventable communicable diseases; there was a poor socioeconomic environment and a lack of roads, communication systems, power and even safe drinking-water. Doctors must be familiar with their environment in order to appreciate the impact such problems had on health.

At the recently established college of medicine in Malawi, students at the department of community medicine, which was located at a district hospital some 100 kilometres from the main campus in the city, spent some of their time in the villages. The curriculum also tried to fill the urgent need for general practitioners who could not only undertake operations but also act as administrators in district hospitals. Reforms to the health system must include all health workers, including nurses and paramedical personnel, who still formed the backbone of the health services in the developing world.

He supported the draft resolution proposed by the Board.

Dr MAREY (Egypt) said that medical training and education undoubtedly had to be adapted to the needs of individual countries, and the medical curriculum in Egypt had been reformed to reflect local health conditions. Resources were being mobilized to continue efforts in that direction. He hoped that the major reduction in resources for the training of health personnel at the regional level would not hinder continued efforts and reforms.

Dr OUM (Cambodia) underlined the importance of re-evaluating the role of doctors in public health and primary health care, and of retraining those who were already practising.

Dr DOSSOU-TOGBE (Benin) said that, when human resources were inadequate, scarce financial and material resources would be badly distributed and used and thus be wasted. A major problem in applying the provisions of the draft resolution at the country level would be to ensure collaboration among teaching institutions, the ministries concerned, medical associations, and users of health services. Nevertheless, it had his full support.

Dr KHOJA (Saudi Arabia) expressing his support for the comments of the delegate of the Libyan Arab Jamahiriya, said that practical mechanisms must be found to implement the trend reflected in the draft resolution. He had noted previously the close relation between headings 3.1 and 3.2 of the programme budget. Curricula had been developed in his country for medical schools, health institutes and midwifery schools to reflect the health environment and to teach health supervision and control within the framework of primary health care. A diploma, a master's degree and fellowships had been established in that field, and a joint programme had been set up between the Ministry of Health and the Royal College of General Practitioners in the United Kingdom.

He supported the draft resolution but proposed an additional subparagraph 2.5, reading:

(5) to advocate an international consultative meeting of concerned universities from the different WHO regions to put forward the appropriate policies, strategies and guidelines for such an approach in health/medical education for undergraduates and post-graduates.

He stressed that the provision of adequate training for health personnel was vital for primary health care.

Dr DURHAM (New Zealand) raised the question of the role of women in the medical workforce. Women doctors made an important contribution and had traditionally been attracted to both public health and primary care, yet throughout the current discussion doctors had been referred to as "he" and never as "she". She proposed that a new preambular paragraph be inserted before the final one, reading:

Recognizing the important contribution that women doctors make to the medical workforce;

Both Member States and the Director-General should carefully consider the contribution of women doctors when defining the "desired profile" of the future doctor, as mentioned in subparagraph 1(2) of the draft resolution, and when defining the "optimal mix" of the workforce, as stated in subparagraph 1(3). In respect both of the promotion and support of health systems research into working conditions (subparagraph 1(3)) and of the implementation of optimal working conditions (subparagraph 2(1)), the particular needs of women doctors, who had to balance the demands of a family and of their profession, should be taken into account. The Director-General could exercise leadership in enhancing recognition of the important contribution that women doctors made. She understood that the positions of several Assistant Directors-General were to become vacant owing to retirement and underlined the importance of appointing women to positions throughout the Secretariat of WHO, including those at the senior level.

Dr NGAPANA (Cameroon) said that after the Declaration of Alma-Ata the Ministry of Health and the universities in his country had acted together to initiate primary health care. Only the Ministry of Health, however, had recognized that the strategy undertaken was foundering in its progress towards health for all by the year 2000 and had taken steps to reorient it. The consequence of the universities' delay in working with the ministry towards that reorientation had been that newly trained general practitioners were confused when they began their professional lives. Both parties were now aware of the problem and wished to coordinate closely to improve the training of doctors in universities.

The international community had organized several conferences on adaptation of the medical curriculum, without really involving the ministries of health. He supported the draft resolution contained in resolution EB95.R6, because it clearly expressed a willingness to implicate ministries of health, professional associations and universities.

Mr MAKHANU (Kenya) said the draft resolution, which Kenya supported, represented a step forward in the training of medical personnel for health delivery to all. In the provision of primary health care in Kenya, the importance of training community-oriented doctors and public health officers had been recognized. A second national medical school had been established for the training of community-oriented personnel.

Mrs HOMASI (Tuvalu) expressed concern at the decrease in the budgetary allocation for human resources for health. Tuvalu was experiencing the disease patterns of both the developed and the least developed world; with a poor economy and few natural resources, it relied heavily on overseas aid to maintain and develop human resources in all fields. The chronic shortage of medical practitioners must be tackled, although the need for training the nurses who were required to staff isolated island medical posts, where they substituted for other essential health professionals, had been given the highest priority WHO fellowships had assisted in the development of nursing skills in such situations but the training needs were yet to be fully met. Tuvalu had no medical or nursing training institutions of its own; all such training of its personnel had to be undertaken elsewhere.

Dr TOURÉ (Guinea) said that there had been an increase in the number of trained doctors in a number of developing countries, and a simultaneous decline in the services in which training took place. Furthermore,

as the curricula were poorly adapted to specific health problems and policies, doctors often received training that was inappropriate to the needs of the community and that thus contributed relatively little to health development. In that respect, WHO had an important role to play: first, by establishing links between countries to enable them to share experiences and avoid mistakes; secondly, by allocating the necessary financial and manpower resources to health development programmes. Guinea earnestly hoped that WHO would show leadership for change in order to maximize investment in health development. He strongly supported the draft resolution and called for an increase in funding.

Dr PICO (Argentina) agreed with previous speakers in stressing the importance of human resources for health. Within the framework of major changes being implemented in the health sector in Argentina, a national coordinating committee had been set up to develop human resources. It was made up of representatives of the training institutes, users, the trainees themselves, the scientific community and universities. Its work would have far-reaching implications for change, which would take time to materialize; one of its objectives was to develop a strategy for changing the attitudes of health personnel, trainers and beneficiaries. Training the correct number of doctors as well as the attainment of acceptable standards were key challenges Argentina was trying to meet. To that end, one university had already changed its curriculum in order to develop general practitioner training; the social security system had also focused on the importance of primary health care, with a resulting marked decrease in the cost of services. In considering the development of human resources, it had been necessary to bear in mind that training was required not only for professional skills, practical knowledge and expertise but also for developing abilities to meet changing requirements.

For those reasons he wished to see an increase in the budget resources allocated and fully supported the draft resolution recommended by the Executive Board.

Dr BOUFFORD (United States of America) said that she fully supported the adoption of the draft resolution contained in resolution EB95.R6; but while she applauded the focus of the resolution on the workforce of physicians, she wished to emphasize the importance of other primary care providers, including nurse-practitioners, midwives and community and public health nurses. With that in mind, her Government had embarked upon a major interdisciplinary programme for the planning of a national primary care workforce. At the next Health Assembly, it looked forward to seeing a resolution similar to the one before the Committee and focusing attention on global nursing workforce development.

Dr ADAMAFIO (Ghana), while appreciating the need for budget cuts, stressed that the development of human resources was fundamental to overall development. Too many countries in the African Region were already dependent upon external consultants and that was often counterproductive for their own manpower development, to which the new Regional Director for Africa had given the highest priority, seeking to streamline the award of fellowships towards greater cost-effectiveness. While there had been cuts in the budget for human resource development across all regions, Africa was the only region without extrabudgetary funding under that heading.

In view of the importance attached to the development of local manpower, he urged the Regional Director and the Director-General to make every effort to maintain the level of funding earmarked for human resource development, or even increase it, in the interests of helping regions to develop their own workforce. Ghana supported the draft resolution with the amendments proposed.

Dr RAI (Indonesia) said that the reference in the title of the draft resolution to changing medical education was rather strong and might be difficult for medical schools to accept. In addition, the term "health for all" in the title was too broad and might dilute the goal of the resolution. He therefore suggested that the title should be: "Reorientation of medical education and medical practice towards primary health care".

Dr ASHLEY-DEJO (Nigeria) said he fully supported the current effort to adapt medical training to demands made on medical practitioners after qualification. In 1965 that need had been recognized in Nigeria, since when all medical students of the country's first teaching hospital at Ibadan had been trained in aspects of community medicine and social health care, a practice followed subsequently in other teaching hospitals.

However, it was still difficult to persuade qualified medical personnel to work in the countryside because of poor remuneration and difficult living conditions.

Nigeria had experienced difficulty in developing expertise in specialist postgraduate training because of the lack of equipment and other resources for almost everything except primary health care, resulting in the migration of qualified staff to countries where facilities were better. Another problem was that nurses, who provided all the care services in some locations where doctors refused to practise, were also unwilling to live in village conditions. Therefore, for the past six years Nigeria had been training various levels of community health extension workers and village health workers who really provided primary health care. If the medical practitioners could not be persuaded to serve in rural conditions, the training should prepare them to supervise and monitor the activities of more junior field health workers.

He fully endorsed the draft resolution and the proposed amendments.

Mrs MANYENENG (Botswana), also supporting the draft resolution, said that for medical education to be relevant to current needs and to accord with the primary health care strategy it must be revised and redirected. Human resources development had been identified as the top priority in the National Development Plan VII of Botswana, which at present had only one medical practitioner per 15 000 population and one nurse per 6000 population. Medical practitioners were trained outside the country, Botswana having no medical school of its own; the majority of trained doctors in Botswana were expatriates.

Professor LOUKOU (Cote d'Ivoire), while endorsing the draft resolution, called for WHO to support regional initiatives concerned with promoting medical training better adapted to the practices of primary health care, such as the activities undertaken by the African and Madagascar Council for Higher Education and the Organization for Coordination and Cooperation in the Control of Major Endemic Diseases. He therefore proposed the addition to the draft resolution of a recommendation that regional initiatives to consolidate research and medical and paramedical training should be promoted.

Dr BATCHASSI (Togo) endorsed the draft resolution and called for an increase in funding for heading 3.2.

Dr OUEDRAOGO (Burkina Faso) laid stress on the importance his Government attached to adapting health training and practice to the needs of the population. Joining other speakers in endorsing the draft resolution recommended by the Board, he hoped that the reallocation of funds from heading 3.2 would not adversely affect the necessary reorientation of medical education.

Professor LEOWSKI (Poland) said that the WHO collaborating centres were in an unique position to spearhead the implementation of WHO programme strategies; their participation in human resources development, at both local and regional level, should be included in their terms of reference. Poland supported the draft resolution.

Dr DIRANI (Syrian Arab Republic) said that his Government laid great emphasis on allocating more resources to the Eastern Mediterranean Region under heading 3.2, as the development of health services in the Region depended upon the corresponding development of health staff.

Dr HU Ching-Li (Assistant Director-General), referring to the reduction in budget allocations about which several delegations had expressed concern, assured the Committee that the Regional Directors had been fully consulted by the Director-General following the last session of the Executive Board before changes had been made, particularly concerning the shift of funds away from the fellowships programme into other priority areas. Regarding the draft resolution contained in resolution EB95.R6, the Secretariat shared Members' views about country priorities for primary health care as well as health for all.

Dr PLIANBANGCHANG (Regional Office for South-East Asia) said that emphasis had been placed on human resources development in the planning of the 1996-1997 programme budget for the South-East Asia Region, when an increase of US$ 194 000 had been foreseen. However, following the decision of the Executive Board to reduce the funding for fellowships, the budget for human resources development had been

reallocated and funds amounting to US$ 3 170 000 transferred to other priority activities in accordance with the Board's decision. Human resources funding was nevertheless maintained in the Region, with emphasis on specific programme areas such as essential drugs, family and community health, and communicable disease control, including eradication of certain diseases.

Dr AL KHAYAT (Regional Office for the Eastern Mediterranean) said that the budget for human resources development for the Region had been reduced by US$ 2 million. However, the Region's Member States were anxious that fellowships programmes should continue to be funded and to be treated as a priority. Fellowships were promoted in the Region through a series of measures: internal fellowships received higher priority than fellowships outside the country; fellowships in other countries of the Region or developing countries with similar conditions in other regions received higher priority than fellowships in the most developed countries; short-term fellowships were accorded higher priority than fellowships for longer periods; and fellowships in health promotion and protection and in disease prevention and control were favoured over fellowships in curative or rehabilitative care. An important departure in the fellowships programme in the Eastern Mediterranean Region was the use of 10% of all general fellowship allocations for the initiation of a leadership development programme. Two regional meetings and one country meeting on that programme had been convened and a fourth was planned. The programme's graduates held senior positions in the administrations of their countries. At least 30% of all fellowships were for women.

Dr NHIWATIWA (Regional Office for Africa) said that Africa, like other regions, had had to make a reduction under the heading of human resources for health, although fellowships had made a major contribution to strengthening the capacities of individual countries and had benefited poor countries in particular. In view of that fact, she hoped that the fellowships programme could be increased. The African Region would continue to emphasize regional training whenever possible.

In April 1995, WHO had cosponsored a medical education conference in Cape Town, South Africa. The conference had brought together medical scholars from the African Region to discuss how to make the training of medical personnel, including doctors, more relevant to health for all and public health care. A major recommendation from the meeting had been for WHO, the World Federation of Medical Educators and the Association of Medical Societies in Africa to meet regularly to ensure the implementation of recommendations such as those outlined in the draft resolution contained in resolution EB95.R6. The Regional Committee would soon be examining those recommendations in Brazzaville.

Dr KEAN (Regional Office for the Western Pacific) said that the development of human resources for health was also a priority in his Region. It had therefore been difficult to make the shift in funding priorities determined by the Executive Board. Core activities at country and intercountry level had not been affected and the shift had been achieved wherever possible by focusing training activities, particularly fellowships, on areas identified as priorities by the Board. Many Member States in the Region had underlined the importance of developing the health workforce, a view the Regional Director took very seriously.

Dr THYLEFORS (Secretary) suggested that, in view of the number of amendments proposed to the draft resolution contained in resolution EB95.R6, a drafting group should be formed to propose a revised text. All the delegations that had proposed amendments, and any others that wished to do so, might participate.

It was so agreed. (See summary record of the tenth meeting, page 136.)

2. FIRST REPORT OF COMMITTEE A (Document A48/50)

Dr HANSEN-KOENIG (Luxembourg), Rapporteur, read out the draft first report of Committee A.

The report was adopted.[1]

3. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (Document PB/96-97) (resumed)

GENERAL REVIEW:[2] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58) (resumed)

Appropriation section 3: Health services development (resumed)

3.3 Essential drugs

The CHAIRMAN drew attention to the fact that two paragraphs in the documents were erroneous and should be disregarded: the paragraph headed "3.3 Essential drugs" on page 2 of Annex 2 of document A48/17, and the last paragraph in document A48/17 Corr.2.

Dr KANKIENZA (representative of the Executive Board) said that the Action Programme on Essential Drugs had been reviewed by a subgroup of the Executive Board in January 1995. The aim of the programme was to cooperate with countries in the preparation and implementation of national drug policies in order to ensure regular access to essential drugs at reasonable cost and rational use of drugs. Access to essential drugs was one of the eight key elements in primary health care and it was also an indicator of implementation of the health-for-all strategy. The Health Assembly had approved the principle behind the strategy and the usefulness of essential drugs in Member States had been recognized on many occasions. However, despite the efforts made, half the world's population still did not have regular access to those drugs, and the Board had acknowledged the crucial importance of the programme's activities. The availability of drugs in health services contributed to the credibility of the health system. It was important not only for therapeutic treatment, but also to promote increased confidence in preventive care and in the delivery of the primary health care strategy.

The Executive Board had decided that the Action Programme on Essential Drugs should be considered a priority programme and should therefore benefit from the reallocation and redistribution of resources currently under consideration within the regular budget. However, the programme would also need extrabudgetary financing if it was to respond to the needs which had been clearly identified.

Dr WIUM (Norway) welcomed the importance given to essential drugs in the programme budget and commended the programme staff on their increased focus on country-level support and health reform. He also commended the collaboration with other programmes and the emphasis on the rational use of drugs as an integrated component of primary health care.

He noted with regret that paragraph 149 of document PB/96-97 said that access to essential drugs remained limited and inequitable in many countries. The freezing of posts in the programme was therefore questionable. His delegation was greatly concerned that the regular budget allocation for the Action Programme on Essential Drugs had fallen from 12% in 1990-1991 to approximately 7% in 1994-1995, but it was encouraged by the Executive Board's proposal to give priority to primary health care, including essential drugs.

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[1] See page 275.

[2] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

Document A48/17 showed an increased figure of US$ 1.36 million for essential drugs, but he had been given to understand that in real terms the increase would only be US$ 500 000; the remainder represented a reclassification of funds which were already covering posts in the supply unit responsible for procurement of essential drugs and biological products. The programme needed increased resources, and he sought reassurance that the increase proposed in document A48/17 would be real.

Dr VAN ETTEN (Netherlands) stressed the importance of the Action Programme on Essential Drugs, and asked when the revision of the 1988 guidelines for developing national drug policies, mentioned in paragraph 165 of the proposed programme budget, would be completed.

In order to ensure the highest possible standards in drugs and vaccines, he proposed that in the last paragraph of document A48/17 Corr.2 the words "biological products of a quality most suited to the purpose for which they have been requested" should be amended to "biological products which have been made according to Good Manufacturing Practices".

Dr FURUHATA (Japan) emphasized the critical importance to health services of quality assurance of pharmaceutical products. Unfortunately, there were still many counterfeit or substandard drugs in international commerce, which were not only illegal, but also dangerous to public health. He welcomed the response to resolution WHA47.17, in particular the initiation of the project to combat counterfeit drugs, the success of which depended on cooperation from Member States and concerned organizations, including nongovernmental organizations.

Dr WINT (Jamaica) said that in countries like his own, where locally produced drugs accounted for only some 15% of the total drug bill so that a large portion of the national health expenditure was allocated to imported drugs, it was essential (a) to limit the number of products procured; (b) to achieve maximum economies in the procurement process; (c) to assure the quality of the drugs imported; and (d) to ensure that the population in need had access to affordable drugs. He therefore supported the giving of priority to essential drugs and looked forward to greater cooperation from WHO in achieving the objectives he had mentioned.

Professor CALDEIRA DA SILVA (Portugal) praised the leading role played by WHO in the area of essential drugs, and the cooperation of the pharmaceutical industry. Cooperation and understanding would also be required not only from the medical profession but also from patients. A great deal of work and effort must therefore be put into health promotion and health education in order to prepare the population to accept the programme, if full success was to be achieved.

Dr LARIVIÈRE (Canada), referring to the last paragraph in document A48/17 Corr.2, said he shared the concern of the Netherlands about the statement that essential drugs, vaccines and other biological products would be supplied "of a quality most suited for the purpose for which they have been requested". Canada's view was that all such products supplied by or on behalf of WHO and moving across frontiers must meet the standards promoted by WHO, which were based on Good Manufacturing Practices.

Speaking personally as a member of the Executive Board, which had reviewed the matter, he could not associate himself with the implication that drugs might be supplied of a quality that varied according to local circumstances. He had been assured that the relevant paragraph of document A48/17 Corr.2 had been included by mistake. He was therefore surprised that a further corrigendum had not been issued.

Professor LOUKOU (Côte d'Ivoire) expressed his delegation's appreciation for the proposed reallocation of resources for essential drugs. Subsequent to the devaluation of the CFA franc in January 1994, 14 African countries in the CFA franc area had defined a joint policy covering the promotion of essential drugs, including generic drugs. Twenty African countries meeting in April in Brussels had entrusted his country with the task of coordinating action to improve supplies to purchasing cooperatives and to introduce generic drugs to the private sector. His delegation hoped that WHO and the international community would strongly support those regional initiatives.

Dr VIOLAKI-PARASKEVA (Greece) drew attention to the statement in paragraph 153 of document PB/96-97 that surprisingly little was known about determinants of drug use that resulted in the spending of thousands of millions of dollars and had profound consequences. She asked what WHO was doing about that.

Dr ISMAIL (Sudan) said that activities concerning essential drugs were of the greatest importance for developing countries, which accorded them high priority in rationalizing and developing their health promotion activities. In his country, however, the financial resources allocated to the programme were spent on training courses for health workers, who were carrying out their task in a poor environment; logistical supplies were scarce, and the administration was poor. WHO should therefore allocate additional financial resources from the programme with a view to the development of institutions that would improve the working environment and the performance of the health workers in question.

Dr PICO (Argentina) supported the priority accorded to essential drugs and thanked WHO for the cooperation his Government had received in developing its new programme designed to improve the effectiveness and quality of medical care. He was glad to inform the Health Assembly that his Government's National Administration for Drugs, Food and Medical Technology (ANMAT) had now come into being thanks to the support and collaboration received from the essential drugs programme. ANMAT was considered an essential instrument in improving health systems and was providing horizontal technical cooperation with other countries in the Region.

Dr ANTEZANA (Assistant Director-General), replying to questions, said that the delegate of Norway's understanding was correct: of the allocation of US$ 1 360 000 shown on page 8 of document A48/17, the cash amount available was US$ 500 000. In reply to the Netherlands' delegate, he said that an expert committee would meet in June to review the guidelines for developing national drug policies; thus a full review of national drug policies, guidelines and strategies would be available before the end of the year. He assured the delegate of Japan that WHO was fully aware of the problem of counterfeit drugs, as was shown in paragraph 154 of document PB/96-97. A project to deal with the problem was already being undertaken, and the Organization appreciated the efforts of those governments already participating in it.

Regarding the importance of public education, mentioned by Portugal, he was pleased to report that several mechanisms for providing direct information to the public, including audiovisual material, were available. Replying to the inquiry of the delegate of Greece, he said that operational research was being conducted to discover and make a comparative analysis of people's perceptions of drug use. In addition, two sets of indicators had been established on rational use of drugs and a third set to assess how drugs were used by the public and by prescribers. Together, those measures should provide a background of information on which governments could base decisions regarding the exact drug consumption pattern.

The Director-General was in full agreement with the views expressed by the delegate of Canada; the erroneous paragraphs in documents A48/17 and A48/17 Corr.2 were to be ignored.

Finally, although the total amount under discussion would be used at the country level, part of the country budget had now been shifted to the Action Programme on Essential Drugs and would be used for training activities such as had been mentioned by the delegate of Sudan.

3.4 Quality of care and health technology

Dr KANKIENZA (representative of the Executive Board) said that one of the main purposes of programmes geared to clinical, radiological and laboratory technology and technological assessment had always been to promote the rational utilization of technology so as to guarantee the quality of health care. That was why an integrated approach had been adopted to guarantee complementarity between the primary, secondary and tertiary health care sectors. WHO had continued to provide assistance to many countries to help them to take informed decisions on such subjects as standardization, procurement, and utilization and maintenance of diagnostic and treatment equipment, in particular at primary health care level. A transfusion safety service had been established in October 1994 to reinforce and coordinate the Organization's activities on that important matter; it examined the problems of the safety of blood and blood products at national and international level and assisted Member States to develop political and technological strategies and self-sufficiency strategies for national blood collection programmes. The quality, safety and effectiveness of drugs

and vaccines had not been examined at the same time as essential drugs during the preceding session of the Executive Board, but the Board had stressed the vital importance of standardization within the programme, and an urgent recommendation had been made that funding of those activities should be exclusively from the regular budget so that donors of extrabudgetary funds would be unable to exercise undue influence. The Director-General had undertaken to find a solution to that problem.

Dr MASIRONI (Italy) said that in agreement with what the Executive Board had recommended in its report to the Forty-sixth World Health Assembly, he was convinced that it was essential to maintain and strengthen normative functions so as to support national drug regulatory authorities. He fully supported WHO's activities in drug management and policies. He requested information on activities in that field for the next biennium and on relative fund allocations and staffing. Under heading 3.4 the programme budget document did not specify the allocation of funds to different activities such as support to countries in assessing health technologies, evaluation of quality of health care, support to countries in improving health laboratory services, and development of normative instruments for national drug regulatory authorities. Any weakening of the drug management policy would not only contradict the recommendation made by the Executive Board two years previously but would also have negative consequences especially for countries with limited resources.

Dr ANTEZANA (Assistant Director-General) said that, as delegates were aware, the new format of the proposed programme budget did not provide a breakdown by budgetary lines such as those mentioned by the delegate of Italy. Full information was, however, available and would be provided to delegates. There was no intention of reducing activities in the fields mentioned; on the contrary it was planned to strengthen all normative activities, particularly with regard to drugs and biological products, so that WHO could continue to fulfil its mandate in that regard.

Appropriation section 4: Promotion and protection of health

4.1 Family/community health and population issues

Maternal and child health and family planning: quality of care (Resolutions WHA47.9 and EB95.R10; Document A48/10[1])

Professor BERTAN (representative of the Executive Board) said that the Board had discussed resolution WHA47.9 in the context of the preparations for the International Conference on Population and Development (ICPD) and subsequently in that of the adoption by the Conference of a Programme of Action, as well as the endorsement of the Programme and recommendations for follow-up action by the United Nations General Assembly in resolution 49/128. The Board had reviewed the Director-General's reports on "A conceptual and strategic framework for reproductive health" and on ICPD (documents EB95/1995/REC/1, Annex 15 and EB95/49) together. The reports had been derived from several sources. The Board had endorsed the framework, among other things emphasizing the importance it attached to leadership by the Organization in the high-priority area of reproductive health as well as the fact that reproductive health was integral to health in the context of primary health care and family health. The Board had urged that the framework should be promoted in the preparatory meetings for the Fourth World Conference on Women and at the Conference itself. Summarizing its recommendations, particularly the importance of reproductive health in the context of primary health care, including family health, the Board had adopted resolution EB95.R10.

It had requested the Director-General to submit a report to the current Health Assembly. That report was contained in document A48/10, together with a draft resolution for consideration by the Health Assembly.

Dr ALVIK (Norway), speaking on behalf of the five Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), said that the Director-General's report on reproductive health (document A48/10) built on the conclusions reached at ICPD the previous year. The Nordic countries welcomed the Director-General's

[1] Document WHA48/1995/REC/1, Annex 2.

assurance in his opening statement to the Health Assembly that WHO would give high priority to reproductive health, women's health and family health. The Organization should provide normative and technical leadership for establishing reproductive health policies, systems and services and integrate its programmes more fully to that end.

Traditional maternal and child health care and family planning continued to have little impact on maternal survival and maternal health. In many countries access to care capable of reducing mortality from pregnancies and abortions was still very limited. Governments must review their progress in achieving reproductive health goals and improve their existing policies and infrastructure, with special emphasis on the implications of vertical family planning programmes and the delivery of essential care. Any significant improvement in reproductive health necessitated health services, medical knowledge and skilled personnel. The Organization should respond to that challenge with appropriate advocacy and normative action at the global and country levels.

The health care needs of adolescents called for particular attention, as the ICPD Programme of Action recognized. The fact that most effort had so far been directed to postponing pregnancy had the unfortunate consequence that girls who did get pregnant were neglected. The Organization should lead action to end that neglect. It should also address the broader moral issues of ensuring access to care and freedom of choice in matters of sexual and reproductive health. The Organization and its Member States had a moral obligation to provide information and foster awareness on those matters so that policies could be based on the realities of life instead of on wishful thinking.

The Nordic countries' assessment of the Special Programme on Research, Development and Research Training in Human Reproduction and the activities of the Division of Family Health led them to conclude that organizational changes were needed if WHO was to play its full part in the implementation of the new global strategy. The necessary integrated and balanced approach could not be achieved by intraprogramme discussions alone; it also required a careful review of research priorities across programmes and a coordinated research agenda that struck a better balance between fertility regulation and broader areas of reproductive health. Mechanisms should be created for ensuring interaction between research and support for systems and services development. It was clearly necessary to improve coordination between programmes with overlapping functions. The Nordic countries did not believe that a high-level coordinating committee would provide the solution. Reform in WHO should lay greater emphasis on adjusting structures and processes for managing its reproductive health programmes.

Countries themselves would have to do most of the work to make reproductive health a reality. The Organization should help them reach that goal by ensuring the availability of technical guidance for analysis and programme development. Country-level coordination among United Nations bodies, and particularly with UNFPA, should be improved. The Nordic countries welcomed the emphasis placed on coordinated reproductive health planning at the national level and called for sex-specific information to be collected on reproductive health issues.

They proposed three additions to the draft resolution in document A48/10: first, a preambular paragraph reading:

> Noting the present fragmentation of reproductive health activities within WHO, and calling for a more coherent approach in priority-setting, programme development and management;

secondly, the insertion of the words "as expressed in document A48/10" at the end of paragraph 1; and thirdly, a subparagraph 5(3) reading:

> to develop a coherent programmatic approach for research and action in reproductive health and reproductive health care within WHO to overcome present structural barriers to efficient planning and implementation. This should be carried out in close consultation with Member States and interested parties, and a report submitted to the Executive Board at its ninety-seventh session and the Forty-ninth World Health Assembly.

Dr OMRAN (Bahrain) said it was a sovereign right of each country to implement health programmes that were consistent with its ethical standards and development priorities and fully respected religious and cultural values as well as universal human rights. The countries of the Eastern Mediterranean Region attached

great importance to the family, meaning a husband and wife united by a legal bond of marriage in mutual love and providing care for those close to them in kinship - male and female, young and old. His country opposed any form of regulation which facilitated promiscuous, extramarital sex. Measures should be directed towards preventing such behaviour rather than encouraging it on the false pretext of assisting the exercise of basic rights. He therefore objected to the reference to individuals in subparagraph 4(2) of the draft resolution in document A48/10. The provision of abortion services for unwanted pregnancies would be a serious step towards legalizing abortion, which should not be regarded as a legitimate method of family control. He suggested the inclusion, in paragraph 5 of the draft resolution, of a request to the Director-General to rename the WHO programme on family/community health and population issues (proposed programme budget heading 4.1) the reproductive health programme.

Mrs JEAN (Canada) stressed the importance of close cooperation in reproductive health matters between WHO and other United Nations organizations, as well as with governments, nongovernmental organizations and all interested parties. A plan of action should be urgently formulated which would mobilize all units concerned with those matters and reflect the results of wide-ranging consultation with governments and other partners. She approved the draft resolution in document A48/10, with the amendments proposed by Norway.

Dr SINGAY (Bhutan) said that, in keeping with the definition of reproductive health adopted by ICPD in its Programme of Action, maternal and child health and family planning should be considered as components of a broader reproductive health programme. The concept of reproductive health encompassed the needs of all individuals and thus of the family as well. He welcomed the fact that WHO approached reproductive health issues not only comprehensively but also incrementally according to national requirements and abilities. In his view, the title of document A48/10 should simply read: "Reproductive health: WHO's role in the global strategy", and the reference to it in the draft resolution should be amended accordingly. Subject to that, he approved the draft resolution.

His Government greatly looked forward to implementing WHO's "mother-baby package" as part of its reproductive health action and requested technical guidance and support for that purpose. It reaffirmed its belief in the unique role of the Organization with respect to advocacy, normative functions, research and technical development in the area of reproductive health.

Dr KORTE (Germany) welcomed the programme activities under heading 4.1. The strategy of preventing in childhood the health problems of adulthood was of particular importance in the industrialized countries. Interventions in adolescent health were of similar importance.

The programme under heading 4.1 was designed to cover the entire life cycle, a sound approach on which health promotion and education in Germany was also based and one that had his full support. He expressed his appreciation for WHO's work on maternal and child health and family planning in preparation for ICPD. The follow-up programme of action, which WHO was actively pursuing, was of even greater importance. He looked forward to close collaboration with WHO on programme implementation at the request of countries and expressed his approval of the draft resolution.

Referring to the occupational health programme, which also came under budget heading 4.1, he said it incorporated the setting up of networks for promoting health in the workplace, requiring close coordination with the appropriate Commission of the European Union. It could be assumed that the Commission would support a project to establish an informal European network proposed by the German Agency for Occupational Safety.

Dr VAN ETTEN (Netherlands) expressed his appreciation of the Director-General's report (document A48/10). Population had not been given sufficient attention until recently and he was therefore gratified that reproductive health had now become a priority area.

A number of different organizations, with various tasks and roles, were involved in the broad field of reproductive health. He felt that WHO had, at the global level, a normative function concerning quality and safety in the area of reproductive health, including family health. At the national level, WHO should contribute to policy development. It also had a technical guidance function in setting standards for safety and for the medical acceptability of family planning and abortion methods. Standards for quality, accessibility and affordability of service delivery should also be developed. In his view, WHO did not have any direct

operational tasks based on technical guidance and normative function; rather, it should support existing national and international networks, organizations such as UNFPA and UNICEF, governments and nongovernmental organizations.

WHO, within its mandate, should fully collaborate in the implementation of the ICPD objectives, Declaration, and Programme of Action.

He endorsed the draft resolution, as amended by the Nordic countries.

Dr RODRIGUES (Brazil) reported that at a meeting in Miami in December 1994 the heads of State and government of 34 States of the Americas had signed an agreement on development and prosperity. The objectives set at that meeting included strengthening the goals of maternal and child health of the World Summit for Children of 1990, the Narino Agreement of 1994 and the International Conference on Population and Development of 1994, which sought to focus efforts on reducing child mortality by one-third and maternal mortality by one-half by the year 2000, taking 1990 as a base.

To achieve those goals, public services must be truly public. Regulation, evaluation and control of health services should be increased. It was also necessary to bring about a profound change in awareness and create a culture of responsibility for health, reflected in the daily lives of individuals and communities. WHO and Member States should initiate a move towards behavioural and cultural change, involving institutions, the community and the family. Brazil had already made efforts towards that end. The Ministry of Health had launched a major campaign, involving community and governmental participation, to combat infant mortality. It had also set up for the first time a budget specifically for family planning programmes, laying down preferences for reversible methods and free choice for couples. Last but not least, the Ministry of Health was endeavouring to improve and diversify health reform strategies in Brazil, seeking to make universality and equity viable, not just rhetorical goals.

She welcomed the policies set out in document A48/10 and expressed approval of the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) commended the Director-General on his report. Reproductive health being an integral part of general health, it was essential to implement reproductive health services within the context of primary health care and family care. Maternal and child health, including family planning, constituted one of WHO's more important programmes. Transparency was essential with regard to abortions, harmful traditional practices, reproductive rights, and sexual and reproductive health, including family planning. A coordinated approach involving members of the United Nations system and other agencies was needed, since resources were scarce.

She expressed support for the draft resolution in document A48/10, but proposed the addition in paragraph 4 of a new subparagraph reading:

> to promote ethical practices in the field of human reproduction to protect the health and rights of individuals in different social and cultural settings.

Turning to paragraph 227 of the proposed programme budget, she welcomed the issue of a number of documents on the health of the elderly, in particular a manual for the training of primary health care workers, given the increase in the percentage of elderly people.

Dr CHÁVEZ PEÓN (Mexico) proposed the addition of the word "individuals" before the word "parents" in subparagraph 4(2) of the draft resolution. Support and guidance should certainly be given to parents and teachers, but also to individuals and the community at an early stage in preparation for parenthood.

He added that reproductive health should be a leading WHO activity, conducted at country level; it should not become subsumed under other programmes. Finally, he reported that Mexico had launched in January a national reproductive health programme following the principles in the Director-General's report.

Dr ABU BAKAR Dato' SULEIMAN (Malaysia) said that Malaysia regarded reproductive health as fundamental to basic health and development and crucial to efforts to improve the health status and care of the population. Reproductive health affected the entire lifespan of every person. It had important

intergenerational effects and implications for the quality of life, notably in regard to HIV/AIDS and sexually transmitted diseases.

Malaysia was in favour of presenting reproductive health programmes as a part of general health care and making them accessible through primary health care. They should be based on existing infrastructures and use available resources, which would involve the reorganization and integration of services and the reallocation of resources to improve coverage and the quality of care.

Some components of reproductive health touched on sensitive and controversial issues, such as abortion and reproductive health care and services for young people. Malaysia would abide by the principle set out in chapter II of the ICPD Programme of Action that the implementation of reproductive health programmes was the sovereign right of each country, that they should be consistent with national laws and development priorities, and that they should fully respect religious, ethical and cultural values in conformity with universally recognized human rights. In that regard, Malaysia supported WHO's position on abortion and its stand on the reproductive health of young people.

As there were no set models or universal formulas for countries to plan and implement reproductive health programmes, Malaysia's programme development would be based on the principles of national priorities, equity (for both sexes), and partnership with governmental, nongovernmental and private sectors. An incremental approach would be adopted, building on existing resources and needs. Links within and between sectors would be strengthened in order to create opportunities. Family planning interventions, the prevention of maternal and neonatal deaths and disabilities, and the prevention and management of sexually transmitted diseases would be given priority, with the necessary information, education, counselling, care and rehabilitation.

He urged WHO to take a leading role and step up action in its global, regional and country strategy in the four broad areas of advocacy, research and development, normative functions and the provision of technical support to Member States. For the purposes of immediate action, the policies set out in document A48/10 could be translated into operational guidelines for countries.

He expressed his support for the draft resolution contained in the document.

Dr PAVLOV (Russian Federation) expressed support for WHO's activities under heading 4.1 and welcomed document A48/10.

In the period of political and economic transformation which the transition economy countries, including his own, were currently undergoing, a number of complex problems had arisen relating to the health status of various demographic groups, in particular women and children. Those problems included increased maternal and child mortality, reduced fertility and a high level of abortions. For those reasons, among others, family health and maternal and child health were currently a very important issue in his country. In 1990 the Russian Federation had ratified the United Nations Convention on the Rights of the Child and the World Declaration on the Survival, Protection and Development of Children, which had given impetus to State activities to promote maternal and child health and protect the family. The programme for the children of Russia and the family programme, among others, had been launched. The President had set up a commission on women, families and population. Thus, intensive work was being carried out in all the areas. He appealed to WHO to provide more tangible assistance in that work.

In some transition economy countries there had been a decrease in life expectancy. Statistics had shown that poor working conditions, insufficient protection and low levels of health care for workers were responsible. Expressing support for the programmes under consideration, he stressed that WHO should attach greater importance to medical care for working people. The working population was the productive population and should therefore be given higher priority in the Organization's programme budget.

Mr THORPE (United Kingdom of Great Britain and Northern Ireland) congratulated the Director-General on preparing the outline global strategy for reproductive health, describing WHO's roles and responsibilities in following up the ICPD Programme of Action, from which many statements in the document were taken. He found the outline framework to be generally satisfactory, though lacking precision on the implementation of the strategy. He inquired whether the document had yet been considered by the United Nations interagency task force for follow-up of ICPD. Responsibility for developing the global strategy did not lie with any one organization of the United Nations system, but should be an interagency exercise.

With reference to paragraph 11 of document A48/10, he requested clarification of the meaning of "a public health approach to reproductive health within the context of primary health care". He hoped it would not be taken to imply that all reproductive health services had to be made available through particular kinds of public health package; more emphasis might be given to the need to ensure that people were able to have access to what they needed from a variety of sources, both public and private.

In expressing support for the four main areas identified in paragraph 36 as WHO's responsibility, he emphasized that it was essential for work in all four areas, but especially in the first and fourth, to be linked to the activities of other United Nations bodies, in particular UNFPA.

He supported the draft resolution contained in document A48/10.

The meeting rose at 12:25.

SEVENTH MEETING

Monday, 8 May 1995, at 14:30

Chairman: Dr Fatma H. MRISHO (United Republic of Tanzania)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

GENERAL REVIEW:[1] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58)

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

4.1 Family/community health and population issues (continued)

Maternal and child health and family planning: quality of care (Resolutions WHA47.9 and EB95.R10; Document A48/10[2]) (continued)

Dr ABUSALAB (Sudan) said that, although Sudan had not attended the International Conference on Population and Development (ICPD), it had welcomed the improvement in atmosphere that had followed the acknowledgement in the Programme of Action adopted by the Conference of the need to take the different situations and religious and ethical standards prevailing in different countries into consideration in implementing it. On that basis, Sudan was now able to accept the Programme.

Sudan had, since 1990, applied a population policy of which the cornerstone was protection of the family as the fundamental unit of society. Although the impact of population growth on the economy was acknowledged, other social, behavioural and ethical factors were considered equally important and deserving of attention. Family planning programmes were provided which observed the moral principles respected in Sudan - abortion, for example, was not acceptable. Early marriage was encouraged with a view to protecting the family and young people; family planning services were available following marriage to ensure young people were properly informed on reproductive matters and in order to protect maternal and child health. Sudan endorsed the view that all such aspects should be covered under the heading "Reproductive health" and considered that WHO should remain the agency in charge of the medical and technical aspects of management, research and follow-up of reproductive health. He endorsed the draft resolution contained in paragraph 56 of document A48/10.

Dr BERGER (Switzerland) said that, in the follow-up to ICPD, Switzerland was in favour of a multisectoral approach to reproductive health, a topic that had implications far beyond the health sphere, touching on matters affecting women in general and involving cultural aspects, social structures, education and the economy. A comprehensive outlook and an across-the-board approach were essential in order to deal with the subject within the general framework of health and development. In view of the way the relevant activities were scattered within WHO, there were grounds for concern as to whether action on reproductive health was sufficiently consistent and coordinated to ensure maximum effect, avoid waste and make the best

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[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

[2] Document WHA48/1995/REC/1, Annex 2.

use of the expertise available. She shared the views expressed on behalf of the Nordic countries at the previous meeting and endorsed the amendments they had proposed to the draft resolution.

Dr KHOJA (Saudi Arabia) said that it was time for WHO, without neglecting its major task of protecting and promoting maternal and child health, to give greater attention to the broader aspects of women's health, both in research policy and primary health care, since many noncommunicable diseases affecting women called for urgent measures. WHO should concentrate on the training of nurses and midwives, the protection of women's and children's health and the promotion of safe motherhood - all within the framework of primary health care. That should include efforts to draw the attention of young mothers to the dangers of smoking. In the context of public and family health, priority should be given to assessing the health care provided for women and children. In order to improve medical teaching, guidelines should be prepared for the production of training materials and teaching programmes. In that context he commended the technical briefing on the mother-baby package that had been provided the previous week. Saudi Arabia itself had, with assistance from WHO and UNICEF, prepared guidelines on maternal and child health for health workers.

He endorsed the draft resolution, emphasizing that activities in the field of reproductive health should conform to the ethics and morals obtaining in the country concerned. Health education, women's health and maternal and child health were all matters in which WHO, rather than other agencies, should play the leading role. He too was in favour of the whole area of activity concerned being referred to as reproductive health, both at headquarters and in the regional offices.

Dr SULEIMAN (Oman) commended the technical briefing that had been provided the previous week on the mother-baby package and the initiatives that had been taken in the field of maternal and child health. In dealing with the problems associated with family planning and maternal and child health, attention ought to be focused on communicable diseases, which through their impact on the individual, the family and society at large had important implications for reproductive health. WHO should therefore continue to play the key role in that field, in association with other concerned organizations. He endorsed the recommendation made by Bahrain that budget heading 4.1 should be changed to "Reproductive health", it being understood that its various components would be provided mainly through primary health care services.

Professor DIF (Algeria) said that for the past 10 years Algeria had been implementing a national programme for the control of population growth. Various areas of government, and national and international nongovernmental organizations, were involved in the programme, which was essentially applied by means of a network of community-level structures throughout the country. Family planning had been integrated with maternal and child health activities; it was also included in medical studies. As a result, 50% of married women of reproductive age were now using modern contraceptive methods, compared with 14% in 1984. The introduction of new methods of contraception (such as injectables) and the increasing level of education of young married women should increase that figure further in the next decade. Use of contraceptive methods was in no way enforced on the public. Access to oral contraceptives and intrauterine devices was universal, since they were provided free of charge in public clinics as well as being available in the private sector. The assistance of the international community had done much to ensure the success of the programme.

He supported the draft resolution.

Dr MAREY (Egypt) said that the report (document A48/10), which dealt comprehensively with the recommendations adopted by ICPD, indicated clearly the rationale for the definition of reproductive health and the global strategy for its promotion, which he endorsed. The health of women and of children, in particular the school-age child, was very important; political commitment and interaction between the various agencies of government, both legislative and executive, was essential in order to lay the groundwork for a successful strategy. There must also be greater awareness of basic care needs; university education should include training in practical approaches. The active participation of all those concerned in a consolidated effort was essential in the drive to improve reproductive health. In addition the best use should be made of available technical, consultative and financial resources if maximum impact was to be achieved.

He supported the proposal to change the title of budget heading 4.1 to "Reproductive health". Egypt attached special importance to maternal and child health and he therefore welcomed initiatives such as the

mother-baby package, in view of its importance to family planning and protection against sexually transmitted diseases.

Dr GEORGE (Gambia) commended the achievements. Maternal mortality was a matter of great concern in the African Region; he therefore asked why, despite a modest increase in the budget and the wide interest of donors, a considerable decline was shown in extrabudgetary contributions for activities in Africa.

Raising the status of women, especially in traditional settings where men were usually dominant, was of the utmost importance; he therefore welcomed the global strategy for reproductive health. The Organization should direct research efforts towards the removal of traditional barriers disadvantaging women, the improvement of women's means of access to credit, and the promotion of literacy and numeracy among women.

He welcomed the mother-baby package, which addressed the fundamental health problems of developing countries in a comprehensive manner while allowing for capacity-building and strengthening of the health system. The package provided an opportunity to integrate services and action directed to two major health problems and at the same time provided a focus for coordination of donor efforts. WHO must retain its leadership in the field concerned.

Quality of care was an important aspect of the programme; he therefore proposed that the words "progress and effectiveness" in subparagraph 4(3) of the draft resolution should be replaced by "progress, quality and effectiveness".

Dr KALAÇA (Turkey) said that there had been general consensus for the use of a broader concept of reproductive health, based on WHO's working definition, in the Programme of Action adopted by ICPD. That broader concept could best be applied within primary health care. Its implementation called for appropriate policies and energetic and pragmatic programmes of action in countries. Creative approaches by WHO, such as the mother-baby package, were needed to establish operating links between the services providing family planning, maternal and child health care, and management of sexually transmitted diseases, all of which were priorities in most developing countries. The mother-baby package had the potential to become an important tool for the reduction of maternal and neonatal mortality and morbidity. Reproductive health programmes should cover the needs of men, women, children and families. The problems of adolescents, and their need for information and services, had been a neglected area in reproductive health and should be addressed as a matter of urgency. All reproductive health activities undertaken by WHO should be regarded as an evolving process, subject to continuous review, research, reorientation, and innovation. He endorsed the view that WHO should maintain its leadership in advocacy, standard-setting, research and technical cooperation in reproductive health.

Dr FREIRE (Spain) said that the Director-General's report (document A48/10) covered a subject of major importance for human health. WHO should continue to promote reproductive health in international forums and in all its programmes as an essential component of the strategy of health for all. It was particularly important that maternal and child health and reproductive health should form an integral part of development programmes and be included in the work in the United Nations system and other bodies providing resources for development; the request to the Director-General in resolution EB95.R10 to report to the Economic and Social Council and the General Assembly on the continued high priority given by WHO to reproductive health would guarantee attention to reproductive health by political leaders.

He supported the draft resolution, with the amendments proposed by the Nordic countries and Mexico at the previous meeting.

Dr LEGNAIN (Libyan Arab Jamahiriya) said that her country was making considerable efforts to put the recommendations in the Director-General's report into practice in a way compatible with its cultural and religious beliefs. She thus supported the amendment to the draft resolution proposed by the delegate of Greece at the previous meeting.

Reproductive health was given high priority in the Libyan Arab Jamahiriya; women benefited from all necessary care throughout pregnancy and following delivery. Men and women enjoyed equal responsibilities in any decision on pregnancy and birth spacing. Women were entitled to be fully informed

of family planning methods compatible with Islamic teaching. The country had the lowest level of maternal mortality in the Eastern Mediterranean Region.

Because of the particular importance her country attached to reproductive health, she considered it should remain a priority for WHO. She also agreed that the title of budget heading 4.1 should be changed to "Reproductive health".

The mother-baby package was also very important, especially in its approach to sexually transmitted diseases.

Dr AL-SALAH (Kuwait) endorsed the views expressed by the delegates of Bahrain, Egypt, the Libyan Arab Jamahiriya and Saudi Arabia. Reproductive health practices must be compatible with religious beliefs and cultural practices in the various regions and he supported the inclusion of a phrase to that effect in the draft resolution. He also proposed that in paragraph 3 "collaboration" should be replaced by "coordination"; it was important to ensure that other organizations did not encroach upon WHO's mandate.

Dr BAATH (Syrian Arab Republic) expressed satisfaction with the draft resolution, stressing the importance of reproductive health, including maternal and child health, adolescent health and care for the elderly, as the family was the cornerstone of society. Despite the divergences in the opinions expressed on reproductive health at ICPD in Cairo, that topic covered a wide range of aspects within the field of competence of WHO; other organizations should not have a monopoly in those areas. He commended the work done and welcomed the mother-baby package, which covered important matters including protection against sexually transmitted diseases. Considerable efforts had been made in the Syrian Arab Republic to promote the package as an essential part of primary health care, and to ensure participation of a wide range of organizations in such activities. He supported the proposal that the title of budget heading 4.1 should be changed to "Reproductive health" and that the use of the term should be standardized throughout WHO documents and resolutions. He endorsed the Greek proposal to take into account the cultural practices and religious beliefs of different countries and regions in the draft resolution.

Ms LIU Guangyuan (China) welcomed the emphasis on reproductive health; it was essential to ensure better health for women in the neonatal period and improve prospects for infants. Research in reproductive health must be conducted if the goals of the Ninth General Programme of Work were to be attained. WHO should provide assistance so that optimum use might be made of national resources to meet the needs of the different population groups. China attached great importance to maternal and child health and family planning, to the improvement of living conditions and to the attainment of the goals for the year 2000 regarding the survival, protection and development of mothers and children; appropriate laws had been passed and a system established for integrating primary health care and clinical care. Mortality among mothers and infants had decreased. China would make every effort to participate fully in the work of the Fourth World Conference on Women to be held in Beijing, at which there would be technical discussions on reproductive health.

Dr SHONGWE (Swaziland) welcomed the comprehensive report in document A48/10 and commended WHO on its important contribution at ICPD where its definition of reproductive health had been endorsed and consensus reached. Swaziland fully supported that definition and welcomed WHO's action on population matters. The challenge was now to translate the conclusions of the Conference into strategic and action plans, in which WHO could assist countries. Swaziland attached great importance to the health of women and children and welcomed the mother-baby package. WHO should also assist countries in strengthening reproductive health programmes in the context of primary health care, family planning and adolescent health. He hoped that WHO would have some influence on the agenda of the forthcoming Fourth World Conference on Women. He supported the draft resolution.

Dr CHAMOV (Bulgaria) expressed satisfaction with WHO's activities in maternal and child health and family planning. The development of a complex strategy in the broad context of sexual and reproductive health and of a plan of action clearly determining the role of scientific research, of the elaboration of a normative base and of technical collaboration was extremely timely and called for WHO leadership. Bulgaria had as yet no consistent policy in family planning. Prevention of undesirable pregnancy was unsatisfactory

owing to lack of contraceptives, and abortion was still the most frequent method of birth control. The usefulness of an integrated approach in coping with demographic problems had been underestimated and such problems, combined with the social and economic crisis, had led to a sharp decrease in the birth rate, an increase in total and infant mortality, and population decline. In the framework of the planned assistance for the health care system in Bulgaria, the European Union's PHARE programme had provided financial support for the family planning programme, for which WHO would supply the necessary technical assistance. He supported the draft resolution, with the amendment proposed by Greece.

Dr DURHAM (New Zealand) supported WHO's role in international coordination with respect to normative functions, research and technical cooperation in reproductive health. There must, however, be close cooperation with other organizations in the United Nations system, so as to provide international support for the broader purposes of reproductive health. She endorsed the conceptual and strategic framework for reproductive health in the context of primary health care and supported the draft resolution as amended by the Nordic countries.

Dr AL-JABER (Qatar) stressed the importance of maternal and child health, which concerned more than half the population, and welcomed the mother-baby package. He agreed that budget heading 4.1 should be entitled "Reproductive health" and that reproductive health should be compatible with the ethical, religious and cultural traditions in each region. He supported the draft resolution with the amendments proposed by Greece and Kuwait.

Dr BASHI ASTANEH (Islamic Republic of Iran) supported the draft resolution, with the amendment proposed by Greece. He welcomed the global strategy for reproductive health which grouped together all activities relating to maternal and child health and the family. It should be implemented within the context of primary health care and health for all. He hoped that funding could be provided for the translation of reproductive health training modules into local languages, including Farsi. He stressed the importance of political commitment as a fundamental basis for the success of reproductive health activities, including accessibility of family planning methods. Reproductive health programmes should pay special attention to the reduction of maternal and neonatal mortality, and should take into account specific country needs and capacities. He agreed with other speakers that the title of budget heading 4.1 should be "Reproductive health" and that of the draft resolution "Reproductive health: WHO's role in the global strategy". He supported the draft resolution, with the amendment proposed by Greece. He also supported integration and the establishment of links between related services. WHO had indeed a unique role to play with respect to advocacy, normative functions, research and technical cooperation in reproductive health.

Dr OMRAN (Bahrain) expressed strong support for the amendment proposed by Greece concerning the promotion of ethical practices.

Mrs NGURE (Kenya) supported the draft resolution, which was consonant with Kenya's overall maternal and child health and family planning objectives: to increase the demand for contraceptives and at the same time maximize access; to improve the quality of prenatal care at community and institutional levels; to reduce maternal morbidity and mortality; and to meet the needs of adolescents. Strategies adopted with those objectives included: an integrated approach to the training of health personnel, with emphasis on their role in reproductive health; information and education of both men and women on the importance of reproductive health; and provision of appropriate equipment, drugs and supplies. She thanked WHO and the Member countries which had provided support for that endeavour. She was pleased to note that reproductive health also covered other aspects with direct implications for girls, namely general education, nutrition and elimination of female genital mutilation. Adolescent health was receiving special attention in Kenya through the introduction of family life education, the development of a curriculum for service providers in selected areas to enable them to manage adolescent health more effectively, and the development of clinic-based projects to solve specific problems. She welcomed the mother-baby package.

Mr CHAUDRHY (Pakistan) expressed appreciation for WHO's action on reproductive health, an essential component of human health. In support of that strategy, the Prime Minister of Pakistan, while

attending ICPD, had emphasized the importance of planned pregnancy and of love and support for every child. She had also called for a global partnership for social action promoting the objectives of planned parenthood for population control, one aspect of social development being "empowerment" of women to achieve the goal of population stabilization while at the same time promoting human dignity. She had stressed that all interventions in the area of reproductive health and family planning must conform with the teachings of Islam. He endorsed the views expressed by the delegates of Bahrain and Greece in that respect.

Ms GIBB (United States of America) said that health and population goals were mutually reinforcing: advancement of health and population stabilization both contributed to sustainable development and individual quality of life. WHO was to be commended on its crucial leadership in facilitating consensus at ICPD on a redefinition of reproductive health and on raising understanding of reproductive health needs throughout the world. Tackling reproductive health problems was not a burden to be borne by health systems alone: commitment and action must come from society as a whole, including the private sector, religious institutions and communications media, in order to reduce inequality between the sexes and promote education, information and services.

For three decades WHO had played a leading role in research on fertility regulation and in building biomedical research capacity in developing countries through its Special Programme on Research, Development and Research Training in Human Reproduction. It was essential for the Programme to retain its clear focus and leadership in reproductive health research, even as WHO developed research and technical cooperation in related areas.

Progress towards the goals set by ICPD would require a cooperative multisectoral approach involving all members of the international community. In reproductive health, careful planning was required as well as determination of optimal roles and administrative structures for coordination both within and among organizations. It was not clear from document A48/10 how the proposed WHO coordinating committee on reproductive health was going to function. She hoped that WHO would consult Member States concerning its organizational plans before they were implemented.

She supported the draft resolution, with the amendment proposed by the Nordic countries.

Mr JAKUBOWIAK (Poland) supported the draft resolution and the activities presented under budget heading 4.1 in the proposed programme budget, particularly the projects to improve the effectiveness of maternal and child health care. Reduction of infant mortality was a priority in many countries, including Poland, which had established a task force to formulate and implement a new programme based on an analysis of the current situation in Poland and a comparison with countries that had achieved good results in perinatal care. Poland was also giving special attention to the supervision of the quality of procedures of consultancy, training and health promotion; the programme structure and process of implementation conformed to current WHO recommendations.

Mr ACHOUR (Tunisia) supported WHO's efforts to promote maternal and child health, family planning and other aspects of reproductive health and the new global strategy for reproductive health. Given the differences in conditions and systems, it was essential to establish guidelines that would take into account both the ultimate objectives - controlling demographic growth and ensuring health for all - and the multidimensional constraints which varied from one country to another. While cultural values and human rights must be upheld, the future of the population, the well-being of the family and the health of the individual should take precedence in decisions concerning the safeguarding of health and the family. He therefore welcomed document A48/10 and supported the draft resolution, with the amendment proposed by Greece. He stressed the need to integrate reproductive health activities into primary health care.

Dr AMMAR (Lebanon) endorsed the view that WHO should remain the leading agency in the field of reproductive health and supported the proposal to change the title of budget heading 4.1 to "Reproductive health". Given the need to take account of different social, cultural and religious beliefs in order to make activities more acceptable to national authorities and populations, he supported the Greek amendment to the draft resolution.

Professor MONTALVÁN (Panama) endorsed the view expressed in document A48/10 that reproductive health should constitute an integral part of health for all, taking into account the needs of the individual, the family and society, as well as the normative activities of WHO. He supported the amendments to the draft resolution proposed by Mexico and the Nordic countries.

Dr MUKHERJEE (India) said that since the level of population growth in India was a serious problem there was political commitment at a high level to a major family welfare and maternal and child health care programme of a participatory nature, as well as to the promotion of all ethically acceptable methods of contraception. Maternal and child health care was integrated with family planning services and birth spacing was being actively promoted. In rural areas, access to family planning services was through primary health care. Reduction in birth rate and total fertility rate were being monitored and were expected to have a favourable impact on maternal morbidity and mortality rates.

He was pleased to note the important role being played by WHO in reproductive health.

Professor GUMBI (South Africa) supported the draft resolution.

In 1994 South Africa had set up a task force to promote reproductive health. Local research had indicated: the need for instruction in life skills; the importance of compatibility of interventions with religious beliefs and cultural values, using the primary health care model; the need for accurate data on which to base policies and decisions in order to improve the efficiency and effectiveness of services; the need to train health personnel who could offer counsel and guidance and to ensure that ethical principles and professionalism were maintained at all levels; the need for widespread education and dissemination of information using all strategies including the mass media; and finally, the need to guarantee the health of mothers and children through a system of free care for pregnant women and for children aged under six years.

South Africa supported an integrated primary health care approach aimed at improving quality of life through multidisciplinary action, together with continuing research relevant to the needs of each country.

Dr AL-SHABANDAR (Iraq) said that Iraq attached great importance to maternal and child health and family planning services, together with primary health care services, for the community. The aim was to ensure safe motherhood and infant feeding and to provide immunization services.

WHO had a constitutional responsibility to foster progress in family planning and should continue to act as a leader in the field. He supported the proposal to change budget heading 4.1 to "Reproductive health" and endorsed the view that reproductive health activities should conform to moral and cultural values in each country.

He commended the mother-baby package, in particular the objective of protecting families against communicable diseases.

Dr MZIGE (United Republic of Tanzania) stated that improving the health of women and children and reducing maternal mortality were priorities in the Tanzanian mother and child health/family planning programme. Free health care was provided for pregnant women and children aged under five years, who together made up 40% of the population. WHO through the Regional Office for Africa had supported various initiatives which had helped to give a sense of direction to safe motherhood activities. Although family planning trends were encouraging, anaemia, malnutrition, malaria and overwork continued to contribute to the high maternal mortality rate. A further aim was to ensure that all deliveries were conducted by trained personnel; 55% of traditional birth attendants had so far received training.

He supported the draft resolution.

Dr DODD (United Nations Population Fund) said that all activities in UNFPA-assisted programmes would henceforth be undertaken in accordance with the principles and objectives of the Programme of Action adopted by ICPD and endorsed by the United Nations General Assembly through its resolution 49/128.

In future UNFPA proposed to concentrate its funding in three core areas: reproductive health and family planning, population policy, and advocacy. "Gender concerns" would be integral components of all aspects of UNFPA programmes and therefore of all activities undertaken in those core areas. Details would be presented to the Executive Board at the forthcoming ninety-sixth session.

UNFPA's reproductive health strategy would be based on a pragmatic and participatory public health approach, which would promote sustainability and specify measures for the greatest effect for the most people at an affordable price. The ultimate goal was to develop comprehensive and integrated systems of reproductive health care offering a full range of services as outlined by WHO in document A48/10.

The tasks ahead were beyond the capacity of any one organization and would require the strengthening of partnerships at many different levels. UNFPA would strengthen collaboration and cooperation with WHO, UNICEF and other United Nations organizations, and with bilateral agencies and nongovernmental organizations. At the global level, UNFPA would look to WHO to provide an overall framework to operationalize reproductive health activities, and to define policies, identify research needs and give normative and technical guidance. At the country level, UNFPA would continue to collaborate with all parties concerned in assisting countries to formulate and implement comprehensive national reproductive health programmes. Modalities for interagency collaboration at country level would be the subject of a forthcoming meeting.

Miss WALKER (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said that since reproductive health was an integral part of primary health care, she welcomed the decisions taken at ICPD. She also welcomed document A48/10 and the draft resolution before the Committee. Midwives recognized the importance of promoting the total health of women, which was also reflected in the health status of the newborn.

Adequate and accessible primary health care services were essential to meet the health needs of populations at critical times in life, and should incorporate reproductive health services. Often the high maternal, neonatal and infant mortality and morbidity rates reported by so many developing countries were preventable. The provision of reproductive health care as a means of prevention should therefore be a high priority. Communities should be encouraged to become involved in developing, implementing and maintaining health care programmes that were appropriate to their needs, taking into account local cultural and social values, and offered a high standard of care. To do that, communities and countries needed an overall awareness of how health could be promoted and protected, including the influence of factors such as the economy, education, the working environment and the status of women. That would require a harmonious partnership between all those involved in the provision of health care at local, national and international level. It was also essential to support countries themselves as they developed and implemented their actions.

The role of women in identifying the scope of reproductive health care and making it available was paramount and midwives, other health care workers and obstetricians must work with women to ensure success.

Health and development centred around women and she therefore supported initiatives for health and well-being of women, such as the mother-baby package.

Dr LUEDICKE (International Federation of Gynecology and Obstetrics), speaking at the invitation of the CHAIRMAN, said that the specialized health professionals could no longer expect to go their own way in developing and delivering reproductive health care. At local, national, regional and international levels, they must seek out and work with other professionals and non-professionals, and with the populations to be served. A more sympathetic and less prescriptive approach should be adopted in any recommendations or actions.

Since gaps and inadequacies had been identified it was now important to set priorities at local and national level, together with realistic targets according to the resources available. Attention should be directed to particularly disadvantaged and vulnerable groups. Health professionals should develop their advocacy skills so as to strengthen action with a broad range of "partners" in order for reproductive health to be presented as a logical and integral part of community development. It was important to increase the awareness of decision-makers at all levels. The roles and responsibilities of men must not be neglected and opportunities should be taken at all levels to ensure their involvement, and there should be continuous evaluation, in all reproductive health programmes.

The Federation would play an active role in trying to ensure the implementation of the Programme of Action adopted by ICPD. Links must be established at local, national and international levels. A joint WHO/Federation task force had been active for 12 years; it was an excellent mechanism for collaboration which he hoped would be expanded in the future.

Professor BERTAN (representative of the Executive Board) said that the draft resolution under consideration had been discussed at length by the Board, which had underlined the need to consider reproductive health within the context of primary health care, especially in the implementation phase, and to develop strategies for close collaboration with other organizations of the United Nations system.

Dr HU Ching-Li (Assistant Director-General) welcomed the many comments on the Director-General's report and the draft resolution. As the report indicated, WHO had participated for over 30 years in a global strategy for reproductive health. The desire had been expressed for WHO to strengthen its role in implementing the strategy. As a result of ICPD, WHO had taken a fresh look at its experience in collaborating with Member States and its partnerships with other international agencies and nongovernmental organizations. As recently as March 1995, those parties had been consulted in the preparation of document A48/10. Serious consideration would be given to the suggestion made by the Nordic countries and supported by many other delegations that the efficiency of the Organization's reproductive health policies needed to be improved, and consultations would continue on that subject.

In response to the question raised by the United Kingdom regarding the involvement of the United Nations interagency task force in following up ICPD and the role of other United Nations organizations in development of the strategy, he stressed that all partner agencies had been involved in the process of developing document A48/10. WHO had initiated a broad-based consultative process involving a variety of partners including WHO headquarters and regional offices, Member States, other organizations of the United Nations system, especially UNFPA, development agencies, and nongovernmental organizations, including women's and youth groups, in order to develop further a comprehensive framework for a global strategy on reproductive health and WHO's roles in implementing the strategy.

The delegate of the United Kingdom had also requested clarification of the meaning of "the public health approach to reproductive health", mentioned in paragraph 11 of document A48/10. The approach was based on an assessment of needs and community involvement that sought long-term sustainability and optimum use of resources. As emphasized in paragraph 11, such an approach would involve public and private sectors and promote sharing of responsibilities between governments, agencies and nongovernmental organizations.

He assured delegates that in collaborating with Member States in implementing the ICPD Programme of Action WHO would respect different national cultures, laws, religions and regulations. It was important to emphasize that abortion was not a means of family planning.

He had noted the suggestion that the title of budget heading 4.1 should be changed from "Family/community and population issues" to "Reproductive health" and that that should be reflected in a parallel change in the title of the draft resolution to "Reproductive health: WHO's role in the global strategy". He had also noted the desire for increased emphasis on the ethical aspects of reproductive health. In fact, WHO had already taken action in that field. In response to the inquiry by the delegate of Gambia regarding the extrabudgetary resources for 1996-1997, in particular for Africa, he said that the current figure was only an estimate and would undoubtedly increase as the period in question approached. Finally, WHO headquarters and the regional offices would follow up the request for assistance in translating guidelines and training models into local languages.

Dr THYLEFORS (Secretary), noting that a number of amendments had been proposed to the draft resolution, suggested that a working group, consisting of the delegates of the Nordic countries, Bahrain, Bhutan, Gambia, Greece, Iraq, Islamic Republic of Iran, Kuwait, Lebanon, Libyan Arab Jamahiriya, Mexico, Syrian Arab Republic, and any others interested, should meet to prepare a revised version.

It was so agreed. (For continuation see page 138.)

Occupational health and Health of the elderly

Professor BERTAN (representative of the Executive Board) introduced the two remaining topics under budget heading 4.1.

Occupational health, as a component of the primary health care approach, was an important programme for all countries, particularly for developing countries where workers were faced with work-related health

hazards and had no access to health services. With the expansion of industrialization the significance of health at work had increased greatly; WHO must therefore pay more attention to the matter. The Executive Board had noted the declaration and global strategy on occupational health for all developed by the global network of the WHO collaborating centres in occupational health. The declaration needed further review by the Executive Board before possible endorsement.

With regard to the health of the elderly, the members of the subgroup of the Executive Board that had reviewed the programme had suggested a change in its direction, to be reflected in a change in its title to "Aging and health". Programme collaboration and orientation should be broadened. The integrated programme should emphasize the health implications of population aging, a rapidly growing phenomenon throughout the world, and focus on healthy aging to counteract negative concepts of aging. The Board had agreed that WHO should pay attention to: the need to raise awareness of the implications of the rapid increase in older populations for health care provision, including better use of the opportunities provided by primary and informal health care; training needs relating to population aging, not only for social and health workers but also for families and the general public; health promotion and education programmes to encourage self-help and self-care; and the use of WHO collaborating centres in raising awareness and coordinating expertise concerning aging.

Dr FREIRE (Spain) said that the elderly made up the population group growing most rapidly throughout the world and the one making the highest demands on social and health services. Furthermore, most of the elderly were women, often living alone and in poverty. Spain supported the proposed activities for the health of the elderly and hoped that the topic would be given increasing prominence in WHO's social and health policies.

Dr DURHAM (New Zealand) commended the occupational health activities and expressed support for the notion of the workplace as a setting in which to promote health. The important contribution made by environmental health technology in promoting occupational health should be emphasized and she expressed concern that no explicit mention was made of occupational health matters under budget heading 4.4: Environmental health, as they were implicit in many of the activities outlined. How exactly would the occupational health activities outlined under budget heading 4.1 be coordinated with those activities?

She commended the strategic approach to aging and health and would await a progress report by the Director-General, preferably to the Forty-ninth World Health Assembly, with interest.

Professor CALDEIRA DA SILVA (Portugal) said that the figures for population aging reflected progress made in improving life expectancy. In many countries, including Portugal, the problems of population aging had been largely neglected; they deserved more attention, resources, funds and initiatives; WHO had the opportunity to develop its activities and play a leading role in that area. He endorsed the views expressed by the delegate of Spain.

Dr RAI (Indonesia) said that the momentum of occupational health activities, particularly in developing countries undergoing economic transition, was increasing. Indonesia now attached greater priority to such activities. In 1997 it would host an international meeting on occupational health under the auspices of WHO.

Mr KIRIČENKO (Russian Federation) said that the critical situation regarding occupational health in the Russian Federation had, in turn, negative repercussions on the health of the elderly. About 17% of the workforce worked in conditions that failed to conform to health and safety regulations. The poor working conditions and insufficient protection of workers had produced a high level of occupational diseases: 1.76 per 1000 workers in 1993. Morbidity was high in enterprises in many leading economic sectors, for example the coal industry, light industry, vehicle manufacturing, energy and engineering; the basic reasons for chronic occupational diseases, constituting 95.2% of all related pathology, were the insufficient development of technological processes, construction faults, faults in the design of equipment and insufficient individual protection. Many problems had arisen in organizing the employment of pregnant women; special work stations had not been created and they were often forced to work in the same unfavourable conditions as all other workers.

He supported the programme budget proposals in the two areas under discussion.

Ms INGRAM (Australia) said that increasing longevity was one of the important indicators of the progress towards health for all. However, improved morbidity and mortality rates among younger populations meant that the elderly constituted a larger proportion of the overall population. Australia was one of many countries facing the health and social challenges of an aging population. She therefore endorsed the views of the delegate of Portugal and welcomed the increased emphasis on health of the elderly in 1996-1997, including investigation of the determinants of healthy aging, the promotion of healthy aging and the development of appropriate care models. The third meeting of WHO's Global Commission on Women's Health, hosted by Australia in April 1995, had focused on women and aging, in particular the health needs of older women.

Dr NAPALKOV (Assistant Director-General) thanked delegates for their comments. The three areas, reproductive health, occupational health and the health of the elderly, were closely connected. The realities of the situation regarding community and family health must be accepted; the health of working people was one of the major determining factors. In many countries the insufficient attention given to occupational health problems was responsible for 10%-15% of the average annual decrease in gross national product. Further, in most countries one worker was responsible for the health and survival of four or five dependants, usually children and the elderly. He noted the comment made at the previous meeting by the delegate of Germany regarding the need for better coordination of WHO occupational health activities with those of the European Union.

As noted by the delegate of Saudi Arabia, account must be taken of increases in noncommunicable diseases among future and young mothers, and the increase in smoking and the problems of health education must also be tackled. Currently almost all mothers worked and their working conditions were of serious concern, linking workers' health with maternal and child health. In a progressively developing society, sound organization of work was a determining factor for the physical and mental health of the majority of the population.

In response to the delegate of New Zealand, he stressed the interdependence of problems of occupational and environmental health. Close collaboration between both programmes had already been achieved for chemical safety, radiation health, and healthy cities. WHO would continue to coordinate the occupational and environmental health programmes; a joint action plan was under development. As had been stated by the delegate of the Russian Federation, the countries whose economies were in transition faced particular occupational health problems worthy of serious attention.

The views of the delegates of Portugal and Spain had also been noted; account should be taken of the health requirements of different age groups, especially in developing the programme on aging and health, as well as family health and reproductive health.

The WHO concept of reproductive health was very broad and embraced all stages of the human life cycle. Aspects of occupational health and aging and health were therefore closely related to the whole scope of community and family health problems. The recent changes in the title and direction of the programme, now called "Aging and health" would correspond better to the future orientation of the WHO concept and strategy for the elderly.

4.2 Healthy behaviour and mental health

Tobacco or health (Resolutions WHA43.16, WHA44.26, WHA46.8 and EB95.R9; Document A48/9)

Professor BERTAN (representative of the Executive Board) said that the Board had stressed that tobacco control was a major global health challenge and had commended WHO's efforts to meet it in spite of a shortage of human and financial resources. WHO activities were instrumental in the struggle to prevent tobacco-related diseases, while taking account of the concerns of developing countries which were largely dependent on tobacco production. The Board had noted the alarming projected increase in tobacco-related deaths, especially in developing countries. It had commended the information tools utilized by the programme, i.e. the publication of *Tobacco alert* and the annual celebration of World No-Tobacco Day, as valuable means to educate the public and give WHO a justifiably high profile. It had considered a draft resolution on an international strategy for tobacco control requesting the strengthening of WHO's capacity

in the field of "tobacco or health" and a study on the feasibility of initiating action to frame an international convention on tobacco control to be adopted by the United Nations. Board members had expressed their concern that the draft resolution might give the impression that WHO was adopting or endorsing recommendations from another international body, thereby giving rise to controversy. The Health Assembly was invited to consider the adoption of the resolution recommended by the Board in its resolution EB95.R9.

Turning to the area of public information and communication, which was also included under budget heading 4.2, she said that the WHO communications and public relations policy had been approved by the Board after an extensive debate. The Board had welcomed the policy as a step forward in strengthening WHO's use of modern communications technology and all pertinent social communication systems for promoting health, preventing disease and making WHO actions at all levels better known throughout the world. In a world where demand for health knowledge was growing fast, WHO should make full use of all recent communications and public relations developments, including the use of international media and related networks. It was essential that appropriate health messages and information on WHO activities should be regularly and actively disseminated through international, regional and national networks targeting, in particular, policy- and decision-makers, health and development workers, media professionals, intersectoral institutions, nongovernmental organizations and groups, and the public at large. Adequate attention should be paid by WHO to internal audiences and to the proper coordination, planning and systematic evaluation of media strategies and other communications and public relations activities.

Mr ZI Naiqing (China) said that statistics showed that the Western Pacific Region had one of the highest consumptions of tobacco; active measures were being taken and the Regional Director had expressed the hope that there would be no tobacco advertising in the Region by the year 2000. China had banned it on television and in the press. Regulations also prohibited smoking on all domestic public transport. For World No-Tobacco Day, the Ministry of Health and public authorities would be promoting public information and education against tobacco. China also took an active part in global control activities, would be hosting a world conference on tobacco and health in August 1997, and would continue to do its best to encourage a reduction in tobacco use and to promote health.

Dr KORTE (Germany) said that Germany generally endorsed the draft resolution in resolution EB95.R9 but had a specific reservation concerning the reaffirmation of resolution WHA43.16, which *inter alia* urged Member States to implement a comprehensive ban on direct or indirect tobacco advertising; such a ban was not in conformity with the liberal German Constitution. Germany was not in favour of smoking, however; on the contrary, it had run campaigns for prevention, training courses for smokers to stop their habit, and health promotion campaigns, especially for young people. In that connection, the Ministry of Health had concluded a voluntary agreement with the tobacco industry to reduce advertising in the neighbourhood of schools and other places frequented by the young. The industry had also ceased to offer samples to the public; there was a warning in cinemas after each tobacco advertisement; and advertising in general was discouraged or banned in a number of places. With the reservation he had already expressed, he supported the draft resolution.

Mrs RINOMHOTA (Zimbabwe) noted that the Director-General's report (document A48/9) mentioned the developing countries' dependence on tobacco as an income-generating product but made no suggestion for a substitute when advocating tobacco control. Zimbabwe acknowledged the hazards of tobacco use but requested the Committee to suggest what assistance might be given in that regard.

Dr DURHAM (New Zealand) said that New Zealand was committed to the principles underlying resolution EB95.R9 and believed that an international strategy for tobacco control was needed urgently. Although the hazards of tobacco use had been identified over 40 years earlier, worldwide tobacco sales were increasing. A large proportion of the tobacco trade was controlled by the major transnational companies, which operated similar policies throughout the world and sought to challenge national laws aimed at restricting tobacco use. Over US$ 5000 million was spent annually on global advertising of tobacco, and action should be taken without delay.

She therefore believed that subparagraph 3(2) of the draft resolution recommended in resolution EB95.R9 was too narrow in its focus. The Forty-ninth World Health Assembly should debate the full range

of international instruments or mechanisms to underpin an international strategy for tobacco control, and she therefore proposed the words "initiating action to prepare and finalize" should be replaced by "developing some international instrument relating to tobacco control such as guidelines, a declaration or".

In addition, she supported efforts made by Member States to encourage implementation of resolution WHA46.8 on banning the use of tobacco in United Nations system buildings and urged that such action should be recommended forthwith.

Dr KHOJA (Saudi Arabia) thanked the Organization for its efforts to encourage healthy behaviour; the Holy Koran referred to the need to maintain one's health.

In Saudi Arabia, a royal decree had banned smoking in government and public offices and a charitable organization to help combat smoking had been established; a number of clinics had been opened with that aim. In 1989, the national airline had been given an award for banning smoking on all flights and in 1994 a national company had prohibited smoking in its offices.

He proposed the addition of "women and" before "young people" in the second preambular paragraph of the draft resolution recommended in resolution EB95.R9.

Combating tobacco addiction required changes in health care structures and the social and legal framework, and innovative yet practical ideas to that effect were needed. In Saudi Arabia, for example, the holy city of Medina had been designated a smoke-free area. Similar initiatives could be developed and awards made in that field. A number of other financial, fiscal, social, preventive, agricultural and health education measures could also be taken. Applied research into social and cultural habits relating to smoking should be encouraged. The idea of healthy cities and citizens should also be promoted through a ban on smoking in cities and the encouragement of healthier lifestyles. Finally, countries and organizations seeking to control tobacco should be supplied with suitable promotional literature, and guidance on possible measures such as legislation.

Mr HALIM (Bangladesh) referred to the high incidence of death and serious illness caused every year by smoking as well as its adverse effects on pregnant women and on children and to the alarming increase in smoking in the developing countries. In Bangladesh, cigarette smoking had spread rapidly to the rural areas in the past 25 years and had become a mark of social status.

The anti-tobacco movement in Bangladesh had begun in the mid-1980s and there was now a strong anti-smoking lobby which had succeeded in banning cigarette advertising on radio and television and on domestic flights. School textbooks now included information on the ill effects of smoking, certain government offices had been declared tobacco free, health warnings were printed on cigarette packets, and taxes on tobacco had been increased.

Bangladesh fully supported WHO programmes against tobacco smoking and the draft resolution recommended in resolution EB95.R9.

Dr ÁVILA DÍAZ (Cuba) referred to the growing campaign by the tobacco industry against WHO's work on "tobacco or health"; it was therefore timely for the Health Assembly to reaffirm its support for the anti-tobacco programme. The tobacco industry had stated that WHO devoted vast sums of money to its work against tobacco, whereas in fact the resources available were meagre; that criticism should be taken as an indication that WHO was on the right track. The programme should continue to be given priority.

Stressing the importance of the new plan of action for 1996-2000 to be submitted to the Health Assembly and the agreement reached at the Ninth World Conference on Tobacco and Health held in 1994, he advocated that whatever resolution was adopted should be based on WHO's own decisions, although that in no way belittled the work of other organizations.

The possibility of preparing an international convention against smoking and tobacco to be adopted by the United Nations system should be studied; such an instrument might be of very great value in the campaign against tobacco.

He supported the draft resolution recommended by the Executive Board with the addition of a number of amendments which he hoped would receive approval so that WHO could continue the fight against the adverse effects of tobacco. He proposed that the preamble should be amended to read:

The Forty-eighth World Health Assembly,

Recalling *inter alia* resolutions WHA33.35, WHA39.14, WHA43.16 and WHA45.20, which state that national and international tobacco control strategies must constitute a priority, and which call for the application of multisectoral, long-term strategies that cover such matters as the promotion of tobacco products, demand reduction especially among young people, smoking cessation programmes, economic policies, health warnings, regulation of the tar and nicotine content of tobacco products, smoke-free environments and marketing and monitoring;

Recognizing the praiseworthy work of the Organization in the area of "tobacco or health", and noting that the plan of action 1988-1995 of the "tobacco or health" programme comes to an end this year;

Noting that the Director-General and other WHO staff members actively contributed to the success of the Ninth World Conference on Tobacco and Health (Paris, October 1994), which adopted an international strategy for tobacco control covering the fundamental areas of WHO policy in this field;

He proposed that paragraph 1 should be amended to read as follows:

1. REAFFIRMS resolutions WHA33.35, WHA39.14, WHA43.16 and WHA45.20, which call for the application of comprehensive, multisectoral, long-term tobacco strategies, and which set out the most important aspects of national and international policies and strategies in that area;

He further proposed the addition of a new paragraph 3 reading:

3. REQUESTS the Economic and Social Council of the United Nations to discuss at its next session the feasibility of initiating action to prepare and finalize an international convention on tobacco control to be adopted by the United Nations, taking into account existing international trade and other conventions and treaties;

Paragraph 3 of the draft would be renumbered 4 and should be amended to read:

4. REQUESTS the Director General:

(1) to strengthen WHO's capacity in the field of "tobacco or health", including financial and human support, where possible;

(2) to submit to the Forty-ninth World Health Assembly a plan of action for the "tobacco or health" programme for the period 1996-2000;

(3) to report to the Forty-ninth World Health Assembly on the result of the consultation in the Economic and Social Council on the feasibility of an international convention on tobacco control.

The proposed amendments would strengthen the Organization's commitment to the development of a society free of the disease and death caused by tobacco use.

The meeting rose at 17:30.

EIGHTH MEETING

Tuesday, 9 May 1995, at 9:00

Chairman: Professor N. FIKRI BENBRAHIM (Morocco)

1. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

GENERAL REVIEW:[1] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58) (continued)

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

4.2 Healthy behaviour and mental health (continued)

Tobacco or health (Resolutions WHA43.16, WHA44.26, WHA46.8 and EB95.R9; Document A48/9) (continued)

Dr MELKAS (Finland) said that as a result of his Government's long-term health promotion policy the country now had the lowest consumption of tobacco products in Europe. However, international pressure continued to threaten national policies, and international trade conventions were being exploited in order to undermine Finland's total ban on tobacco advertising. The Executive Board's proposal for the development of an international convention on tobacco control represented a promising opportunity; it would bring to the attention of decision-makers the fact that trade in cigarette products could not be regarded in the same light as that in other goods. Any such convention must be based on the key elements of sound principles, commitment and adequate resources. Considerable political courage and economic insight would be needed to achieve the objectives. He supported the draft resolution recommended in resolution EB95.R9, as amended by New Zealand.

Mrs JEAN (Canada), recalling the first resolution on tobacco control adopted by the Health Assembly in 1970 (resolution WHA23.32), said that despite the efforts of WHO and other organizations of the United Nations system progress towards preventing the suffering and death caused by tobacco had been insufficient. Indeed, WHO had channelled into tobacco control programmes no more than US$ 1.9 million of its 1994-1995 regular budget, supplemented by voluntary contributions of little more than US$ 1 million, including extrabudgetary contributions from Canada - far too little to tackle the epidemic described in such catastrophic terms in the Director-General's report (document A48/9). WHO must consolidate its leadership in the global battle against tobacco and ensure that public health concern was widely publicized. Furthermore, Member States must undertake strong individual and collective actions to counter the aggressive strategies of tobacco multinationals. The international convention called for in the draft resolution was precisely the type of collective regulatory instrument required. She therefore supported the draft resolution and looked forward to a further WHO plan of action for 1996-2000.

Professor CALDEIRA DA SILVA (Portugal) said that given the social and health problems created by increased population concentrations in urban societies, metropolitan cities and major conurbations, as well as an aging world population with its high incidence of dementia, particularly Alzheimer's disease, WHO

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[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

should concentrate its efforts on matters relating to healthy behaviour and mental health as priorities among the activities under Appropriation section 4. In that endeavour, television could provide vital public information, particularly State television stations, which should be encouraged to give their support to the international campaign for health promotion and protection. He endorsed the plan of action for "tobacco or health" and advocated negotiation with the International Air Transport Association and national airline carriers to ban smoking on all flights. The Organization should also encourage all WHO collaborating centres to become tobacco-free zones.

Dr PAVLOV (Russian Federation) endorsed the views of previous speakers and supported the draft resolution contained in resolution EB95.R9.

Dr VAN ETTEN (Netherlands), welcoming the Director-General's report, expressed full support for the programme of activities and for the draft resolution on an international strategy for tobacco control.

Dr MOORE (United States of America) said that increased international effort and cooperation were still required to combat the devastating effects of tobacco. The Director-General's report highlighted considerable worldwide progress in the development and implementation of comprehensive national tobacco control programmes but pointed out that many nations and regions of the world continued to struggle with formidable political, economic and health barriers to progress. The complex and multisectoral nature of the problems had led to the establishment in 1993 of the United Nations system focal point on "tobacco or health", which was concerned with economic and social aspects of tobacco production and consumption; she had been heartened by its initial efforts.

As a result of collaboration between the WHO Regional Office for the Americas and the United States Surgeon General, two important topics of concern to Member States had been highlighted in a report on smoking and health in the Americas issued in 1992: the prevention and control of smoking in youth and the biological and behavioural factors influencing increased smoking among women.

She shared the concern expressed by New Zealand at the failure of the United Nations to implement resolution WHA46.8, adopted in 1993 and calling for a ban on the use of tobacco in all United Nations buildings within two years. WHO, UNICEF, the World Bank and the new UNHCR headquarters in Geneva were already smoke-free premises and UNESCO was shortly to follow that example. It was inexcusable that the United Nations continued to permit smoking in its buildings in Geneva and New York. The Director-General should work as closely as possible with the United Nations Secretariat to implement a consistent non-smoking policy throughout the United Nations system without further delay and report back on an anticipated implementation date to the Executive Board in January 1996.

Dr EMIROĞLU (Turkey) commended WHO's activities on "tobacco or health", an important topic of great concern to developed and developing countries alike. WHO publications providing epidemiological information and guidance on planning national programmes were greatly appreciated. However, despite control efforts, smoking was still prevalent in many parts of the world and the young were particularly susceptible to its lure.

Having drawn up a country profile of tobacco consumption, Turkey, like most other countries, was developing a health information system specifically geared to discouraging the consumption of tobacco products.

Referring to surveys on mental health, she observed that questionnaires were often used, or tests applied, without regard to country-specific conditions, thus impairing the validity of conclusions drawn from them. Had WHO drawn the attention of researchers to the need to validate survey material taking into account the specific social factors of the country concerned?

Dr RODRIGUES (Brazil), recognizing the importance of adopting a strategy for the control of tobacco and aware of the need to continue national and international efforts to reduce consumption, supported the amendments proposed by the delegate of Cuba, which gave emphasis to the development of an international instrument for coordination within the United Nations system for an international strategy against tobacco. WHO had an important role to play in that regard.

Dr MILAN (Philippines) said that the "tobacco or health" programme continued to face an uphill struggle, primarily because of strong opposition from the tobacco industry. WHO's advice and assistance to Member States in their efforts to implement comprehensive policy change and to adapt the experiences of others to their own needs was therefore greatly appreciated.

There were encouraging signs that initiatives at the local level in the Philippines would soon pave the way for the enactment of more far-reaching national legislation. The Department of Health had already banned smoking in its own premises as well as in all other government health facilities. A successful national antismoking campaign in schools, workplaces and communities had depicted smoking as socially unacceptable behaviour. Tobacco advertising greatly influenced smoking practices and she supported advocacy for the banning of such advertising throughout the Western Pacific Region by the year 2000. She also supported the draft resolution in resolution EB95.R9, as amended by the delegate of New Zealand.

Dr CICOGNA (Italy) expressed concern at the way in which the topics under consideration had been grouped in the proposed programme budget. Community-based rehabilitation, health promotion, substance abuse, and mental and neurological disorders were important subjects in their own right and deserved greater attention. He requested additional information on the individual budget allocations within those areas. Health promotion activities in appropriate settings, such as the European initiative for health-promoting schools supported by the WHO European Region, the Council of Europe and the Commission of the European Communities, were of great value. He also requested details of the activities relating to disabilities, which had been mentioned in a somewhat piecemeal fashion. He would have preferred to see the subject included under programme budget heading 4.1, Family/community health and population issues. The Government of Italy, endorsing the view that disability was frequently linked with poverty, had financed a community-based rehabilitation programme in poor urban areas. Further, since mental and neurological disorders represented at least 10% of the total disease burden, they should receive greater attention.

The decision taken by WHO to merge "tobacco or health" activities with those aimed at the prevention of alcoholism and other forms of substance abuse was to be commended. The fact that other United Nations organizations, in particular UNCTAD, were to become associated in the fight against the use of tobacco was most timely. He welcomed the proposal to develop a comprehensive multisectoral international strategy for tobacco control and supported the draft resolution recommended in resolution EB95.R9.

Dr DOFARA (Central African Republic) commended the efforts made by WHO in its "tobacco or health" campaign and the results achieved so far. However, while European countries had taken measures to prohibit tobacco advertising, poor countries were still under pressure from the multinational tobacco companies to continue allowing it. In Africa, cigarette packets did not carry the same warnings as those sold in Europe. He therefore proposed the addition to the draft resolution contained in resolution EB95.R9 of a request to producing countries to make it obligatory that the warnings on the harmfulness of tobacco printed on cigarette packets sold there should also appear on packets exported to the Third World.

Dr VIOLAKI-PARASKEVA (Greece) endorsed the views expressed by Italy concerning the grouping of activities under discussion.

She commended WHO's progress in implementing the plan of action on "tobacco or health" despite the difficult financial position, and endorsed the views of previous speakers on the need to strengthen activities. It would be necessary to coordinate national policies in the fields of health, economics, agriculture, finance and development. Assistance could be channelled through WHO and the United Nations on the basis of bilateral agreements. The integration of WHO's activities in programmes on healthy lifestyles and living conditions and a strategy for their promotion would also be necessary. Greece had developed an active anti-smoking campaign, despite being a tobacco-producing country.

The draft resolution contained in resolution EB95.R9 should be further amended to reflect the need for a broader approach in combating the problem of tobacco by the addition of a subparagraph 3(3) reading:

(3) to ensure that WHO plays an effective global advocacy role in "tobacco or health" issues.

Mrs ZUMA (South Africa) commended the Director-General on the shift in emphasis towards health care support and promotion. South Africa supported the proposed international strategy for tobacco control as local research findings had illustrated the impact of tobacco on health and quality of life. In 1994, the new

Government of National Unity had formulated an anti-tobacco strategy which included an increase in tobacco excise tax, the placing of clear warnings on advertisements, the banning of cigarette sales to children, and the restriction of smoking in public places. She supported strategies limiting global marketing of tobacco products and the development of the Tobacco Control Commission for Africa. However, the economies of some developing countries were dependent on tobacco exports for foreign exchange and they would need financial and technical assistance from the international community in order to diversify. She endorsed the activities of the United Nations system focal point for tobacco control.

In recognition of South Africa's commitment in that area, President Nelson Mandela was to receive a WHO "Tobacco or Health" Award in 1995; she thanked all those who had supported her country's efforts.

Mr ACHOUR (Tunisia) said that the Director-General's report reflected the importance WHO attached to combating tobacco use. The efforts made to ban smoking on airline flights and in United Nations buildings illustrated a welcome trend.

However, greater efforts were clearly needed, particularly in developing countries, and he supported the call for a global strategy to combat smoking. Tunisia had a multifaceted national strategy including measures such as the restriction of smoking to certain areas in public places and government buildings.

Dr ADAMS (Australia) said that Australia had always been a strong supporter of WHO's efforts in the area of "tobacco or health" and would continue to cooperate with the United Nations system focal point for tobacco control.

The progress indicated in the Director-General's report provided assurance that Australia was working in the right direction; strategies to minimize the harm caused by tobacco consumption involved a range of coordinated educational, fiscal and legislative initiatives.

He joined with the United States delegate in voicing disappointment at the failure to eradicate smoking from all United Nations premises.

He endorsed the view expressed by the delegate of the Central African Republic that all cigarette packets exported from a country where health warnings were obligatory should also carry those warnings and that any objections to such a procedure should be overcome. That was not yet the case in Australia.

He congratulated the Government of Singapore on being the first to have removed cigarettes from sale in duty-free shops and he hoped that other countries would follow that example. The excellent publication referred to in paragraph 21 of document A48/9 showed that, of all cancers, those related to tobacco-smoking were the only ones on the increase and clearly indicated the enormous burden that tobacco-smoking would have on health services in the future. International resolutions and agreements were important mechanisms for achieving progress on "tobacco or health", often empowering or stimulating countries to introduce policies and controls. He therefore supported the draft resolution contained in resolution EB95.R9, with the amendments proposed by New Zealand and Greece.

Mr ORDING (Sweden) said that comprehensive national policies were needed to combat the use of tobacco, which was one of the major causes of illness and premature death.

A new tobacco law, introduced in Sweden in 1992, had been strengthened by the subsequent banning of all forms of explicit advertising of tobacco products. The possibility of banning other more subtle forms of marketing was being explored. The prohibition of the sale of tobacco products to young people below a specified age limit was also under consideration.

Tobacco products and their consumption could not be confined within national borders, so international cooperation and concerted action were essential. Sweden therefore welcomed a strengthening of WHO's capacity in the field of "tobacco or health" and supported the draft resolution contained in resolution EB95.R9, as amended by New Zealand.

Mr Soo Young CHOI (Republic of Korea) commended WHO's "tobacco or health" programme and supported the draft resolution contained in resolution EB95.R9, as amended by New Zealand.

The Government of the Republic of Korea had achieved substantial progress in the promotion of a tobacco-free public health policy since 1989: government regulations required health warnings to be placed on tobacco products, banned smoking in public places, and prohibited the installation of tobacco vending

machines near schools; tobacco advertising was strictly controlled; the sale of tobacco to young people was banned; and public health promotion was to be funded through a levy on products.

The tables in document A48/9 indicated that smoking was more prevalent in developing than in developed countries, and that whereas the number of smokers was decreasing in developed countries, their number continued to increase in the developing countries. WHO's global initiative on tobacco-smoking control could help public health authorities in developing countries to reverse that situation. However, there was little information on how to control the pandemic. WHO should assess intervention programmes to control tobacco-smoking, in order to determine their cost-benefit and cost-effectiveness.

Dr FREIRE (Spain) said that the medical evidence on the harmful effects of smoking dwarfed national and international efforts to combat it. He supported the draft resolution contained in resolution EB95.R9, with the amendments proposed by the delegates of Cuba, Greece and New Zealand, and particularly welcomed the proposal regarding the development of an international convention on tobacco control for adoption by the United Nations. Together with the WHO strategy for tobacco control, such a convention would constitute the essential arm in the fight to eliminate the illnesses and death caused by tobacco use throughout the world. It was important to recognize that the harmful effects of tobacco use were felt more keenly by the disadvantaged and poorest groups in the populations of developed and, more particularly, developing countries.

Dr YAO SIK CHI (Malaysia) commended the initiatives taken by WHO on tobacco control. The Western Pacific Region had adopted a resolution urging advocacy for a Western Pacific Region free of tobacco advertising by the year 2000. However, many of the active steps taken by WHO and Member States to control tobacco abuse had met with opposition. In view of the alarming prospects for the health consequences of the smoking epidemic outlined in document A48/9, he fully supported the development of an international strategy for tobacco control and endorsed the draft resolution contained in resolution EB95.R9.

Mrs HERZOG (Israel) said that it was gratifying to note that ICAO had concluded that there was no technical impediment nor legitimate safety concern which might stand in the way of implementing a ban on smoking on all international flights by July 1996. She hoped that ICAO would be able to operate the ban from that date. It was also important that the duty exemptions on tobacco products should be removed.

So that the draft resolution contained in resolution EB95.R9 should reflect those views more closely, she proposed that a phrase commending ICAO on its support for a ban on smoking on all international flights should be added to the preamble. She further suggested that a new paragraph 2 should be added, reading:

URGES ICAO also to take action to stop the sale of duty-exempted tobacco products on international flights.

Subsequent paragraphs would be renumbered accordingly.

Given the difficulties experienced by some countries in earmarking taxes for specific activities, she had not proposed an amendment on that subject. Nevertheless, it should be noted that in a number of countries increased taxes on the sale of cigarettes had been allocated to special health promotion funds used to campaign against tobacco use. WHO could play a catalytic role in encouraging others to follow that example. Further, the Health Assembly might wish to confirm WHO's policy urging Member States to prohibit direct and indirect cigarette advertising. Regrettably, some countries had not yet done so.

Dr BASHI ASTANEH (Islamic Republic of Iran) commended the Director-General on his report and supported the draft resolution recommended in resolution EB95.R9. More emphasis should be placed on health promotion through public information and education, an activity which required extensive community involvement and a high level of political commitment. In order to achieve that objective, he suggested that World No-Tobacco Day should be extended to one week each year, or that it should be repeated several times per year. Politicians, senior government officials, government employees and health professionals might set an example by voluntarily giving up smoking. Anti-tobacco campaigns would succeed, however, only if measures were taken to limit or ban tobacco production and restrict its availability, in particular to young people.

The Islamic Republic of Iran had been among the first countries in its Region to join the anti-tobacco campaign. Smoking had been prohibited for many years on domestic flights and it was also banned in public places and government buildings. "Healthy cities" projects in the country were beginning to give "tobacco-free health" results. Taxes on imported cigarettes had been increased and the revenue utilized for health promotion.

Mental health care in his country had been integrated into the primary health care system, an approach which had been successful and which he recommended to others.

Dr TOURÉ (Guinea) supported the draft resolution in resolution EB95.R9 because addiction to tobacco constituted an increasingly serious problem in Guinea. Roadside advertising of cigarettes was to be seen all around the capital. Officially, the authorities were against smoking, which was forbidden in offices, but frequently specific situations ran counter to that policy. For example, multinational tobacco firms were prepared to be generous sponsors of sporting and cultural events and it was difficult to resist when the organizers were so frequently in urgent need of funds. He would be glad to know what solutions had been found to that problem in other countries.

Dr ABELA-HYZLER (Malta) shared the concern expressed by the delegates of Italy and Greece at the rather surprising grouping of the activities under discussion and hoped that it would be reconsidered during the formulation of the next programme budget. The current arrangement gave the unfortunate impression that certain important high-priority programmes, including "tobacco or health", were being submerged in others and were thus receiving less emphasis.

An innovative mental health policy had been formulated in Malta and was attracting the attention of a number of neighbouring countries. He therefore hoped that Malta could be considered for inclusion in the evaluation of mental health policies proposed in the programme budget.

Dr ASHLEY-DEJO (Nigeria) commended WHO on its leading role in "tobacco or health" activities and stressed the need for a united, multisectoral approach. The Nigerian Government had promulgated a decree prohibiting smoking in public places and restricting the advertising of tobacco products on radio, television and billboards, which had produced a dramatic fall in tobacco use. It would shortly be reviewing the decree to expand the list of public places, to include the prohibition of sales to minors, and to re-examine the effectiveness of restricting advertising and, above all, the logistics of proper enforcement of the decree.

The Government was also formulating a comprehensive national tobacco control programme with a realistic action plan and it welcomed WHO's participation in the early stages of that programme.

Noncommunicable diseases were now the major causes of morbidity and mortality in Nigerians aged 30-60 years; communicable diseases remained the major causes for those aged 15 years or less.

In addition to the health consequences of tobacco use, attention should also be paid to the economic consequences for the individual, the family and the nation. In a community where lung cancer or other effects of tobacco use on health were not vividly manifest, health alone as a campaign reference might not be so effective as when other parameters were added. He asked why a similar campaign on alcohol use had not been considered, since it also had economic and social consequences.

There was a lack of accrued data for use in programme planning in most developing countries and he therefore welcomed the proposals for assisting countries with data collection. It was important to maintain the effective leadership role of WHO in the field of "tobacco or health", and he supported the draft resolution recommended in resolution EB95.R9.

Mr URANGA (United Nations Conference on Trade and Development) thanked delegates for their encouraging comments on the work of the United Nations system focal point on tobacco control. The initiative for the establishment of the focal point had been launched following Health Assembly resolutions WHA39.14 and WHA43.16, which had recognized that the socioeconomic context of tobacco production and the interests of the tobacco-producing countries required broad multisectoral strategies calling for close collaboration by many interested international organizations. It had led to the adoption of a resolution on the subject (resolution 1993/79) by the United Nations Economic and Social Council. The Council had requested the United Nations Secretary-General to seek the collaboration of a large number of organizations within the United Nations system, including of course WHO, as well as many other governmental and nongovernmental

organizations. To that end, the Secretary-General, with the aid and under the auspices of WHO, had established the United Nations focal point within UNCTAD.

During the 18 months since his designation as the focal point, he had worked to promote the objectives of the Economic and Social Council resolution. He had presented a report to the Council in July 1994 on an important series of contacts which had taken place between Member States, United Nations organizations and intergovernmental and nongovernmental organizations, and as a result it had adopted a second resolution (1994/47) reaffirming and strengthening the first. He had subsequently continued his work of coordination with all Member States and international organizations and a further report would be presented to the Council at its forthcoming session in July 1995.

He had developed contacts with many governmental and nongovernmental organizations active in the campaign against smoking, and recent initiatives were beginning to have an impact. For example, the Ninth World Conference on Tobacco and Health, held in Paris in October 1994, had led directly to the draft resolution before the Committee.

While his work continued to develop, he was operating under serious budgetary constraints. UNCTAD alone could not continue to fund the project indefinitely; it had accepted the responsibility for initial funding on the understanding that the sponsoring governments and other United Nations organizations, above all WHO and UNDP, would contribute. Improved financing would permit the development of a whole series of activities, including some of those mentioned by delegates in connection, for example, with the role of transnational tobacco companies and their dubious advertising tactics, and the need for substitute crops which was a serious problem for developing countries. He hoped that the search for such crops could be undertaken in conjunction with FAO and the World Bank. In the important sector of education, where WHO was playing a leading role, he would like to see greater participation by UNESCO and UNICEF.

Dr FLACHE (World Federation for Mental Health) spoke at the invitation of the CHAIRMAN on behalf of the standing committee of Presidents of 10 international nongovernmental organizations concerned with mental health, which he said together had more than 200 000 individual members and more than 200 voting member associations in over 120 countries. The standing committee had noted with satisfaction the appropriate status given to mental health in the classification of WHO's programmes, as presented in the proposed programme budget (document PB/96-97) and the way in which the Division of Mental Health had been restructured, and welcomed the support given to the activities of the organizations he represented.

The mentally ill suffered widely from stigma, abuse and gross neglect. To alleviate that situation, the United Nations General Assembly, in resolution 46/119, had adopted a set of general principles for the protection of persons with mental illness and the improvement of mental health care. The nongovernmental mental health community was establishing mechanisms for monitoring the implementation of the resolution. It was the task of WHO to prepare specific guidelines to supplement the principles and adapt them to the geopolitical and socioeconomic situation of particular regions and countries.

An excellent report on world mental health, prepared by the School of Medicine of Harvard University, would be issued in New York later in May 1995. The nongovernmental mental health community greatly hoped that the recommendations in the report - a document which fully reflected WHO's views on the subject - would be widely implemented internationally and that its launching would result in the establishment of a substantially funded multilateral mental health programme which placed emphasis on the developing countries and was coordinated and executed by WHO. The organizations he represented pledged full support for the creation of the programme and wished to participate in it.

Dr NAPALKOV (Assistant Director-General) thanked delegates for their comments, proposals and information, which he had noted.

In reply to points raised by Greece, Italy and Malta regarding the grouping and relative budgets of the activities under budget heading 4.2, he said that in the course of rearranging the Organization's programme budget so as to reflect the new strategic approach to planning, the number of main headings in the classified list of programmes had been reduced to 19. That had inevitably involved difficult choices in the reallocation of certain important activities from one work area to another. The location of rehabilitation activities had been a case in point. The programme budget proposed in document PB/96-97 was the first attempt at presentation according to the new principle. Corrections to the structure could be made, where necessary. Detailed budget figures for the programme on substance abuse could be found in a document available in the

meeting room. The regular headquarters budget for the programme on rehabilitation had been US$ 477 000 in 1992-1993 and US$ 565 000 in 1994-1995; the figure proposed for 1996-1997 was US$ 518 000. The corresponding figures for the programme on mental health were US$ 2.4 million, US$ 2.6 million and US$ 2.5 million.

In response to comments on the Organization's efforts to bring an end to smoking in United Nations system buildings, the objective of resolution WHA46.8, he reported that WIPO had recently set up on its premises a focal point on tobacco use in those buildings, the World Bank had reaffirmed its prohibition of smoking in Bank buildings, and the Universal Postal Union had issued an internal communication restricting smoking to designated areas. In addition, the Permanent Representatives at Geneva of seven countries had written to the Director-General of the United Nations Office at Geneva requesting a total ban on smoking in all United Nations buildings in Geneva by May 1995. The Director-General of WHO and the Officer-in-Charge of UNCTAD had supported that request. Further, all participants in the Fourth World Conference on Women to be held in Beijing in September 1995 would be requested to refrain from smoking.

Many participants had raised the question of tobacco advertising. Its harmful effects should not be overlooked during antismoking campaigns. For example, a recent study had shown that the introduction of special brands of cigarettes for women had led to an increase in tobacco consumption not only overall but also by young girls, an extremely vulnerable group. WHO would continue its efforts to curb tobacco advertising.

Dr THYLEFORS (Secretary) suggested that a drafting group should meet to prepare a revised version of the draft resolution contained in resolution EB95.R9 taking account of the amendments proposed.

It was so agreed. (For approval of amended text, see page 140.)

4.3 Nutrition, food security and safety

World Declaration and Plan of Action for Nutrition (Resolution WHA46.7; Document A48/8)

Professor BERTAN (representative of the Executive Board) said the Board had affirmed that food and nutrition continued to be a priority for WHO. Because of the extent and gravity of malnutrition and foodborne diseases, the Organization needed additional human and financial resources to enable it to meet its responsibilities in that respect. It had been asked to pursue its technical collaboration with countries in their plans for implementing the World Declaration and Plan of Action for Nutrition, and especially with the least developed countries in strengthening their ability to control malnutrition. The Director-General's report (document A48/8) outlined the progress achieved.

The Board, recognizing the importance in combating malnutrition of normative activities and the widespread dissemination of up-to-date guidelines and methodology, had agreed that such action required the full use of WHO's network of collaborating centres and the strengthening of its global nutritional databanks. The Organization must communicate the health sector's food-and-nutrition message to politicians in all countries.

In view of the use of health-related Codex Alimentarius standards and recommendations in the implementation of the World Trade Agreement, the Board had urged the strengthening of health-sector involvement in the Codex Alimentarius Commission and the initiation of contacts between WHO and the World Trade Organization. It had also recommended that WHO should expand its collaboration with the World Food Programme in regard to the provision of food aid in emergency relief work.

Mr KIRIČENKO (Russian Federation) said the global food situation left a great deal to be desired and urgent action was needed to find an answer to the problems. He therefore commended the action undertaken in following up the World Declaration and Plan of Action for Nutrition. The proposed WHO activities were well structured and should improve food support to population groups suffering from poor quality of nutrition and food shortages.

The Russian Federation was currently formulating a national plan of action on nutrition and setting its priorities, particularly for children. A national scientific and technical nutrition programme was also being

prepared and implemented under the leadership of the Ministry of Science with the participation of the Ministry of Health and other bodies. Research was being undertaken on standards of nutrition for children and adults in various regions of Russia with the aim of improving production of foodstuffs and following WHO guidelines. Legislation was being prepared on the quantity and quality of foodstuffs. Methodological and normative measures were being improved with a view to meeting food safety standards, to identifying and dealing with food contaminants, and to harmonizing regulations on the permitted level of concentrates and contaminants in foodstuffs in Russia and other countries. He was in favour of setting up an international working group to look at the evaluation and registration of food additives which had active biological components.

Dr MILAN (Philippines) observed that, as well as indicating the progress made so far, the Director-General's report was a reminder of how much remained to be done to implement the World Declaration and Plan of Action for Nutrition. The Philippines had been among the countries that had formulated and submitted a national plan of action ahead of the December 1994 deadline. Initial indications suggested that, thanks to the active involvement and support of both national and local governments, nongovernmental organizations, the private and business sectors, academic institutions and international organizations such as WHO and UNICEF, the Plan of Action was being implemented as intended. However, while there were indications of general improvements in the nutrition situation, document A48/8 rightly pointed out that the decline in the prevalence of various forms of undernutrition might be small relative to population growth and that the target population was still increasing in absolute terms. Additional resources would therefore still be needed to maintain programme gains.

Some matters called for particular attention if the goals set were to be achieved on time. Food safety measures along the lines suggested in paragraphs 22 and 23 of the report should be part and parcel of a nutrition programme, especially education of and inspection services for food handlers. Finding appropriate and effective monitoring and quality control mechanisms to reach the ubiquitous ambulant food vendors of the urban slums and sidewalks of many developing countries remained a challenge.

Food safety, particularly in households, was crucial. Programmes should focus on supply strategies, for example home and school vegetable gardens using biointensive gardening technology. Other important considerations were the economic aspects of food production and distribution, perishability and quality, availability and affordability, etc. With regard to demand, health education had a role to play in influencing food preferences, food preparation and household distribution practices. That crucial link in the food chain, from production to the family table, was largely outside the ambit of nutrition programmes. National economies should ensure a threshold level of income that would enable households to purchase at least the recommended minimum amounts of the proper kinds of food for good nutrition. Innovative, intersectoral planning and collaboration mechanisms must be explored in order to ensure that demand and supply were considered in a consistent manner.

While welcoming the increase in the prevalence and duration of breast-feeding in some parts of the world, she expressed concern at their decline in other areas, especially those where it was crucial to infant survival. Breast-feeding was important not only for nutrition but also for promoting optimum birth spacing, and there was a need for innovative communication and education strategies to promote the practice and for more vigorous advocacy of the Baby-friendly Hospital Initiative.

Dr KHOJA (Saudi Arabia) said that nutrition was one of the most important components of primary health care and should be given higher priority, with challenging and forward-looking plans of action.

Malnutrition was not only a matter of protein deficiency, but also one of dietary habit; for example, overconsumption of certain foodstuffs, such as sugar, was known to be harmful to health. WHO should promote healthy lifestyles and emphasize them in its policies and programmes. Education on nutrition was one of the components of the Saudi Arabian programme to combat noncommunicable diseases. WHO support in that regard would be welcomed. In that context, WHO had produced a number of useful publications and documents in the area of education and training on nutrition.

Anaemia prevalence in children was considerable in many countries - over 50% of children under the age of five in developing countries - indicating a lack of micronutrients in the diet. Essential nutrients should be guaranteed until adolescence.

WHO should give greater emphasis to preventive aspects: good nutrition was essential to prevent disease, including cancers in later life.

Saudi Arabia was taking steps to improve nutrition technology in its hospitals, some of which had been designated as "baby-friendly". There was a national programme on breast-feeding and the country had hosted an international conference on the subject, with WHO support. Saudi Arabia had been represented at all relevant international meetings, and had incorporated food quality standards and nutrition in a realistic plan of action. Food imports were strictly regulated, in accordance with international standards. Some 70% of diarrhoeal diseases were attributable to lack of cleanliness in handling foodstuffs and countries should develop legislation in that regard.

Dr ABDELAAL (Egypt) said that, following the adoption of the World Declaration on Nutrition in December 1992, a multisectoral committee on nutrition had been set up in Egypt, enjoying strong political support and composed of representatives of all concerned ministries. It had recently issued a national programme for salt iodization and the addition of iron to bread flour, with the aim of correcting micronutrient deficiencies. A major integrated ministerial approach had been implemented to protect consumers through improved control of food quality and safety. The Ministry of Health had also launched a project for the manufacture of appropriate carts for food vendors.

As a gastroenterologist, he had noted that the word "undernutrition" seldom occurred in document A48/8, while "malnutrition" was used inappropriately. For example, in paragraph 2 "malnutrition" in the phrase "overcoming micronutrient malnutrition" would be better rendered by "deficiencies" or "undernutrition". An undernourished person lacked one or more of the essential nutritional elements, while the malnourished had unbalanced but nutritive diets. Similarly, an undernourished marasmic child was usually a victim of many microbiological pathogens while a malnourished child could be obese as well as unhealthy; ironically, the malnourished child could be eating man-made foodstuffs full of chemical additives and preservatives.

People could, of course, make the choice to consume healthy foods, yet in developed and developing countries alike they were becoming increasingly exposed to "fast" or "junk" food, and there was also widespread addiction, starting in early childhood, to non-nutritive carbonated beverages. In the context of nutritional planning, people must be rescued from the aggressive marketing of unhealthy foods of low nutritive value which led to malnutrition or what he preferred to call "dysnutrition". Why were responsible people reacting so passively, and gradually abandoning the fresh, healthy and highly nutritive recipes of previous generations? Was it not a strange policy to treat iodine-deficiency goitre and iron-deficiency anaemia while encouraging the upbringing of chubby malnourished children? He called for a reconsideration of document A48/8 so that the type of malnutrition he had described, which was emerging worldwide, was not neglected. Emphasis should be given to an integrated United Nations approach, involving WHO, UNICEF, UNESCO and FAO, with a concerted campaign to oppose modern nutritional illiteracy, preserve authentic national healthy foods and put an end to the misuse of food preservatives. It required strength to oppose the entrenched global industrial tycoons, but that must be done for the sake of future generations.

Dr MAHJOUR (Morocco) joined in commending the Director-General's report; in addition to emphasizing the progress achieved in the areas of protein-energy malnutrition, micronutrient malnutrition, and breast-feeding, it also stressed the extent and gravity of foodborne diseases. Food was often a vector for pathological microorganisms, but also for chemical contaminants, especially in developing countries where surveillance mechanisms were not well developed. He therefore endorsed the Director-General's call for urgent action to control foodborne diseases (paragraph 22). Particular importance should be attached to strengthening national food surveillance capacities.

Mr MAJARA (Lesotho) requested clarification of the term "countries and territories" used several times in the report; the term "countries and/or regions" might have been more appropriate. Although he appreciated that December 1994 had been set as the time-limit for submission of national plans of action on nutrition, not all countries had been able to comply and he requested WHO to set a new date and communicate it to Member States. WHO should make every effort to ensure that data provided in reports were accurate and presented in a way that facilitated comparisons. For example, there appeared to be a

contradiction in paragraph 18 of document A48/8, where the breast-feeding rate in Burkina Faso was stated to be 4% for infants at four months but 97% at 12-15 months of age.

Lesotho was facing the worst drought it had experienced in about 60 years, and the sporadic rains had had little effect on agricultural productivity. Food stores were being depleted rapidly in spite of foreign aid, especially from WFP, and sources of water were drying up at such an alarming rate that the Government had declared a state of emergency in October 1994. He therefore requested that Lesotho should be included in the list of countries to benefit from intensified cooperation with countries in greatest need.

Dr FURUHATA (Japan) said that international regulations for food standardization were of increasing importance. The newly established World Trade Organization, which would gradually take over the activities of the Secretariat of the General Agreement on Tariffs and Trade, would make regulation of food standards mandatory. WHO should strengthen its capacity, its scientific expertise and its influence with other international organizations in that area; it should also strengthen its collaboration with FAO in the area of food safety. He welcomed WHO's support to countries in developing their national plans of action, as described in section II of document A48/8, and the action described in section IV. He was encouraged by the progress in overcoming micronutrient deficiencies and supported WHO's renewed efforts to conduct behavioural studies on the root causes of nutritional and dietary problems in many countries. All those areas had been identified as important at the International Conference on Nutrition. Member States should be encouraged to act upon their pledges and to make all efforts to implement the World Declaration and Plan of Action for Nutrition in order to achieve nutritional well-being for all.

Professor DIF (Algeria) congratulated WHO on the preparation, running and follow-up of the International Conference on Nutrition. The intersectoral nature of the Conference was a model that could be applied in other fields of public health. Algeria had adopted a national plan of action, and each ministerial department had named a representative on a follow-up committee coordinated by the Ministry of Health and Population. Several working groups had met, with useful results, particularly with regard to eliminating iodine deficiency; iodized salt was currently being distributed throughout the country. A progress report was in preparation. To counteract malnutrition, it was important to determine population groups at risk and implement integrated development projects; those two points, which were mentioned on page 115 of document PB/96-97, should be spelt out in greater detail. Algeria was pleased that special attention had been accorded to the African continent throughout the International Conference on Nutrition and during its follow-up.

Professor LEOWSKI (Poland) said that the Plan of Action for Nutrition was of such importance that it did not require detailed justification. Following the International Conference on Nutrition, during a national conference on food, nutrition and health organized in Poland in May 1994, with many foreign participants and representatives of WHO and FAO, a national plan of action had been formulated and national priorities in the area had been set.

Mr ACHOUR (Tunisia) noted that the number of children suffering from malnutrition had increased concomitantly with population growth. WHO should therefore coordinate its activities on nutrition with those on child and infant health. Although WHO had made considerable progress in reducing the effects of iodine deficiency, it should strengthen its assistance to developing countries in that respect. Each country should define a balanced diet in accordance with local conditions, and should encourage good nutritional behaviour. As a result of population growth and the spread of certain epidemic diseases, and despite a certain increase in life expectancy, child mortality had increased and other diseases had appeared that were linked to nutritional problems, for example diabetes and high blood pressure. Tunisia had developed strategies to combat such diseases within the framework of primary health care.

Dr DOFARA (Central African Republic) commented that the problem of iodine deficiency was of particular relevance to the Central African Republic, where 2% of the population suffered from goitre. Regrettably, certain countries that produced salt took advantage of the absence of monitoring in poor countries to sell them salt falsely labelled "iodized salt". He appealed to WHO, FAO and UNICEF to assist countries in setting up a monitoring system in order to achieve the objective of universal iodization of salt.

Mr HALIM (Bangladesh) fully endorsed document A48/8 and drew attention to the pledges made by the countries that had adopted the World Declaration on Nutrition. Like other Member States, Bangladesh had developed a plan of action in order to meet those objectives. Raising the level of nutrition and improving public health were among the primary duties of the State described in his country's Constitution. Good nutrition was basic to the ability of individuals to grow and function in society; good nutrition and health resulted in an economically productive and socially active nation. Bangladesh was a poverty-stricken nation with a dense population; malnutrition was endemic, and the morbidity and mortality rates were high among mothers and infants under the age of five. About 94% of children in Bangladesh were malnourished, and 30 000 became blind each year from vitamin A deficiency. Many other people also suffered from micronutrient deficiency. A similar picture could be found in many developing countries. Paragraph 17 of the summary of *The world health report 1995* (document A48/3) indicated that in 1990 more than 30% of the world's children under the age of five had been underweight and up to 43% of children in the developing world - 230 million - had been small for their age. A ray of hope was provided in the same document, however, in the section entitled "Charting the future", which projected the eradication of poliomyelitis and leprosy and an end to death from neonatal tetanus and measles. By the year 2000, maternal mortality could be half what it had been in 1993, at least 85% of the world's population could be within one hour's distance of medical care, and malnutrition among children under the age of five would fall by 50%. However, as stated in paragraph 89 of the summary, those goals would be met only if the world cared enough and the necessary resources were made available. He therefore endorsed paragraphs 94 and 95.

Dr VIOLAKI-PARASKEVA (Greece) expressed the hope that existing resources would be used widely to attain WHO's nutritional goals. WHO collaborating centres should be involved at all levels. Nutrition concerned not only health but also the agricultural, social and economic sectors. It was encouraging that many countries had established national plans of action for nutrition and that some had developed mechanisms for coordination between international agencies. WHO should take steps to reverse the regrettable decline in breast-feeding noted in paragraph 18 of document A48/8. Paragraph 20 noted a rise in the prevalence of diabetes and predicted that more than 100 million people might be affected by the end of the century. It was known that certain chronic noncommunicable diseases were closely related to diet; the Mediterranean diet was one that helped to decrease their prevalence. The prevention of foodborne diseases would depend on the development by Member States of adequate food legislation. Food inspection services should be strengthened, especially during the summer and tourist seasons, and food handlers should receive health education.

In view of the magnitude and gravity of the problems of over- and undernutrition, nutritional deficiencies and foodborne diseases, more financial resources should be provided to ensure implementation of the World Declaration and Plan of Action for Nutrition.

Dr BRUMMER (Germany) said that since nutrition was an intersectoral issue, close collaboration was required between a number of organizations of the United Nations system and governments. The collaboration of WHO, FAO and UNICEF was crucial. The coordinating role of the Subcommittee on Nutrition of ACC had been very important in that context. He had noted with some concern attempts to restructure cross-programme coordination; that would have obvious financial implications and might lead to duplication of functions. He would not support a transformation of the Subcommittee on Nutrition into another global body in autonomous association with the United Nations, with enlarged functions, staff, equipment and funding. However, WHO's role in nutrition, which supplemented the functions of FAO and UNICEF in particular, merited continued support.

2. TRIBUTE ON THE OCCASION OF THE FIFTIETH ANNIVERSARY OF THE END OF THE SECOND WORLD WAR IN EUROPE

Mrs DROBYSHEVSKAYA (Belarus) evoked the fiftieth anniversary of the day that Europe had been liberated from violence, fascism and genocide. One-third of the population of Belarus had died during that

conflict. As doctors, delegates should speak out against any form of violence, and she proposed that the Committee should pay tribute to the millions who had died during the Second World War.

The Committee stood in silence for one minute.

The meeting rose at 12:30.

NINTH MEETING

Tuesday, 9 May 1995, at 14:30

Chairman: Dr E. NUKURO (Solomon Islands)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

GENERAL REVIEW:[1] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58) (continued)

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

4.3 Nutrition, food security and safety (continued)

World Declaration and Plan of Action for Nutrition (Resolution WHA46.7; Document A48/8) (continued)

Dr MUKHERJEE (India) said that, although India had achieved self-sufficiency in food production, nutritional deficiencies were still prevalent in many parts of the country owing to unequal distribution and improper use of food. Considerable efforts were being made to improve the nutritional status of the population, with emphasis on diversification and improvement of diet. Programmes with a direct impact on nutritional status included supplementary feeding, education on nutrition, fortification and enrichment of foods, and prevention of specific deficiencies; related activities included promotion of breast-feeding, improvement of food safety and quality, and the assessment, analysis and monitoring of nutritional status.

Diet-related changes in the epidemiological pattern of disease were being observed in India, and diabetes and cardiovascular diseases were increasing as a result of those changes. Health education thus had to lay stress on socially and culturally acceptable eating habits in order to reverse that trend.

Micronutrient status was being carefully monitored. Iodine deficiency continued to be a major problem. Although national programmes existed for rectifying deficiencies in iodine, vitamin A and vitamin B, there was still a need to ensure that such action reached grass-roots level; a new programme to combat micronutrient malnutrition and provide extensive education and information on the subject was about to be launched.

Manpower training was an important area which did not receive adequate attention. Many major hospitals lacked dietitians, and lack of a training programme and the shortage of trained staff impeded the implementation of the nutrition programme. Provision of a regional training programme would be welcomed.

The leadership WHO provided in the field of nutrition was noted with approval. In the context of the multisectoral approach to nutrition, the Organization should continue to play the major role through the primary health care approach.

Dr CHAMOV (Bulgaria), while welcoming the Director-General's report (document A48/8), said that it would have been even more useful if a more detailed analysis could have been provided, especially at regional level, of the information provided by Member States so as to reflect the positive results achieved, as well as the difficulties and obstacles encountered in implementation of the World Declaration and Plan of Action for Nutrition and ways of overcoming them so that Member States could adapt them for their own

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

use; examples would stimulate more effective efforts in the field. The status of implementation was reported for only some of the World Declaration goals; progress on decreasing the consequences of poor sanitation, implementing strategies connected with poor social and economic conditions, and promoting healthy lifestyles had not been mentioned.

Part IV of the report should have given some indication of the problems and difficulties faced by the regional offices in implementing the World Declaration and Plan of Action. For example, the transfer of the food safety functions of the Regional Office for Europe to the European Centre for Environment and Health in Rome had adversely affected coordination among Member States in the Region. There was an urgent need for a food safety specialist to be appointed to the Regional Office, despite present financial constraints, in order to improve such coordination and allow the Regional Office to fulfil its commitments within the environmental health action plan for Europe adopted in Helsinki in 1994.

Dr RODRIGUES (Brazil) said that Brazil had participated in the 1992 International Conference on Nutrition and signed the World Declaration and Plan of Action for Nutrition. It had subsequently strengthened its work on nutrition, including supplementary feeding programmes for women and children, as a permanent measure against poverty. A community solidarity programme had also been launched to integrate and coordinate action in various sectors, including food and nutrition, that a number of ministries were undertaking as part of the fight against hunger and poverty.

In 1994, working through the National Institute of Food and Nutrition, the Brazilian Ministry of Health had given priority to a number of areas. A programme for rehabilitation of children suffering from malnutrition and of pregnant women at nutritional risk had to date allocated US$ 120 million to assist some 1 500 000 persons in over 800 municipalities in the most deprived areas. The nutritional status of the population was being monitored through integrated analysis of data on health, agriculture, food supply and prices, employment and wages. In the pursuit and exchange of knowledge, the National Institute coordinated the work of various committees engaged in research on hunger, food and nutrition and in combating hunger. In the area of micronutrients, priority was being given to combating iodine and vitamin A deficiencies. In the drive for promotion of breast-feeding to prevent infant malnutrition, health workers were being trained through six regional centres, a television advertising campaign had been conducted, and promotional messages were printed on bills, receipts, etc. Large amounts of educational and promotional material had been produced, 15 hospitals had achieved the "baby-friendly" status and guidelines had been prepared (jointly with the national HIV/AIDS programme) for the treatment of children born to HIV-infected mothers and mothers with AIDS.

In 1994 the Ministry of Health had initiated a campaign to promote healthy eating habits as a means of prevention and control of disease. A working group on alternative foods had been established to guide the public on eating habits, to develop programmes for provision of information and education on food and eating habits, to produce training material and provide training for health personnel giving guidance on diet, to prepare guidelines for school meals, and to encourage and provide funding for studies and research on new food alternatives.

She asked why no recommendation had been submitted regarding the nutrition of children born to HIV-infected mothers or mothers with AIDS, as had been requested by the Brazilian delegation in 1993. Brazil welcomed the efforts undertaken by WHO to implement the Plan of Action at global level and commended the report.

Ms MIDDELHOFF (Netherlands) remarked that neither the Director-General's report nor FAO documents indicated the existence of any focal point for follow-up of the International Conference on Nutrition. Cooperation between FAO, WHO and other United Nations bodies such as UNICEF had not taken place to the extent anticipated. It was, further, regrettable that WHO and FAO had not yet been able to issue a joint report on implementation of the World Declaration and Plan of Action for Nutrition. The lack of information on the important matter of coordination between WHO and FAO was a cause for considerable concern.

She welcomed the progress in countries reported in part II of the report and commended WHO's work on developing indicators for monitoring progress. The information provided about the funding of post-Conference activities in countries was also of interest. It was gratifying that a substantial number of countries had given high priority to nutrition. She asked to what extent the Organization considered the Subcommittee

on Nutrition of ACC could play a coordinating role for WHO and FAO. Was WHO prepared to provide the Subcommittee with all the information it required with regard to the human and financial resources mobilized in various countries?

Dr SULEIMAN (Oman) said that, although good nutrition was essential for health, overeating could also pose problems by increasing the probability of disease and early death. Since many foods eaten by children contained preservatives that could cause side-effects, greater attention should be given, especially in epidemiological surveillance, to combat abuses.

Referring to the indicators set out in Table 1 of the report, he noted that those in charge of nutrition programmes must determine whether iodine and vitamin A deficiencies were the result of social factors that could be corrected.

Oman had made considerable efforts, with the assistance of UNICEF and the application of the Baby-friendly Hospitals Initiative, to give priority to infant feeding and also to train staff to help improve family nutrition and the nutritional status of women.

Dr BASHI ASTANEH (Islamic Republic of Iran) said that while he welcomed the indicators for monitoring Conference goals for the decade, those for "famine and famine-related deaths" and "starvation and widespread chronic hunger" needed to be reformulated to make them more precise.

His country had found breast-feeding very effective in preventing malnutrition in children under two years of age; a comparative survey had shown a 50% reduction in the prevalence of malnutrition in that age group. Breast-feeding was promoted as an aspect of reproductive health in the Iranian health system.

Among the micronutrient deficiencies, iodine deficiency disorders were being given priority attention in his country, as in other countries of the Region. Iodized salt was now available throughout the country and used in over two-thirds of households; its quality was monitored by the health authorities.

His country endorsed all WHO's activities aimed at improving nutrition throughout the world.

Dr BELLAMY (United Kingdom of Great Britain and Northern Ireland) said that meeting the objectives and goals of the World Summit for Children and the International Conference on Nutrition depended on effective "partnerships" between the countries and agencies comprising the international community. WHO was to be commended for completing the important first step in restructuring its headquarters resources to enable it to play a leading role in securing and supporting such partnerships. The Organization should now give consideration both to the need for interagency collaboration as an essential component of technical support offered to countries in preparing national plans of action for nutrition, and to making national plans the basis for assessing future global demands for WHO's technical services. In response to the very wide differences in countries' capacities to reduce levels of malnutrition, it should advocate greater focusing of international effort on the countries and regions most in need. It should also, in collaboration with relief agencies, develop capacities to monitor the condition of the growing numbers of permanently displaced people, particularly in the African Region, and to manage long-term health and nutrition services for them.

With regard to WHO's plan of action, the United Kingdom believed that resources should be directed to priority objectives. For instance, in its description of the follow-up to the International Conference on Nutrition, the report covered both food safety in developing countries and healthy eating in developed countries; the former was clearly the priority.

The United Kingdom regarded its strategy for health, which included dietary targets for the population to help reduce the incidence of coronary heart disease and stroke, as fulfilling its commitment to the International Conference on Nutrition. As part of its efforts to reach those targets, the Government had convened a nutrition task force to draw up a coordinated programme of action to implement its nutritional strategy.

The United Kingdom supported the International Code of Marketing of Breast-milk Substitutes, which had been implemented in the United Kingdom by a voluntary code agreed with the infant-formula manufacturers and overseen by a monitoring committee composed of representatives of industry and the health sector. In 1994, new regulations had been introduced to implement two directives of the European Union on infant and follow-on formulas.

Dr SANGALA (Malawi) said that WHO ought to be involved in the preparation of contingency plans to meet natural disasters and be ready to act promptly on such plans. The four-year drought in southern Africa, mentioned by the delegate of Lesotho, had caused a decline in the average weight of children since their mothers could not produce enough breast milk. In addition, relief food often arrived late. In response to the persistent drought, Malawi was devoting funds to irrigation projects, which themselves brought health problems in their wake.

WHO ought also to strengthen educational programmes, giving instruction on food values and on nutritious diets containing the requisite proportions of proteins, carbohydrates, fats and micronutrients. Most people in Malawi were still ignorant of the nutritional value of common food products. Much wastage also occurred when food was available. WHO should work together with FAO to find simpler methods to preserve food.

Malawi was in the process of setting up a multisectoral nutrition council since it had been found from experience that such work could not be carried out effectively by a single ministry. The council was expected to consider all the nutritional problems of importance to the country.

Dr RODRÍGUEZ VALENZUELA (Honduras) stated that his Government regarded food safety as a high priority closely linked to family welfare. It could not, however, be regarded solely in terms of control mechanisms, nor of the growth and development of the child, but rather as the most important ingredient in fostering social participation. Progress was being made in preparing a national plan of action for nutrition that paid particular attention to the population groups most afflicted by extreme poverty, undernutrition, malnutrition, and resulting diseases, all caused by chronic lack of food safety in families and entire communities. The situation had been exacerbated by processes of economic adjustment unaccompanied by any compensatory social mechanisms. His country's plan of action for nutrition was based on decentralization and gave local authorities considerable responsibility for ensuring food safety. Emphasis had been placed on food aid as an emergency measure in promoting development, and sustainable agriculture protective of the environment was being encouraged. Honduras was focusing on social involvement; there was a need for indicators to show which communities were making the greatest progress in improving nutritional status.

Dr Ki Dong PARK (Republic of Korea) expressed his appreciation of WHO's efforts to achieve the goals identified in the Plan of Action for Nutrition. It was a matter of concern that the number of children under five years of age suffering from protein-calorie malnutrition had not decreased during the last five years. The problem was not solely one of malnutrition, but was also related to the widening of the gap between the developed countries and the countries in greatest need. Future efforts must concern specifically the less developed countries, and better coordination was needed not only between WHO and other agencies, but also between the various WHO programmes. WHO should also make greater efforts to act as a catalyst for the work of multilateral and bilateral donor agencies and should foster technical cooperation among developing countries.

His Government had dealt successfully with malnutrition through economic and health measures over the past three decades, but the country now faced new problems in the form of diet-related noncommunicable diseases such as heart diseases and cancer, mortality and morbidity from which were increasing rapidly. An annual nationwide survey on nutrition was conducted and a community-based nutrition programme had been incorporated into the district health system in compliance with the World Declaration on Nutrition. Unfortunately, governmental intervention and monitoring activities were sometimes hampered by lack of experience and of indicators for diet-related noncommunicable diseases. Additional efforts to develop and monitor the indicators of such diseases should therefore accompany measures to combat undernutrition.

Dr AL-SHABANDAR (Iraq) considered that the problem of undernutrition as well as the indicators needed for surveillance were effectively covered in document A48/8. Adequate nutrition was a human right stipulated in the 1948 Universal Declaration of Human Rights and reiterated in the Convention on the Rights of the Child and the World Declaration issued at the International Conference on Nutrition in Rome in 1992.

And yet undernutrition and malnutrition were two of the principal causes of mortality among children, pregnant women and the elderly. Efforts to prevent nutrition-related diseases and support breast-feeding programmes must be stepped up. Health education was very important for promoting healthy eating habits among mothers and young children and healthy living generally in order to prevent cardiovascular diseases,

hypertension and diabetes, which were all connected with obesity and poor diet. It would have been beneficial if document A48/8 had included data on protein and carbohydrate intake in the diets of under-five-year-olds in the different regions, as recent research, carried out with the help of WHO, the United Nations, FAO and Harvard University, had shown that undernutrition was increasing among children, pregnant women and the elderly partly as a result of protein and carbohydrate deficiencies.

Professor ORDÓÑEZ (Cuba) said that in 1987 Cuba had introduced a national multisectoral food and nutrition programme suited to the prevailing economic and social conditions. Despite the unfavourable economic climate since that year, the programme had enabled the progress made in public health to be maintained. Other important developments included a national food-and-health awareness campaign, improvement of food-and-nutrition surveillance, and programmes to control and prevent noncommunicable diseases related to diet and to chemical and biological substances in food and water. The Institute of Nutrition and Food Hygiene in Cuba had been designated a WHO collaborating centre in 1991.

Mrs RINOMHOTA (Zimbabwe) said that the agenda for dealing with food and nutrition was a long one and that resources were limited. Member States would have to make a considerable effort to ensure that nutrition was integrated into the development planning process and was regarded as a crucial indicator of development. Support from the United Nations system should therefore focus on capacity-building - helping Member States to help themselves - and facilitating progress in nutrition through advocacy. With such support countries could start to formulate and manage effective and realistic plans of action for nutrition, which would then become an integral part of development planning. Some developing countries had been greatly hampered in their attempts to raise nutritional standards by a series of severe droughts. Zimbabwe was in agreement as to the need, identified at the International Conference on Nutrition, to increase political and governmental awareness of the importance of nutrition. WHO could play an invaluable advocacy role in that respect. Not all Member States had reached the same stage of development, and support systems should take account of individual needs.

Dr GEORGE (Gambia) noted the action taken by WHO to facilitate the implementation of the World Declaration and Plan of Action for Nutrition and urged the Organization to intensify its technical support to Member States, especially for completing their plans of action. Implied in the Declaration was the eradication of micronutrient deficiencies as set out in the mid-decade goals. He exhorted the Organization to provide the technical support necessary to establish accurate baseline data on levels of micronutrient deficiencies so that countries could monitor future trends. WHO should also encourage the development of appropriate simple technology to detect micronutrient deficiencies.

Mr CLAY (Food and Agriculture Organization of the United Nations) said that, while he was aware of widespread concern about the need for improved collaboration within the United Nations system, he wished to emphasize how much FAO valued its long-standing and wide-ranging collaboration with WHO, aimed at achieving and sustaining the nutritional well-being of the world's population. FAO was committed to strengthening its cooperation with WHO at the national, regional and global levels. He fully realized their unique opportunity and responsibility in food and nutrition and the need to work together to meet the expectations of Member governments. He also noted with satisfaction the appreciation expressed by the vast majority of delegates regarding collaboration between WHO and FAO, as well as the progress made by many Member States in following up on the initiatives that had come out of the International Conference on Nutrition. The Conference had been much more than just an exceptional example of WHO/FAO collaboration. It had also provided the opportunity to build partnerships aimed at promoting nutritional well-being. Clearly a healthy, well-nourished population was both the object of effective development and a means of achieving it. The expansion of national plans of action presented an opportunity for most sectors of government - agriculture, health, social welfare, education, finance, commerce and so on - to work together to set realistic and acceptable targets and to propose workable solutions. It was not just a governmental process, however; the support of people, communities, the nongovernmental sector, the private sector and the food industry was also needed to ensure a supply of nutritionally valuable foodstuffs as well as the knowledge, income and opportunity to ensure its proper consumption. With regard to the Conference, the difficult part still lay ahead: to give life to the aspirations, hopes and plans associated with it. That would

require enormous contributions and collaboration by United Nations organizations, donors and developing countries. FAO looked forward to continuing to work together with WHO in that respect.

Mr SIMONS (Industry Council for Development), speaking at the invitation of the CHAIRMAN, said that the World Declaration and Plan of Action for Nutrition had endorsed the partnership in which the private sector and nongovernmental organizations played essential roles in helping to meet nutrition objectives at both national and international levels. The Industry Council for Development (ICD) had therefore given highest priority to practical activities in partnership with WHO, other organizations of the United Nations system and governments that helped to implement the goals of the International Conference. ICD members, major food and related companies, had committed managerial, technical, scientific and financial resources for such partnership projects. ICD was collaborating with WHO and with governments in south-eastern and central Asia to help strengthen national food safety.

Experience from WHO/ICD training seminars for government and industry officials was being incorporated into new joint training materials that would facilitate governmental efforts to adopt modern food safety strategies. Similarly, in the environmental sphere ICD was cooperating with WHO to develop a pilot country programme to improve drinking-water quality and promote greater awareness of sanitation and hygiene practices for safe water supplies. Cooperative activities relating to noncommunicable diseases, particularly initiatives related to nutrition and lifestyles, were also being explored. ICD found encouragement in the priority the Executive Board had already given to the work of those programmes. Such support would greatly facilitate the efforts of nongovernmental organizations to mobilize additional resources and initiate new Conference follow-up activities at national and international levels.

Professor BERTAN (representative of the Executive Board) said that in January the Board had stressed the importance of raising awareness of food safety problems and the need to train staff appropriately. The Board had also noted that, in performing its unique leadership role, WHO must ensure that a multisectoral approach was taken and that activities involving nongovernmental organizations and other United Nations bodies were strengthened and supported, especially at country level, since the prevention and control of nutritional disorders were not solely a health sector task.

Dr ANTEZANA (Assistant Director-General) said that the comments made on the topic under discussion and earlier on the subject of emergency and humanitarian action plainly showed the importance that all delegations attached to nutrition. Tackling malnutrition in its many forms was an urgent and worldwide concern and one of the priority areas for action by WHO. The Director-General appreciated the support expressed for the new Division of Food and Nutrition, which was the WHO focal point for the follow-up to the International Conference on Nutrition. WHO recognized that malnutrition was a problem requiring a multidisciplinary approach and that it would be inappropriate for the health sector alone to attempt to deal with nutrition, and food safety.

Several delegations had mentioned the importance of lifestyles, and more particularly the relation between diet and noncommunicable diseases. In that connection a joint WHO/FAO consultation on the preparation and use of food-based dietary guidelines had been held in Cyprus, in March, as part of the follow-up to the International Conference on Nutrition. Its aim was to develop strategies and activities that would permit Member States to develop their own guidelines. The report, which would soon be available, would answer some delegates' concerns.

Regarding the comments of Japan on food standards and safety and the new challenges presented by the establishment of the World Trade Organization, there was already excellent and long-standing collaboration on the matter between WHO and FAO through the Joint FAO/WHO Food Standards Programme and the Codex Alimentarius Commission.

In answer to the delegate of Lesotho, the apparent inconsistency in paragraph 18 of document A48/8 was explained by the fact that, while 97% of infants in Burkina Faso were still partially breast-fed at 12-15 months, only 4% were exclusively breast-fed at four months of age, indicating that supplementary feeding was being introduced too early, at less than four months. He assured the delegate of Lesotho that efforts would continue to ensure the highest accuracy and reliability of statistics provided by WHO, which were based on information supplied by Member States. With regard to the meaning of the word "territories", he referred him to Articles 8 and 47 of the WHO Constitution.

Replying to the question from Brazil, he indicated that WHO was preparing guidelines on the feeding of infants of HIV-infected mothers; they were intended for national policy-makers and for persons dealing on a daily basis with health workers or serving as health workers.

The comments of the Islamic Republic of Iran regarding indicators were most pertinent, particularly with regard to refugees. The collection of global data on famine-related deaths was a very difficult and complex task but considerable efforts were being made and he hoped it would be possible in future to provide more useful information.

Many delegates had raised the issue of iodine deficiency disorders and it was pleasing to note the real progress being made throughout the world in their reduction. Nevertheless, some 650 million people, mainly children, were affected by iodine deficiency, which was still one of the main preventable causes of brain damage. For the Director-General to be able to submit a comprehensive report to the Forty-ninth World Health Assembly, Member States would be requested to provide information on prevalence and control.

Reverting to the question of cooperation and coordination between WHO and FAO, about the importance of which the FAO representative had just spoken, he said that, in addition to the established and continuing joint activities by the two organizations in nutrition and food standards and safety, further challenges were presented by the new regulations governing foreign trade that arose from GATT and World Trade Organization agreements. Active cooperation would be pursued within the United Nations system and bilaterally with nongovernmental organizations, for neither those challenges nor the need to provide support to countries seeking to implement nutritional plans of action could be dealt with by the health sector alone; joint action was essential. WHO remained strongly committed to coordination of nutrition-related activities by the Subcommittee on Nutrition, to which Germany and the Netherlands had referred. The Organization agreed that such coordination should be further strengthened according to the guidance provided by ACC, of which the Subcommittee was and should remain a part. He assured Members that WHO would continue to seek optimum cooperation with all institutions.

Dr JARDEL (Assistant Director-General) said that the request of Lesotho to benefit from the intensified cooperation with countries in greatest need had been noted. Contacts had already been made through the Regional Office for Africa with a view to cooperating with Lesotho in mobilizing resources for the implementation of its national health policy. The Secretariat was ready to discuss with the delegation of Lesotho how such cooperation could be further accelerated.

4.4 Environmental health

International Programme on Chemical Safety (Resolutions WHA45.32, and WHA46.20; Document A48/11)

International programme to mitigate the health effects of the Chernobyl accident (Resolution WHA44.36; Document A48/12)

The CHAIRMAN requested the Committee to note that document A48/INF.DOC./2, although prepared for the discussion on agenda item 32.1, was relevant to the debate on environmental health, since it was the Director-General's report on community water supply and sanitation.

Dr KANKIENZA (representative of the Executive Board) said that programmes to promote environmental health and chemical safety were solidly anchored in the world strategy for health and the environment studied and approved by the World Health Assembly in 1993. The strategy and programmes for 1996-1997 emphasized the importance of an integrated approach to the problems of relations between health and the environment and accorded less importance to support for sustainable national development. The Commission on Sustainable Development had designated WHO as the coordinating body for health matters in the implementation of Agenda 21, and the Organization was responsible for promoting intersectoral action in the health field in favour of sustained development in the framework of the United Nations system.

The Executive Board in January had identified community water supply and sanitation as a priority area, stressing the inadequate provision of safe water and sanitation in Africa and the associated prevalence of diseases such as cholera and diarrhoea. It had also emphasized the need to adopt an intersectoral approach and to mobilize extrabudgetary resources.

Two reports by the Director-General, one on the International Programme on Chemical Safety (document A48/11) and the other on the International Programme on the Health Effects of the Chernobyl Accident (document A48/12) had also been reviewed by the Board. Under the latter programme, the pilot projects initiated in 1991 and 1992 had been almost complete by the end of 1994 and a comprehensive report was in preparation; a major international conference would be held in Geneva in November 1995. In reviewing the Director-General's report, the Board had stressed the need to mobilize extrabudgetary resources to continue the programme. The importance of coordination with institutions outside the three States most affected by the Chernobyl accident had been noted, as had been the need for the programme to call on additional experienced centres for further work on the consequences of the accident.

The United Nations Conference on Environment and Development (UNCED) in 1992 had called for improved coordination and cooperation in international work on chemical safety. Six international organizations (WHO, ILO, UNEP, FAO, UNIDO and OECD) had since established an Interorganizational Programme for the Sound Management of Chemicals, as a mechanism for coordinating work on chemical safety. In response to resolution WHA46.20, the Director-General had convened, in Stockholm in April 1994, an international conference which had established an Intergovernmental Forum on Chemical Safety. WHO acted as the administering agency for the Interorganizational Programme and as secretariat of the Forum.

The Board had given its full support to the International Programme on Chemical Safety (IPCS), which it commended as an example of a good management approach that encouraged the development of partnership with concerned agencies and of cross-sectoral work. The significance of the internationally accepted and authoritative risk assessments and of the methodology provided by IPCS was recognized. In particular, the activities of the Programme in harmonizing at the international level the approaches used in risk assessment were regarded as a cost-effective way of using the limited expertise available and of avoiding wasteful duplication of effort in different countries.

Dr LARIVIÈRE (Canada) expressed his country's support and appreciation for WHO's work as the primary coordinator for intersectoral activities relating to the health aspects of Agenda 21 and sustainable development. Canada had participated in and supported IPCS and approved its expansion as outlined in document A48/11, which showed that, so far, 27 countries had signed memoranda of understanding covering cooperation in IPCS and that negotiations were in progress with 14 more. That was encouraging but still represented only a small proportion of the total number of Member States. As more came to participate, the Programme's significance and relevance to countries' needs would continue to increase. He noted that IPCS collaborated closely with IARC, for example in the field of chemical carcinogenicity, and with the International Register of Potentially Toxic Chemicals (IRPTC) in relation to risk assessment and human resources development.

The IPCS budget for the current biennium stood at US$ 13 million, funded partly from the WHO regular budget but mainly from voluntary contributions. He shared WHO's concern regarding the lack of long-term stability in extrabudgetary funding and the lack of flexibility in the use of voluntary funds, which were increasingly designated for specified activities. Although over 120 countries had endorsed the importance of chemical safety work and the establishment of the Intergovernmental Forum on Chemical Safety, very few had pledged contributions to support the expanded role of IPCS. Canada therefore urged Member States, agencies and all interested parties to provide financial support for the Programme.

While chemical risk assessment could be adequately carried out at global level, chemical risk management required strong regional participation. Canada was pleased with the steps taken to strengthen links between the global IPCS and the regional programme in the Americas and urged other regions to adopt similar measures to strengthen regional risk management activities, including the involvement of regional funding institutions.

Dr ADAMS (Australia) also expressed his country's strong support for IPCS and its work. The increasing importance of chemical safety was insufficiently appreciated, as was the fact that the health aspects of that safety must remain paramount. Noting that UNEP, which had been assigned the role of "task manager" by the Commission on Sustainable Development, would suffer a 50% reduction in its budget for chemical management, he sought reassurance that such a cut would not jeopardize the work of the Programme.

Mrs MILEN (Finland) said that IPCS, which had Finland's full support, had made a valuable contribution to the health and safety of populations by publishing numerous environmental health criteria documents, health and safety guides, and international chemical safety cards. Expansion of its activities to the Intergovernmental Forum was a very significant development, although the impact of that on risk management was not yet clear. The scientific integrity and independence of IPCS were of great importance for the credibility of its work, and that credibility must be safeguarded by a policy of transparency at all stages of document preparation. A further point was that the global evaluation of chemical hazards and risks must be based primarily on health aspects; all other matters, for example the economic consequences of risk management and the setting of safety standards, should be decided at national level. In addition, the involvement of developing countries and those in economic transition in the Programme's activities should be strengthened to facilitate prioritization of the chemicals of concern to those countries and the effective use of the Programme's material.

Finland shared the concern expressed in the report on financial constraints and the earmarking of extrabudgetary funding. That could affect the independence of IPCS, and the Director-General was therefore requested to examine the possibility of giving the Programme more priority in future allocations from the regular budget.

Dr FURUHATA (Japan) emphasized the increasing importance of IPCS and of coordination and collaboration among interested international agencies. Japan therefore welcomed the establishment of the Intergovernmental Forum on Chemical Safety, for which WHO acted as secretariat, and encouraged the Organization, the only United Nations specialized agency in the public health field, to pursue its mandate of protecting human health from chemical hazards.

Among the measures WHO should take, information dissemination should receive greater emphasis, as a valuable normative activity, in order to enhance national capacity to ensure chemical management.

Mrs DROBYSHEVSKAYA (Belarus) said both the problem of chemical safety and the effects of the Chernobyl accident were of acute concern to her country. Speaking on document A48/11, she said that the Belarusian Ministry of Health was always guided by the conceptual principles of WHO, and that applied also to IPCS; but the country was in a period of economic transition, and the problem was exacerbated by demilitarization and the disposal of large quantities of armaments. A careful policy was being pursued regarding the handling of harmful chemical substances, consonant with WHO's global strategy for health and environment.

Everything possible was being done, within the limits of resources, to lower risks from all aspects of the handling, use and disposal of dangerous chemicals, but international standards had not yet been reached. It should be stressed, however, that the Ministry of Health was prepared to revise its activities on the basis of international principles and instruments.

Belarus stood ready to discuss its participation in various international organizations and projects dealing with the health and environmental aspects of the management of chemicals. It subscribed to the memorandum of understanding between UNEP, ILO and WHO, and was keen to procure information from those organizations, as well as to participate in educational programmes on environmental health; in return, it could provide medical and environmental information from its own sources, including the results of its own toxicological research, and was willing to share its unique experience, based on the study of the radiation contamination resulting from the Chernobyl accident, as well as of the effects of chemical pollution on the environment. Belarus had also seen the emergence of a new branch of medical science: the study of the health aspects of emergencies.

All the activities and plans she had referred to were, however, severely curtailed by financial constraints; nevertheless, the political will was there, and the Ministry of Health would continue to do whatever it could in support of WHO initiatives.

Speaking on document A48/12, she thanked WHO for the enormous contribution it had made to the International Programme on the Health Effects of the Chernobyl Accident (IPHECA). For nine years the Ministry of Health had done its utmost, in totally unprecedented circumstances, to mitigate the negative health impacts of the Chernobyl tragedy, notably where children were concerned. The country's scientific and research institutes had all been mobilized in the effort, and had accumulated a huge amount of factual information on the consequences of the accident.

The incidence of thyroid cancer among children had increased enormously. The Ministry of Health was endeavouring retrospectively to determine the dose of radiation received, and it was already clear that the incidence of thyroid cancer would increase. Several other kinds of illness, including disorders of the digestive and nervous systems, especially among children and young people, were being detected with greatly increased frequency in the areas subjected to radiation; she cited relevant statistics. Delayed mental development, emotional disorders and even *in utero* problems were occurring among the population of those areas, and also among the recovery workers although they had received lower doses of radiation. It would not be possible to pursue all the necessary studies or to tackle problems effectively without the assistance of WHO; for the moment, the meagre financial resources of Belarus would be devoted mainly to alleviating the situation of the most severely affected.

Rather than merely noting the Director-General's report, as was suggested in paragraph 34 of document A48/12, the Health Assembly might ask the Director-General to continue his efforts to secure funding for continuing the work of IPHECA.

Dr KHOJA (Saudi Arabia) stressed the importance of the safe disposal of chemical, biological and other types of waste. WHO should draw up criteria and guidelines on the subject in order to prevent short-, medium- and long-term ill-effects on human populations. It should also assist countries with training programmes to reduce chemical hazards and to develop assessment and surveillance methods. His country was preparing guidelines and implementing a strategy to that end but needed the support of WHO.

He expressed his appreciation to the previous speaker for the important information she had given, particularly on the subject of children affected physically and mentally by harmful substances.

Dr ZOBRIST (Switzerland) said that document A48/12 was a good review of IPHECA, distinguishing clearly between the health effects scientifically linked to the Chernobyl radiation and others. Although it gave a rather beautified picture of the programme, providing little information on the problems encountered especially in regard to coordination, she welcomed the projected organization by WHO, in November 1995 in Geneva, of an international conference on the health consequences of the Chernobyl and other similar accidents. To yield credible results, that conference should be held at the highest scientific level. In addition, the media and the general public should be kept fully informed on the content and findings of the conference.

For the future, she agreed that it was essential to determine the fields of activity having greatest need of outside support and offering the best prospects; she wished to have some information regarding selection criteria, as some health problems stemming from harmful radiation would appear only in the years to come.

The accurate determination of individual radiation doses received was essential for research on the health effects of exposure, but she wondered whether that was possible nine years after the Chernobyl accident. It was vital to assemble all available data, to have access to dose registers, and to collaborate with the countries and institutions concerned, including IAEA.

In conclusion, she stressed that her country continued to support the relevant activities through the Regional Office for Europe.

Dr MAPETLA (Lesotho) said it was clear that the provision of safe drinking-water and waste disposal could solve very many health problems and she therefore supported the initiatives of WHO and other organizations to that end. Her country was concerned, however, about water quality control and monitoring; in many instances, water and sanitation were provided by ministries in non-health sectors without any quality control, and seepage from latrines, for example, resulted in pollution of drinking-water. That problem had to be faced but it was not highlighted in the Director-General's report. Her country had conducted a pilot project on quality control in one district and would need support for establishing countrywide guidelines.

Dr BRUMMER (Germany) endorsed the environmental health programme and welcomed the fact that it was modelled on the objectives and pertinent chapters of Agenda 21. It was essential that activities under the European Programme of Action for Environment and Health, adopted in Helsinki in 1994, and the comprehensive global activities should complement each other. Germany also expressly endorsed programme activities in environmental health devised for countries which urgently needed basic guidance and support in that field.

His country, which was continuing its support through voluntary contributions to IPCS and other programmes, felt that consideration should be given to merging some activities in order to attain a critical mass, and also to carrying out some monitoring activities in closer coordination with other international organizations so that funds could be released for other activities.

Germany endorsed the report in document A48/11. The extensive scientific and technological accomplishments of IPCS had been instrumental in disseminating scientific findings throughout the world and advancing chemical safety on the global level. His country therefore supported the expansion of IPCS, decided at the International Conference on Chemical Safety in April 1994 in pursuance of UNCED resolutions, Germany's foremost aim being the expansion to global level of the international chemical safety concepts established in his country.

It was essential that IPCS scientific and technological activities should be pursued unabated, that the implementation of UNCED resolutions should progress at international political level, and that WHO should retain its leading role in the Programme to ensure that health-related aspects remained central. Thanks to its wide experience, Germany could provide contributions to future international activities.

Mrs LIU Guangyang (China) said that health hazards had become increasingly serious and that all governments must manage the relations between the environment and development soundly. Developed and developing countries alike must implement IPCS at country level, relying on experience to increase the capabilities of the developing countries, and taking into full consideration the actual situation in the developing countries in order not to restrict economic development.

The scope and work of IPCS should be increased, with further financial support if necessary. The developed countries were large producers and exporters of chemical products and should therefore make a greater financial and technical contribution.

Chemical safety was of great concern to the Chinese Government and a joint coordinating committee, involving the sectors of environmental health, labour and the chemical industry, had been established to coordinate action on chemical safety management, with the Ministry of Health responsible for all health aspects. Her country would actively support chemical safety management.

Dr VIOLAKI-PARASKEVA (Greece) said that, in addition to the serious environmental problems existing in many countries - poor housing and sanitation, lack of access to safe water, inadequate sewage systems - new health problems were being created in developed countries by industrial pollution from chemicals and increasing urbanization. The report in document A48/11 showed that, with the constant increase in the number of chemicals as a result of advancing technology, more attention would have to be given to environmental health, with emphasis on prompt and accurate dissemination of information, so as to ensure more effective management. The fact that the expanded IPCS would provide a mechanism to build up collaborative international programmes on chemical safety was encouraging. Collaboration with other international organizations, WHO acting as coordinating body, was important.

Regarding the Chernobyl accident, she hoped that the comprehensive report on the implementation of the IPHECA pilot projects would be widely disseminated.

Dr WOLVAARDT (South Africa) commended the achievements of IPCS. A number of lessons could be learned from that Programme: emphasis had been placed on results that were measurable; progress had been made in interorganizational cooperation between the six concerned agencies, to prevent duplication; and there was an obvious need to strengthen the involvement of Member States in the work of the United Nations system in that field. The establishment of the Intergovernmental Forum on Chemical Safety and the memoranda of understanding being negotiated with various countries, including his own, were important steps in that direction. He was concerned about the proposed reduction of UNEP funding for chemical safety, which was and would remain an important aspect of preventive medicine in developed as well as developing countries.

Ms MIDDELHOFF (Netherlands) observed that document A48/11 contained little reference to the problems of developing countries. The expansion of IPCS into an interorganizational programme for the sound management of chemicals was welcome as a step in the right direction towards implementing Agenda 21. In response to the request for guidance in paragraph 44(1) of the document, the development

of protocols for needs assessment concerning capacity and institutions might be required, and the organization of training called for policy development and an institutional framework, without which training programmes would remain inadequate.

Referring to document A48/12, she pointed out that the relation between the increase in morbidity and mortality among recovery workers and radiation exposure had yet to be established. Regarding the project on "dose reconstruction", she requested clarification as to the reliability and practical value of the data. Her delegation looked forward with interest to the issue of the comprehensive report.

Dr PAVLOV (Russian Federation) expressed general satisfaction with the progress report, although he would have liked to see more details concerning progress in the activities mentioned in paragraphs 12, 14, 16 and 18. Nor was there sufficient reference to prevention: information on training measures should be accompanied by an indication of the practical measures to be taken to ensure chemical safety at regional and country level. While welcoming the range of epidemiological studies, he felt that closer attention might be given in IPCS to global problems, such as those posed by dioxin, heavy metals other than mercury, and biochemical problems of anthropogenic origin. He considered that IPCS was one of the most authoritative bodies on chemical safety in the United Nations system.

He also generally approved IPHECA. Expressions of sincere gratitude and appreciation were due in connection with the opportunities provided by the Programme, which had given rise to a number of recommendations of great value not only to the victims of the disaster but to humankind in its entirety. The fact that the Chernobyl accident had occurred at all demonstrated the need for a well-coordinated international programme of preparedness. The many experts and institutions involved had, in the short space of a year, proposed additional projects which reflected the interest taken by the scientific and medical communities in the Programme. The limited funding in the programme budget for 1995-1996 was a cause for concern, consisting mainly of voluntary contributions and placing considerable constraints on activities, particularly in priority areas such as assistance to recovery workers and dose reconstruction with respect to the incidence of thyroid disease, haemoblastoses and other radiation-induced illness. Further fund-raising activities were called for so that the Programme might be effectively pursued. The Russian Federation, which had allocated considerable sums from the federal budget to support activities to mitigate the effects of the Chernobyl accident, including IPHECA, believed it would be wasteful, to say the least, to break off the Programme, especially when a sound basis had been laid for its future development.

He endorsed the comment of the delegate of Belarus regarding paragraph 34 of document A48/12.

Dr DURHAM (New Zealand) said that New Zealand considered the work of IPCS to be essential and particularly supported the development of interactive electronic networks for toxicological information. She asked what were the intentions regarding the labelling of incompatible chemicals that should not be transported together.

Professor ORDÓÑEZ (Cuba) said that Cuba was probably one of the countries which had contributed most to mitigating the effects of the Chernobyl accident, by providing medical care for 3000 children from Belarus, Russia and Ukraine, who had received treatment in a special child care centre. Although details of the Cuban programme had been given at a number of Health Assemblies, there had been little response. In March 1990 the child care programme had been set up under the Ministry of Public Health in consultation with the Executive Secretary for Nuclear Affairs. Rehabilitation and recreational activities had been provided. Experts in paediatrics, haematology, endocrinology and radiation medicine had travelled to affected areas with colleagues from the three affected States to select children for medical attention in Cuba. The cases had been classified into a number of groups: children with serious onchohaematological disorders; children requiring hospitalization but not considered to be in a serious condition; children requiring outpatient treatment; and relatively healthy children. The programme had included: detection of the onset or aggravation of diseases related to the accident; special treatment for serious disorders; treatment of less serious cases; physical and mental rehabilitation; dosimetry and radiobiology studies; haematological and biochemical studies; and comprehensive follow-up care. The lack of epidemiological data prior to the disaster in the affected zones made it difficult to conduct comparative studies in order to assess to what extent the pathologies were related to the radiation exposure. An agreement had recently been signed with the Ukrainian Ministry of Health to continue the humanitarian action, and the Executive Board had recommended an evaluation of the Cuban

experience with a view to future cooperation in that area. Cuba offered the collaboration of the Institute of Endocrinology for thyroid studies in relation to this accident. He requested that the report to the scientific conference on the health effects of the Chernobyl accident, to be held in November 1995, should include mention of the Cuban work and findings.

He concluded by noting that Cuba had a plan for investment in the environment and health and a meeting with possible donors was planned for September.

Dr BELLAMY (United Kingdom of Great Britain and Northern Ireland) expressed full support for the work of IPCS as outlined in document A48/11. Regarding the guidance sought in paragraph 44, he considered that the procedures used to draft, review and finalize technical documents should be as transparent as possible; for example, members of task groups finalizing technical documents should declare their interest when appropriate, and consideration could be given to achieving more openness in their selection.

Regarding the Intergovernmental Forum on Chemical Safety, his country considered that, in order to achieve the ambitious but desirable targets set at the International Conference on Chemical Safety in Stockholm, on the basis of the priorities for action established in chapter 19 of Agenda 21, close cooperation between IPCS and the other international agencies was essential, in order to make full use of existing work and avoid duplication. The establishment of the Interorganizational Coordinating Committee involving UNEP, ILO, FAO, WHO, UNIDO and OECD was especially welcome. He considered that the secretariats of the Intergovernmental Forum and the expanded IPCS should work closely together. Countries should establish coordination mechanisms, linking all departments and agencies concerned, to deal with national contributions to, and follow-up of, meetings of the Forum and its intersessional group. The Department of Health in the United Kingdom had therefore established an interdepartmental coordination group involving, *inter alia*, the Departments of the Environment and of Transport.

He expressed deep concern over the reported reduction in the funding provided by UNEP for IPCS and fully supported the representations that had been made by the chairmen of the Intergovernmental Forum, of the Interorganizational Coordinating Committee of IPCS, and of the Interorganizational Programme for the Sound Management of Chemicals, who had written to the Executive Director of UNEP expressing their disquiet.

Dr BASHI ASTANEH (Islamic Republic of Iran) welcomed document A48/11, for chemical safety was a matter of grave concern. Innumerable chemicals were essential for industry, but both the raw materials and the final products were often hazardous to the community and particularly to children. Chemicals in workplaces and factories and in agriculture were sources of environmental pollution, also causing occupational diseases. He was greatly impressed by the global efforts that had been made regarding chemical safety, facilitated by WHO. Greater attention should be paid, however, to implementing the Organization's recommendations, and he therefore proposed the formulation of guidelines for the preparation of national programmes for chemical safety. Effective implementation of guidelines required appropriate legislation as well as basic political commitment; in his country a proposed law on chemical safety had been submitted to the Cabinet for consideration. He was in favour of expanding urban and rural health projects through intersectoral coordination, and also supported the views expressed in document A48/INF.DOC./2.

Mr MAKHANU (Kenya) welcomed the report in document A48/11 and the planned activities outlined on pages 130-132 of the proposed programme budget for 1996-1997. He hoped that, within those activities, developing countries such as Kenya would receive IPCS support to set up poison control centres and chemical emergency information response centres and to train the requisite technical personnel.

Dr BERLIN (European Commission) commended the IPCS report for its clarity, brevity and completeness in view of the growing complexity of chemical safety, a topic which had been an important concern for the European Community for nearly 30 years since the first European legislation enacted in 1967. Comprehensive European legislation now existed, protecting the public as consumer, the labour force and the environment, and applicable by the Member States of the European Union and by the countries of the European Economic Area. Similar legislation was being drawn up by the countries of central and eastern Europe having association agreements with the European Union. Fruitful cooperation had been established with IPCS since the programme had been set up in 1980. As that cooperation, the importance of which had

been underlined at the ninety-fifth session of the Executive Board and which had been mutually beneficial for IPCS and the European Community, was not mentioned in document A48/33 on collaboration within the United Nations system and with other intergovernmental organizations, he felt that it was appropriate to stress it in the context of the present discussion. Continuing close cooperation was mentioned in paragraph 6 of document A48/11. The European Commission was also particularly active in the Intergovernmental Forum on Chemical Safety. Furthermore, the Convention on Chemical Safety at Work, adopted by ILO, was inspired largely by European Community legislation; the current efforts to harmonize existing classification and labelling systems for chemicals by ILO within the IPCS context had strong links with the system proposed by the European Commission for the European Union. Finally, the European Commission was also participating in the European Environmental Health Committee.

Dr KREISEL (Office of Global and Integrated Environmental Health) thanked delegates for the support they had expressed for WHO's work in environmental health. WHO had followed up the recommendations of the United Nations Conference on Environment and Development in the field of chemical safety through the establishment of the Interorganizational Programme on Sound Management of Chemicals and of the Intergovernmental Forum on Chemical Safety, in close collaboration with Member States and other United Nations bodies. As a cooperating organization in the Interorganizational Programme, WHO had stressed the health-related aspects of chemical safety. However, stronger support was needed from UNEP, as had been pointed out by those speakers who had expressed concern over the decrease in UNEP funding to IPCS. The Executive Director of UNEP had in fact indicated very recently that UNEP did not intend to reduce its contribution to IPCS, but no indication of the total amount of funding could be given until the forthcoming meeting of the UNEP Governing Council. UNEP's contribution was much appreciated in that field.

Replying to the delegate of Canada, he said that 32 countries had now signed memoranda of understanding and negotiations were under way with others that had shown interest in joining IPCS. While voluntary contributions were essential to the Programme, substantial regular budget support was required to ensure its long-term stability and independence. Cooperation at regional level concerning chemical safety had increased in recent months, especially in the Region of the Americas.

Regarding dissemination of information on chemical safety, WHO was cooperating with Japan in establishing the Global Information Network on Chemicals. Concerning the issue of accurate and reliable information for dissemination at field level, he noted that countries required support, for example in the form of guidelines on chemical waste. Regional cooperation was of particular value in that area.

Regarding labelling of chemicals, cooperation within IPCS was satisfactory, as a working group on the harmonization and classification of labelling had been established and would, it was hoped, subsequently be given greater legal status.

Regarding chemical accidents, IPCS was involved in emergency preparedness activities in cooperation with UNEP. That programme needed to be extended to more Member States.

He thanked countries that had contributed financially to the International Programme on the Health Effects of the Chernobyl Accident (IPHECA), and noted that the short-term objectives had been achieved, including the provision of medical care to the affected population. More than 500 cases of thyroid cancer had been scientifically confirmed in the three affected States but further work was needed to establish the correlation with radiation exposure. The Programme had developed protocols for the five pilot projects and had provided medical equipment and supplies, including equipment for the haematology project. No increase in the incidence of haemoblastoses had been reported in the affected population. Mental retardation due to radiation exposure had not been observed in the 4500 children screened in the project on *in utero* brain damage. More work was needed on dosimetry: dose reconstruction was highly reliable only with the electron spin resonance method, which determined free radicals in tooth enamel. It was hoped to expand the use of the method in long-term longitudinal studies on radiation exposure and health effects.

The Management Committee of IPHECA had identified priorities for the future, for which international support was needed. The thyroid project must be continued, for more than 3000 cases of thyroid cancer in children might be expected in Belarus alone. Accident recovery workers needed medical care, and studies on those who had received radiation doses exceeding 20 cGy could provide useful scientific information. Work on psychosocial problems in affected children was also desirable, as was the development of public

health guidelines for dealing with nuclear accidents. Work on those priorities, and the future of IPHECA, would depend on further strong financial support.

A scientific conference on the health consequences of the Chernobyl accident and other radiological accidents would be held in Geneva from 20 to 23 November 1995. A further conference, sponsored by IAEA, WHO and the European Commission, would be held in Vienna in April 1996; it would be based on the outcome of the Geneva conference and another conference organized by the European Commission and would discuss environmental, political and social issues.

The CHAIRMAN said that, in the absence of further comments, he took it that the Committee wished to take note of the two reports under discussion.

It was so agreed.

Appropriation section 5: Integrated control of disease

5.1 Eradication/elimination of specific communicable diseases

5.2 Control of other communicable diseases

The CHAIRMAN suggested that, in order to simplify the discussions, the activities under budget headings 5.1 and 5.2, together with the relevant resolutions under item 19, should be considered in four groups: (1) the Global Programme for Vaccines and Immunization and control of diarrhoeal diseases and acute respiratory infections, including the initiative for the management of the sick child; (2) the implementation of the global AIDS strategy; (3) tuberculosis, tropical diseases and leprosy; and (4) emerging, re-emerging and new infectious diseases and prevention of hearing impairment. He invited the Committee to comment on the first group (document PB/96-97, section 5.1 and paragraphs 362-368 of section 5.2).

Control of diarrhoeal diseases and acute respiratory infections: sick child initiative (Resolutions WHA40.34, WHA44.7 and EB95.R11; Document A48/13)

Professor BERTAN (representative of the Executive Board) said that the Executive Board subgroup that had examined the Global Programme for Vaccines and Immunization had recognized that progress in the eradication of poliomyelitis was a major achievement; WHO was realizing its full potential in work on the elimination of such diseases. However, some countries had insufficient funds for purchasing vaccines. The subgroup had stressed that the development of surveillance for cases of acute flaccid paralysis, including laboratory capacity to isolate and type wild polioviruses, was essential if eradication was to be achieved.

Concerning the progress outlined in document A48/13, the Board had commended the move towards an integrated strategy for the management of the sick child and away from activities specific to the control of acute respiratory infections and diarrhoeal diseases, but had warned that care should be taken when implementing the new approach not to disrupt progress already being made against specific childhood diseases. The approach held out the promise of exceptional results provided implementation was supported by a strong commitment by Member States. In reviewing particular aspects of the strategy, the Board had pointed out the need to promote the rational use of antimicrobials and to monitor the antimicrobial resistance of the main agents of infection. Attention had been drawn to the fact that the integrated approach addressed the problem of malnutrition, which was often a risk factor for acute respiratory infections and diarrhoeal diseases. In view of the widespread move towards integration of programmes and the solid technical and managerial basis of the proposed approach, the Board had recommended, in its resolution EB95.R11, the adoption by the Health Assembly of a resolution in support of activities to strengthen the integrated management of the sick child.

Mr CHAUDHRY (Pakistan) commended WHO's efforts directed to the control of diarrhoeal diseases and acute respiratory infections and the integrated management of the sick child. While he endorsed the content of the draft resolution recommended by the Board, it was necessary to consider whether, in view of

child morbidity and mortality due to such infections, the actions taken by WHO and its Member States were proportional to the problems. He therefore proposed the addition to paragraph 2 of a new subparagraph reading:

> (1) to accelerate and sustain the programmes for control of diarrhoeal diseases and acute respiratory infections in order to reach the target of reduction of infant and child mortality rates by the year 2000;

the other subparagraphs to be renumbered accordingly.

Dr ADAMS (Australia) supported the draft resolution recommended by the Board and the amendment proposed by the delegate of Pakistan. It made sense to combine immunization, trials of bednets to prevent malaria and activities against diarrhoeal diseases and respiratory infections in the same age group. Australia was providing 800 000 dollars for the initiative for the management of the sick child in 1994-1995, in addition to 1.09 million dollars for control of diarrhoeal diseases and acute respiratory infections. He requested information on coordination and communication between WHO and UNICEF in implementing the initiative.

Dr BRUMMER (Germany), drawing attention to population movements and the fact that communicable diseases were not bound by national borders, stressed the need for worldwide cooperation in the control of infectious diseases. Since that applied to the Member States of the European Region, it was difficult to understand why the proposed regular budget allocation for implementing specific programmes in that Region was so low. The incidence of communicable diseases such as diphtheria, tuberculosis and sexually transmitted diseases was increasing in many countries in the Region. The alarming developments caused by lack of vaccines and the deterioration of primary health care in such countries might spread to others unless early countermeasures were taken, with international cooperation. Recognizing the urgency of the situation, Germany had supported a conference held in January 1995, on vaccine requirements for the European Region, which had made recommendations aimed at harmonizing vaccination schedules and improving public information.

Mr PÉREZ (Spain) supported the draft resolution recommended by the Board in resolution EB95.R11, although diarrhoeal diseases and acute respiratory infections were not a serious cause of infant morbidity and mortality in Spain. The activities were justified, given the worldwide problems posed by such infections, and comprised all the necessary countermeasures.

Dr ESSOMBA (Cameroon) said that Cameroon's health policy was based on primary health care and the district health approach, together with appropriate reforms of the health sector. The cornerstone was integrated and high-quality care, with active community participation. He hoped that the initiative for integrated management of the sick child would strengthen Cameroon's efforts to ensure that essential care was permanently accessible - geographically, economically and socially - to all population groups. He asked when the initiative would be implemented, whether the necessary resources were already available and how countries would be able to get access to them.

He supported the draft resolution recommended by the Board, with the following three amendments: in paragraph 1, the replacement of "a most effective approach" by "a more cost-effective approach"; at the end of subparagraph 2(1), the addition of "using, where available, all the primary health care development logistics"; and in subparagraph 3(6), replacement of "to continue to seek" by "to step up the search for".

Mrs VOGEL (United States of America) said that the Executive Board, in reviewing the proposed programme budget for 1996-1997, had considered control of diarrhoeal diseases and acute respiratory infections to be among WHO's highest priorities. Despite significant reductions in child morbidity and mortality in recent years, those conditions continued to be the major contributors to child deaths in many Member States; stronger action was needed to reduce the toll.

She welcomed the progress in facilitating the integration of strategies, policies and activities for the integrated management of the sick child at country level. The integrated approach, which incorporated both preventive and curative components, would have a major impact on child mortality. However, continued

attention should be paid to the successful elements of the previously separate programmes. She asked for information on the level of additional resources made available for activities to control diarrhoeal and acute respiratory diseases through the reallocation of 5% of the regular budget, as recommended by the Executive Board in resolution EB95.R4.

She supported the draft resolution contained in resolution EB95.R11.

Dr VAN ETTEN (Netherlands) commended the integration of activities for the management of the sick child. However, the importance of prevention was not made clear in the Director-General's report; activities, including research, for prevention should be incorporated into the initiative. He therefore proposed the insertion at the end of subparagraph 2(1) of the draft resolution of the words "with continued efforts to prevent sickness among young children" (that amendment would need to be reconciled with the one just proposed by the delegate of Cameroon to the same paragraph). He also proposed: the insertion of "prevention," before "in-service training" in subparagraph 2(2) and of "prevention and" before "control" in subparagraph 2(3); and the addition of a new subparagraph 3(2):

to promote the prevention of the major causes of child mortality;,

and a new subparagraph 3(3):

to facilitate the provision of tools for preventing acute respiratory infections, such as *Haemophilus influenzae* B vaccine and a conjugate pneumococcal vaccine, for the vaccination of children in developing countries;.

The other subparagraphs of paragraph 3 would be renumbered accordingly.

Professor HUTTUNEN (Finland) noted with satisfaction that the programmes for the control of diarrhoeal diseases and acute respiratory infections were effective against two major causes of mortality in children under five years of age. There were, however, some problems with the focus on treatment. Not only was treatment, as a rule, less effective and more costly than prevention, but it was often difficult to provide life-saving therapy to the child quickly enough. Furthermore, while the effective treatment of diarrhoea was easy enough, there was no simple therapy for acute respiratory diseases as they required accurate assessment of the severity of the infection, care of symptoms, and antimicrobial chemotherapy at home or referral to hospital. Antimicrobial chemotherapy was itself associated with problems of availability, affordability and development of drug resistance, among others.

As early treatment was a critical factor in diarrhoeal diseases and acute respiratory infections, it was of paramount importance to influence the care-seeking behaviour of the mother and family. Further, in view of the advantages of the preventive approach, greater attention should be paid to new interventions such as vaccines, improvement of the skills of health-care workers, health education, and influencing the health behaviour of families. Finland valued the programmes highly and hoped that, despite budgetary constraints, more resources would be directed to activities underpinning prevention and the integrated management of the sick child.

Mr ORDING (Sweden) noted that diarrhoeal diseases and acute respiratory infections remained major global health problems in terms of child morbidity and mortality, as well as of demands on health services. While WHO should continue its efforts to control those diseases, he endorsed the broadening of activities into integrated management of childhood illness. The diarrhoeal disease control programme had pioneered a combination of research and action, an approach relevant for a number of other programmes within WHO. Achieving an optimal combination of research and action was, indeed, a topic that should be included in discussions on the restructuring of programmes as part of WHO's reform process. He endorsed the draft resolution in resolution EB95.R11.

Ms TIHELI (Lesotho) supported the draft resolution recommended in resolution EB95.R11, with the amendments proposed by the Netherlands. Malnutrition, acute respiratory infections and diarrhoeal diseases were the commonest causes of child morbidity in her country. She therefore viewed the sick child initiative as the most cost-effective approach to child care and noted with appreciation paragraph 2(3) of the draft resolution as amended by the Netherlands. Full implementation of the initiative was urgently needed and there should be more emphasis on preventive than on curative care. Lesotho's immunization programme had been successful and measles was not a great cause for concern, but the three problems she had referred to

needed integrated care at primary level. Health education and nutrition, especially breast-feeding, should be given priority over curative measures. It was also important to take a multisectoral approach, with emphasis on nutrition, at community level, in order to prevent the frequent return of children, even after successful treatment, to hospital, ending sometimes in loss of life.

Dr FURUHATA (Japan) commended the excellent progress made by the Global Programme for Vaccines and Immunization towards developing an integrated approach. More than three years had passed since the last case of poliomyelitis had been detected in the Western Hemisphere, and eradication had been certified in the Region of the Americas in September 1994; all countries concerned were to be congratulated. The Western Pacific Region was also making excellent progress, and was close to its target of eradication by 1995. However, the importance of follow-up after eradication should also be stressed. WHO should continue its efforts in areas such as surveillance for poliomyelitis and high vaccination coverage.

Dr ASHLEY-DEJO (Nigeria) welcomed the initiative and the resolution proposed by the Board, but found the emphasis on integration a sad reflection of the fact that child care had become separate for different diseases and was no longer given in polyvalent medical centres. Paradoxically, it appeared that that vertical approach had accompanied the emphasis on primary health care after the Declaration of Alma-Ata in 1978. Good results had been achieved by prioritizing diseases for control, but that had also led to waste of human and other resources. It meant that five or six health workers might currently be needed in a clinic to attend separately to diseases such as diarrhoea, malaria, acute respiratory infections and leprosy and to provide immunization; another was needed for nutrition, growth monitoring, vitamin supplementation and similar activities.

As a result, care for different diseases was available on different days, according to the schedule of the health worker concerned. Mothers had to interrupt their economic activities to get their children to the right place on the right day. That drift towards inefficiency and waste was viewed with concern in Nigeria. However, it was encouraging to note that in some areas disease incidence and prevalence had fallen appreciably, and that WHO was moving towards an integrated approach to child care.

The re-emergence of the well-baby clinic, in addition to clinics for curing sick babies, was desirable. The former should provide health-promotion, preventive and rehabilitative services, and the latter care for children with malaria, diarrhoea, acute respiratory infections, measles, tetanus and other such illnesses, in the same place and at the same time. That would save resources and make it easier for communities to sustain their own programmes.

Nigeria had made good progress in diarrhoeal disease control but that was offset by problems of water safety and sanitation. A programme on acute respiratory infections was being set up. A well-designed five-year plan for the expanded programme on immunization, integrated with primary health care, was in place, but there were problems of vaccine supply and cold-chain maintenance.

Dr MUKHERJEE (India) commended the report in document A48/13. India strongly believed that an integrated approach would reduce infant morbidity and mortality and supported the resolution recommended by the Board. India was committed to the eradication of poliomyelitis by the year 2000. Prior to 1986, less than 50% of India's infants had received the three-dose immunization; in 1995 coverage exceeded 90%, and reported cases had been reduced by 90%. Prospects for eradication by the year 2000 were good.

Dr RODRIGUES (Brazil) said her country had started its programme on diarrhoeal disease control in 1982, and in 1984 had added programmes on comprehensive child health, growth and development monitoring, breast-feeding, acute respiratory infections and the control of immunopreventable diseases. The aim had been to shift the focus from pathology to the growth and development of the child as a whole. So the integrated approach currently proposed had been endorsed by Brazil since 1984. The current administration in Brazil had strengthened those efforts with a plan for the reduction of infant mortality focused on sanitation, maternal and child health, nutrition, immunization and community health work. The activities involved would include human resource development and health promotion in a multisectoral context involving all areas of government in improving the living conditions of infants.

Mortality caused by diarrhoea, acute respiratory infections and immunopreventable diseases had been reduced in the 1980s, and consequently the current main cause of infant mortality was perinatal diseases,

which accounted for about half of all infant deaths. To reduce that mortality, family planning assistance, antenatal care, midwifery and care of the newborn were essential.

With regard to the promotion and rational use of antimicrobials, not only training and family counselling were necessary, but also specific legislation to regulate the production and sale of those products. In 1994 her Government had prohibited the sale and use of drugs known to be harmful for the treatment of infant diarrhoea. Antidiarrhoeal products must be of proven safety and effectiveness, work done on developing them must comply with the standards recommended by WHO, and the printed information with which they were sold must confine itself to scientifically proven effects.

Brazil strongly supported the draft resolution.

Dr EMIROĞLU (Turkey) thanked the Director-General for the efforts that had been made in the integrated control of diseases, particularly under heading 5.1, Elimination/eradication of specific communicable diseases. Turkey was pleased to note that the surveillance, prevention and control of those diseases and the strengthening of the Global Programme for Vaccines and Immunization would continue to be a priority. The increase in the regular budget for the eradication and elimination of specific communicable diseases was welcomed, as were the efforts made in various countries to strengthen their immunization and disease control programmes.

To achieve poliomyelitis eradication by the year 2000, routine immunization activities needed to be strengthened and supplemented with special activities. A successful interregional initiative had been launched with the support of WHO and other agencies. Turkey and 17 other countries had started a series of national immunization days and had recently completed a first exercise with very high coverage rate. Eradication of poliomyelitis was not the only benefit to be gained. Those efforts also strengthened primary health care structures, surveillance systems and other disease control programmes, as well as political will, public awareness, personal motivation and intersectoral cooperation. Surveillance for cases of acute flaccid paralysis needed special attention if eradication was to be achieved; that required performance indicators. The integrated laboratory network for confirmation of wild poliovirus infection was also essential. Technical guidance and support from WHO and the partner agencies should continue to strengthen national poliomyelitis eradication programmes and immunization programmes.

Document A48/13 and efforts to promote integrated management of the sick child were also welcomed. Vertical programmes should be integrated in the context of primary health care according to the progress being made in each country. Integrating the control of diarrhoeal diseases and acute respiratory infections should be accompanied as necessary by other priorities to promote effective management of the sick child.

Turkey supported the draft resolution contained in resolution EB95.R11, but would propose some minor amendments. In subparagraph 2(2) the words "supervision and monitoring" should be replaced by "supervision, monitoring and evaluation"; and in subparagraph 2(3) the words "strengthen and" should be inserted before the word "maintain".

Mrs LORD (Canada) welcomed the draft resolution, as amended by the Netherlands, and the establishment, mentioned in document A48/13, of a working group to start making tools such as guidelines and training courses available. WHO's approach, involving both field testing and evaluation of the training programme, with funds earmarked for related research, was especially welcomed. It showed commitment to accountability and to ensuring that the programme was adaptable to local needs. Of particular importance in the progress report was the fact that the principle of equity was met by the integrated approach, since it made early preventive treatment available to children who would not otherwise receive it. Such access was essential if they were to achieve the health status enjoyed by other children as a matter of course. In addition to the draft resolution, Canada supported the direction taken by WHO in recent years towards integrated disease management.

Dr RAI (Indonesia) commended WHO on the integrated approach, which would improve the flexibility and effectiveness of child care and lead the way to other integrated programmes in the future. He therefore urged Member States to give that programme particular emphasis. He supported the draft resolution and could accept the amendments proposed.

Dr ABDELAAL (Egypt) expressed support for the draft resolution proposed by the Board and for document A48/13, although in paragraph 19 of that document the link between diarrhoeal diseases and acute respiratory infections might have been emphasized more strongly. Upper respiratory tract infections could be a secondary cause of diarrhoeal episodes and, conversely, repeated attacks of gastroenteritis could exacerbate respiratory infections because of the child's lowered immunity. Egypt had achieved encouraging results from the use of oral rehydration therapy and a pragmatic approach to acute respiratory infections as part of the child survival project. Environmental health activities were important for the control of diarrhoeal diseases and acute respiratory infections. The gastrointestinal tract constituted a highly balanced ecological environment in which benign saprophytic microorganisms coexisted with malignant ones. He would therefore have liked to see in the last subparagraph of paragraph 19 the additional phrase: "an adequate, healthy envirotherapeutic (or climatotherapeutic) approach". Also, in paragraph 11, referring to what mothers needed to know, he would have liked to see a reference to how to prevent infection as well as when to seek care for it.

The meeting rose at 19:00.

TENTH MEETING

Thursday, 11 May 1995, at 9:00

Chairman: Professor N. FIKRI BENBRAHIM (Morocco)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

GENERAL REVIEW:[1] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58) (continued)

Appropriation section 5: Integrated control of disease (continued)

5.1 Eradication/elimination of specific communicable diseases (continued)

5.2 Control of other communicable diseases (continued)

Control of diarrhoeal diseases and acute respiratory infections: sick child initiative (Resolutions WHA40.34, WHA44.7 and EB95.R11; Document A48/13) (continued)

Dr OUEDRAOGO (Burkina Faso) commended the analysis in document A48/13 of the role of diarrhoeal diseases and acute respiratory infections in mortality of children under five years of age. Burkina Faso was implementing recently developed programmes for control of malaria and diarrhoeal diseases and had hosted an international symposium on social mobilization and communication to encourage oral rehydration therapy. Following the Bamako Initiative, health services had been restructured and health districts created in the management of which the constituent communities were much involved. Those measures had created a climate which reinforced disease control, and in particular the control of childhood diseases.

He noted with interest the technical cooperation planned between WHO and a small number of countries on integrated management of the sick child, a project in which his Government hoped to participate. Burkina Faso welcomed the involvement of international development agencies and donor organizations in implementing the integrated management initiative and hoped that sufficient resources would be mobilized so that countries in difficulty could obtain adequate support for their efforts to reduce mortality among "under-fives". He supported the draft resolution contained in resolution EB95.R11, with the amendments proposed.

Dr BELLAMY (United Kingdom of Great Britain and Northern Ireland) commended the report on integrated management of the sick child (document A48/13) which clearly illustrated the benefits of such an approach. WHO should be congratulated on its successful collaboration, both within the Organization and with other bodies, in particular UNICEF, UNDP and the World Bank; that collaboration should be maintained and coupled with the flexible use of all available resources.

Integrated management of the sick child was an enormous step forward from disease-specific approaches. Particularly noteworthy were the efforts to augment the technical guidelines with a wider range of interventions aimed at encouraging the prompt seeking and provision of appropriate care. That broad approach should be maintained.

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[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

His delegation supported the draft resolution proposed by the Executive Board in resolution EB95.R11.

Dr CICOGNA (Italy) paid tribute to the efforts that had made possible a dramatic decline in dracunculiasis in recent years. It remained to ensure that the disease had not occurred for five years in all endemic areas before its eradication could be confirmed; human and financial resources and a certain political will would be needed if the project was to succeed. Efforts to eliminate leprosy by the year 2000 had also achieved much success, although it was important not to become complacent. The progress made could be counted as a great achievement for humankind and it could only serve to strengthen the credibility of the Organization. The eradication of poliomyelitis also required concerted national and international effort. Immunization, laboratory support, monitoring and surveillance demanded resources, commitment and collaboration between all those involved. He asked how the funds available under heading 5.1 would be divided among the three major areas of disease control he had mentioned.

Italy endorsed the draft resolution proposed by the Executive Board in resolution EB95.R11. It also supported the sick child initiative but, in view of the multidisciplinary nature of the approach, he sought information on the kind of collaboration put in place and the different units and divisions involved.

Dr JEANFRANCOIS (France) believed that the report contained in document A48/13 should be studied in the context of the 1990 World Summit for Children, which had established 21 goals in order to reduce morbidity and mortality among children and provide them with an environment conducive to their survival and full development. In 1995, a mid-term assessment by each country of the action it had taken to achieve those goals would be carried out. Document A48/13 was a reminder that, despite the progress made, diarrhoeal diseases and acute respiratory infections remained the principal causes of infant morbidity and mortality even though they could be cured and, better, prevented for a modest sum. For that reason, France supported the plan of action put forward in the document, hoping that priority would be given to sick children and that the action plan would receive the necessary funds. Her delegation endorsed the draft resolution contained in resolution EB95.R11, with the amendments proposed by the delegations of Pakistan and the Netherlands.

Professor GUMBI (South Africa) also endorsed the draft resolution. She agreed on the need for an integrated approach to the care of sick children, based on accessibility of services, an expanded programme of immunization to control communicable diseases, and emphasis on integrated preventive, promotive and curative health care. Multidisciplinary action in collaboration with international agencies and donors was essential. She thanked WHO and other agencies for cooperation in promoting an integrated approach to health care delivery, which was of fundamental importance for sick children, and appealed for support for South Africa's attempts to control and contain an outbreak of hepatitis B.

Mr ZI Naiqing (China) said that the integrated management of diarrhoeal diseases and acute respiratory infections in children had proved to be an effective, economic and rapid method of reducing child mortality, a target set by the World Summit for Children in 1990. He hoped that WHO would further strengthen its collaboration with Member States and provide guidance on the formulation of programmes and measures adapted to the specific needs of countries. The Organization could also help to solve problems in implementing programmes and in reporting on control of such diseases as well as in training. International organizations should be encouraged to find extra financial support for the programme.

Dr DURHAM (New Zealand), while endorsing the draft resolution contained in resolution EB95.R11 and welcoming document A48/13, was concerned that both that report and the draft resolution failed to emphasize prevention. Prevention, like management, should be integrated and should embrace environmental factors such as water, sanitation, exposure to environmental tobacco smoke, food and nutrition, and immunization. While lending full support to the amendments proposed by the Netherlands in regard to prevention, she considered that reference should also be made in the draft resolution to an integrated approach to prevention.

Dr YAO SIK CHI (Malaysia) congratulated WHO on its pioneering research and the elaboration of guidelines and training material for integrated case management of the sick child at first-level health facilities.

Such material should not be restricted to diarrhoeal diseases and acute respiratory infections, but should also cover other important causes of child mortality, such as malnutrition, vaccine-preventable diseases, and malaria and other communicable diseases. That would make for a holistic approach to child care. With that proviso, his delegation could support the draft resolution proposed by the Executive Board.

Dr BASHI ASTANEH (Islamic Republic of Iran) expressed his country's appreciation for the work of WHO and other agencies in promoting the Expanded Programme on Immunization and his support for the programme for integrated management of the sick child.

He was concerned that many developing and least developed countries had had difficulty in sustaining childhood immunization programmes in recent years. One of the main causes of failure was the inability of some countries to procure vaccines because the decision of some vaccine-producing countries whether to donate or sell vaccines to needy countries was influenced by political considerations. He supported the children's vaccine initiative and believed that the regions should be self-sufficient in vaccine production.

The Islamic Republic of Iran, which had a long history of vaccine production, was currently self-sufficient in childhood vaccines and was in the process of developing new antigens. In 1994 and 1995, it had donated poliomyelitis vaccine for national immunization days to Afghanistan.

The Islamic Republic of Iran had adopted an integrated child health care policy and strongly favoured the sick child initiative, although it considered that more needed to be done to orient physicians towards that policy.

Elimination of vaccine-preventable and other diseases required close cooperation from Member States at regional and subregional level. His country, which was in the process of eradicating poliomyelitis and eliminating leprosy, neonatal tetanus and measles, was fully conscious of its role in supporting vaccination programmes in the MECACAR operation, a joint effort to eradicate poliomyelitis from the Middle East, the Caucasus and the central Asian republics.

Mr ACHOUR (Tunisia) approved the emphasis in document A48/13 on primary health care, healthy nutrition and breast-feeding as measures to reduce child mortality rates. Immunization and diarrhoeal disease control programmes had yielded positive results throughout the world, but the disparity between different regions made it essential to pursue and intensify the work. Tunisia, while supporting the draft resolution in resolution EB95.R11, and particularly the emphasis on the integrated management of the sick child, considered that there should be an additional paragraph on the need to promote further preventive action relating to the environment, sanitation, breast-feeding and healthy nutrition, and that subparagraph 2(3) should refer to strengthening, not merely maintaining, control activities.

Dr WEINBERGER (Austria) said the successful work to control diarrhoea and acute respiratory diseases provided a solid foundation on which to develop an integrated approach to the control of the major causes of childhood mortality. She was also pleased to note the degree of interprogramme cooperation within WHO, as well as the close collaboration with UNICEF. She supported the draft resolution in resolution EB95.R11 and would like to see further regular budget funds made available to implement the initiative in addition to the extrabudgetary funds referred to in subparagraph 3(6).

Dr GEORGE (Gambia) welcomed the sick child initiative, which called for strengthening peripheral community health services and primary health care in general as an alternative to the plethora of vertical programmes which were confusing the already disadvantaged health workers with different messages and disease-specific interventions. He appealed to donor agencies and nongovernmental organizations that had disease-specific projects to be more flexible and more responsive to a programme rather than a project approach.

Drugs and supplies for malaria, diarrhoea and acute respiratory infections were badly needed at the periphery so that the community health workers could treat the sick child at the earliest stage. In that connection he supported the Bamako Initiative. He welcomed the development of guidelines for the integrated management of the sick child; since those guidelines would in most cases be implemented by nurses, training manuals should be as simple and concise as possible. Finally, he asked whether the sick child initiative would benefit from the 5% shift in the allocation of resources. Gambia supported the draft resolution recommended by the Executive Board.

Professor LEOWSKI (Poland) also welcomed the integrated approach to the management of the sick child and supported the draft resolution. With regard to heading 5.1 in the proposed programme budget (document PB/96-97), he asked for clarification of the meaning of "eradication/elimination of specific communicable diseases".

Dr VIOLAKI-PARASKEVA (Greece), commending the report in document A48/13, said it was a fundamental right of all children in both developed and developing countries to have access to all forms of life-saving treatment, as well as to immunization and improved nutrition. Stressing the importance of the Expanded Programme on Immunization, she said it should examine ways of introducing new vaccines so that they might be made available to all children and that yet greater efforts should be made to improve the coverage of vaccination programmes.

Greece supported the draft resolution in resolution EB95.R11 and proposed that the word "on" should be inserted after the words "research-and-development" in subparagraph 3(2).

Professor DIF (Algeria) said that since 1986 his country had undertaken a national programme against childhood mortality in collaboration with WHO and UNICEF. The programme was based essentially on combating the main causes of mortality, namely diarrhoeal diseases and diseases controllable by vaccination. As a result of widespread immunization, particularly antimeasles vaccination which had been made compulsory in 1985, and the utilization of oral rehydration salts, childhood mortality had been reduced to 55 per 1000 among infants under one year of age within a space of five years. However, for the past two or three years it had remained at that level, partly owing to delay in implementing the programme for the control of acute respiratory infections, which were the main cause of childhood morbidity and mortality in Algeria, with a 35% case-fatality rate. Seminars and training workshops had been organized during the past year and two pilot areas had been identified for the experimental programme against acute respiratory infections, which would be extended as soon as material conditions permitted and would be integrated into the campaign against other causes of childhood mortality. His Government fully agreed with document A48/13.

Dr VOUMARD (United Nations Children's Fund) was pleased to report continuing dynamic and fruitful collaboration with the Global Programme for Vaccines and Immunization. UNICEF had participated actively in the recent MECACAR operation for poliomyelitis eradication mentioned by the delegate of the Islamic Republic of Iran, and collaboration with WHO was expanding to respond to the diphtheria epidemic in eastern Europe and central Asia. Another example of good collaboration between the two agencies was a new joint initiative for improving the safety of injections.

The Children's Vaccine Initiative also continued to provide an effective medium for multi-agency cooperation on vaccine research and development, promoting self-sufficiency in vaccine production and ensuring the availability of vaccines for children in developing countries. With the adoption of the World Summit for Children programme of action, UNICEF had committed itself to assisting governments in their efforts to reduce child mortality and morbidity so as to achieve the end-of-decade goals and targets.

The Director-General's excellent progress report (document A48/13) highlighted the fact that the largest contributors to childhood mortality were diarrhoeal diseases and acute respiratory infections, followed by malaria, measles and malnutrition.

While it was in the home that basic hygiene and oral rehydration therapy must be well understood and practised, the ability of families to make and keep their children healthy also depended on access to health-care services and on the quality of those services. It was crucial that a package of essential and integrated health services to cope with the priority health problems of children should be universally available. The integrated management of the sick child was a new tool to combat the immediate causes of child death more effectively without losing sight of the underlying causes, namely unhealthy practices and lack of access to essential health services. UNICEF fully agreed with the broad support the integrated management of the sick child was receiving and welcomed the cost-cutting interest and collaboration generated by it. It would continue to help WHO's efforts to that end by providing support for improved access to information, essential drugs, vaccines, equipment and medical supplies, and transport for urgent referrals. At country level, UNICEF was making wide use of WHO's managerial tools, including technical guidelines and training materials, and looked forward to further developing its collaboration with WHO and other partners. UNICEF fully supported the draft resolution under consideration.

Professor BERTAN (representative of the Executive Board) said that the Board appreciated the joint efforts of WHO, UNICEF and other bodies to initiate the integrated management of the sick child. The Board had drawn special attention to the problem of malnutrition, which was the underlying cause of acute respiratory disease and diarrhoeal disease. It had also stressed the importance for the implementation and success of that initiative of a commitment to it by Member States.

Dr KABORE (Regional Office for Africa) said that the preceding discussion was of particular importance for the African Region, dealing as it did with diseases that caused high mortality and led to a heavy workload for health personnel. Although some success had been achieved in recent years, mortality still remained high, vaccination coverage in many countries was being reduced, and diarrhoeal diseases and acute respiratory infections were still the major causes of death for children below the age of 5.

To meet the situation, the Regional Office had reorganized its Expanded Programme on Immunization in order to support States on a geographical basis defined by epidemiological criteria. That, indeed, was the basis for intensified support both for the Expanded Programme on Immunization and for poliomyelitis eradication. For diarrhoeal diseases and acute respiratory infections, it had developed strategies of support for countries with a view to strengthening their capacity, their self-reliance and the sustainability of programmes with a view to the future implementation of the integrated management of the sick child. The sick child initiative responded to the needs of many countries in the Region. Technical support would be accorded to them by the Regional Office, in close collaboration with headquarters if needed. He hoped that the new initiative would not divert funds from the existing programmes dealing with diarrhoeal diseases and acute respiratory infections, which formed a solid basis for its implementation.

Dr HENDERSON (Assistant Director-General) expressed his appreciation for the support of delegates for the activities proposed; all comments and suggestions had been noted. In reply to the delegates of the United States of America and Gambia, he said that at headquarters level the diarrhoeal disease and acute respiratory disease programmes would not receive any of the 5% of funds the Executive Board had asked should be shifted to priority programmes; a small increase had already been proposed in the programme budget submitted to the Board before it had requested the transfer of a further 5%. The programmes that did benefit from the 5% shift were identified in document A48/17, section II.2. Delegates would note there substantial increases at regional level for the control of other communicable diseases which would be used in part to support diarrhoeal diseases and acute respiratory disease control programmes, including integrated management of the sick child.

In reply to the question from the delegate of Italy, it was difficult to know what the distribution of funds at regional and country level would be between dracunculiasis, leprosy and poliomyelitis, but at headquarters it was approximately two parts to dracunculiasis, one part to leprosy and one part to poliomyelitis. All three programmes received quite substantial extrabudgetary resources. For dracunculiasis none of the extrabudgetary resources came to WHO itself; they were invested directly by other bodies such as UNICEF, UNDP and Global 2000. Leprosy and poliomyelitis, too, received direct funding from other agencies but also received funding through WHO.

In reply to the delegate of Poland, who had asked about the meaning of eradication and elimination, he said that eradication meant zero cases along with the elimination of the disease-causing agents. Thus for poliomyelitis and dracunculiasis the aim was to have no cases and the complete destruction of the organism causing the diseases. For leprosy and neonatal tetanus, the defined goal was elimination as a public health problem, which for leprosy meant less than 1 case per 10 000 population in each country and for neonatal tetanus less than 1 case per 1000 live births in each district. It was hoped that total elimination of those two diseases would be achieved in future even though the disease-causing organisms for tetanus could not be completely eradicated.

Dr TULLOCH (Division of Diarrhoeal and Acute Respiratory Disease Control) thanked delegates for their statements of support for the programme on integrated management of the sick child. The question by the Australian delegate regarding collaboration with UNICEF had, he thought, largely been answered in the statement made by the UNICEF representative. Collaboration with UNICEF had been excellent. In answer to the Italian delegate's question about collaboration within WHO, that too was excellent. The many WHO programmes concerned were listed in the footnote to paragraph 22 of document A48/13.

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Executive Board in its resolution EB95.R11, with the amendments proposed in the course of the discussion.

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

Appropriation section 3: Health services development (continued)

3.2 Human resources for health (Resolution EB95.R6) (continued from the sixth meeting, section 1)

The CHAIRMAN invited the Committee to consider the following revised text, prepared by a drafting group, of the draft resolution recommended to the Health Assembly by the Executive Board in its resolution EB95.R6:

The Forty-eighth World Health Assembly,

Considering the need to achieve relevance, quality, cost-effectiveness and equity in health care throughout the world;

Mindful of the importance of an adequate number and mix of health workforce to achieve optimal health care delivery;

Recognizing the importance of medical education being put into the context of multidisciplinary education and of primary health care being provided in a multidisciplinary way;

Recognizing the important influence of medical practitioners on health care expenditure and in decisions to change the manner of health care delivery;

Aware that medical practitioners can play a pivotal role in improving the relevance, quality and cost-effectiveness of health care delivery and in the attainment of health for all;

Concerned that current medical practices should be adapted in order to respond better to health care needs of both individuals and communities, using existing resources;

Acknowledging the need for medical schools to improve their contribution to changes in the manner of health care delivery through more appropriate education, research and service delivery, including preventive and promotional activities in order to respond better to people's needs and improve health status;

Recognizing that reforms in medical practice and medical education must be coordinated, relevant and acceptable;

Recognizing the important contribution that women make to the medical workforce;

Considering WHO's privileged position in facilitating working relations between health authorities, professional associations and medical schools throughout the world,

1. URGES Member States:

(1) to review, within the context of their needs for human resources for health, the special contribution of medical practitioners and medical schools in attaining health for all;

(2) to collaborate with all bodies concerned, including professional associations, in defining the desired profile of the future medical practitioner and, where appropriate, the respective and complementary roles of generalists and specialists and their relations with other primary health care providers, in order to respond better to people's needs and improve health status;

(3) to promote and support health systems research to define optimal numbers, mix, deployment, infrastructure and working conditions to improve the medical practitioner's relevance and cost-effectiveness in health care delivery;

(4) to support efforts to improve the relevance of medical educational programmes and the contribution of medical schools to the implementation of changes in health care delivery, and to reform basic education in the spirit and roles of general practitioners for their contributions towards primary health care oriented services;

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[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.12.

2. REQUESTS the Director-General:

(1) to promote coordinated efforts by health authorities, professional associations and medical schools to study and implement new patterns of practice and working conditions that would better enable general practitioners to identify the health needs of the people they serve and to respond to these needs to enhance the quality, relevance, cost-effectiveness and equity of health care;

(2) to support the development of guidelines and models that enable medical schools and other educational institutions to enhance their capacity for initial and continuing training of the medical workforce and reorient their research, clinical and community health activities to make an optimal contribution to changes in the manner of health care delivery;

(3) to respond to requests from Member States for technical cooperation in the implementation of reforms in medical education and medical practice by involving networks of WHO collaborating centres and nongovernmental organizations as well as using available resources within WHO;

(4) to encourage and facilitate coordination of worldwide efforts to reform medical education and medical practice in line with the principles of health for all, by cosponsoring consultative meetings and regional initiatives to put forward appropriate policies, strategies and guidelines for undergraduates and postgraduates, by collecting and disseminating relevant information and monitoring progress in the reform process;

(5) to pay particular attention to the needs of many countries that do not have facilities to form their own medical practitioners;

(6) to present to the Executive Board at its ninety-seventh session a report on the reorientation of education and practice of all other primary health care providers for health for all, complementary to the reorientation of medical education and practice in this resolution, and to request the Executive Board to present its recommendations on this subject to the Forty-ninth World Health Assembly.

Ms NESBITT (Australia) pointed out that the word "form" in subparagraph 2(5) ought more properly to read "train".

Dr SALMON (United States of America) felt that subparagraph 2(6) did not focus adequately on the specific results at which the resolution aimed, particularly since the Committee's discussion of medical education had, *inter alia*, acknowledged the importance of educating the nursing and midwifery workforce. Her delegation therefore suggested the following amendments to that subparagraph: the replacement of the expression "all other primary health care providers" by "the global nursing and midwifery workforce"; and the insertion, after the word "subject", of the words "and suggestions for the study of other key primary health care provider groups".

Dr ABELA-HYZLER (Malta) agreed in general with the comments of the delegate of the United States of America. However, since it might be practically difficult for a report to be presented to the Executive Board as early as its ninety-seventh session on the reorientation of the education of all health care provider groups, as proposed by the United States of America, he would suggest that subparagraph 2(6) should contain, first a request to the Director-General to present to the Executive Board at its ninety-seventh session a report on the reorientation of the medical education of the global nursing and midwifery workforce and at its ninety-ninth session a similar report relating to all other primary health care providers; and secondly, a request to the Executive Board to present its recommendations on the two reports to the Forty-ninth and Fiftieth World Health Assemblies respectively.

Mrs LORD (Canada) and Dr VIOLAKI-PARASKEVA (Greece), stressing the importance of a primary health care orientation for all health care providers, endorsed the views expressed by the United States delegate and approved the amendment proposed by Malta.

Professor GUMBI (South Africa) said she had no quarrel with the multidisciplinary team approach to the education of health professionals; she was, however, concerned at the possibly limited connotations of the terms "medical education" and "medical practice". To her mind, it would be preferable to speak of

"health personnel" education and "health care practice" for health for all. That should help to put an end to the compartmentalization which so many found to be counterproductive.

Dr MUKHERJEE (India) generally concurred with the remarks by the delegate of South Africa. Recalling, however, that consultations on the draft resolution had resulted, *inter alia*, in a compromise agreement to include a preambular statement on the importance of primary health care, he questioned whether it was appropriate to single out nurses, midwives or other primary health care providers in a resolution that dealt essentially with medical education and medical practice.

Dr THEIN MAUNG MYINT (Myanmar) shared the view that the education of the nursing and midwifery workforce was of great relevance to primary health care. At the same time, he queried the relevance of that issue to a draft resolution on medical education and medical practice.

The CHAIRMAN suggested that an informal working group of interested delegations might attempt to arrive at a generally acceptable text.

It was so agreed. (For resumption see page 149.)

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

4.1 Family/community health and population issues (continued)

Maternal and child health and family planning: quality of care (Resolutions WHA47.9 and EB95.R10; Document A48/10[1]) (continued from the seventh meeting, page 92)

Dr HU Ching-Li (Assistant Director-General) recalled that several delegations had proposed that the programme budget heading under discussion should be retitled "Reproductive health". However, the heading in question encompassed several programmes, of which reproductive health was only one. The drafting group appointed to prepare a revised text of the draft resolution contained in document A48/10 had recommended that the Director-General should take the necessary managerial and editorial steps to indicate that reproductive health was a major programme under heading 4.1. That recommendation would be followed up by the Global Policy Committee immediately after the Forty-eighth Health World Assembly.

The CHAIRMAN invited the Committee to consider the revised draft resolution, which read:

The Forty-eighth World Health Assembly,

Noting the report by the Director-General on maternal and child health and family planning: quality of care - reproductive health: WHO's role in the global strategy;

Recalling resolutions WHA32.42, WHA38.22, WHA40.27, WHA41.9, WHA42.42, WHA43.10, WHA47.9 and EB95.R10 concerned with many different aspects of reproductive health;

Welcoming the Director-General's report on collaboration within the United Nations system: the International Conference on Population and Development, and in particular the WHO position paper on health, population and development prepared for the Conference;

Noting United Nations General Assembly resolution 49/128, on the report of the International Conference on Population and Development (ICPD), particularly operative paragraph 22 which requests the specialized agencies and all related organizations of the United Nations system to review and where necessary adjust their programme and activities in line with the programme of action;

Recognizing that, as a central component of women's health, reproductive health needs to be promoted by WHO at the forthcoming Fourth World Conference on Women in Beijing and other international forums;

[1] Document WHA48/1995/REC/1, Annex 2.

Noting the present fragmentation of reproductive health activities within WHO, and calling for a more coherent approach in priority setting, programme development and management,

1. ENDORSES the role of the Organization within the global reproductive health strategy, as expressed in document A48/10;

2. REAFFIRMS the unique role of the Organization with respect to advocacy, normative functions, research and technical cooperation in the area of reproductive health;

3. UNDERLINES the need to coordinate with other agencies of the United Nations system to provide international support for the development and implementation of reproductive health strategies in countries in keeping with the principles elaborated in the Programme of Action of the ICPD and in particular with full respect for the various religious and ethical values and cultural backgrounds and in conformity with universally recognized human rights;

4. URGES Member States to further develop and strengthen their reproductive health programmes, and in particular:

(1) to assess their reproductive health needs and develop medium- and long-term guiding principles on the lines elaborated by WHO, with particular attention to equity and to the perspectives and participation of those to be served and with respect for internationally recognized human rights principles;

(2) to strengthen the capacity of health workers to address, in a culturally sensitive manner, the reproductive health needs of individuals, specific to their age, by improving the course content and methodologies for training health workers in reproductive health and human sexuality, and to provide support and guidance to individuals, parents, teachers and other influential persons in these areas;

(3) to monitor and evaluate, on a regular basis, the progress, quality and effectiveness of their reproductive health programmes, reporting thereon to the Director-General as part of the regular monitoring of the progress of health-for-all strategies,

5. REQUESTS the Director-General:

(1) to include the progress made in reproductive health in his regular reporting of the progress of health-for-all strategies;

(2) to continue his efforts to increase the resources for strengthening reproductive health in the context of primary health care, including family health;

(3) to develop a coherent programmatic approach for research and action in reproductive health and reproductive health care within WHO to overcome present structural barriers to efficient planning and implementation. This would be carried out in close consultation with Member States and interested parties, and a report submitted to the ninety-seventh session of the Executive Board and the Forty-ninth World Health Assembly;

(4) to promote ethical practices in the field of human reproduction to protect the health and human rights of individuals in different social and cultural settings.

Dr ABELA-HYZLER (Malta) said that his reservations on certain views expressed in document A48/10 were well known to the Committee. If a vote was taken on the resolution he would abstain.

Dr VAN ETTEN (Netherlands) proposed the insertion of the word "international" before the words "human rights" in paragraph 3 of the draft resolution.

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

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.10.

4.2 Healthy behaviour and human health (continued)

Tobacco or health (Resolutions WHA43.16, WHA44.26, WHA46.8 and EB95.R9; Document A48/9) (continued from the eighth meeting, page 105)

The CHAIRMAN invited the Committee to consider the following revised text, prepared by a drafting group, of the draft resolution recommended to the Health Assembly by the Executive Board in its resolution EB95.R9:

> The Forty-eighth World Health Assembly,
>
> Recalling and reaffirming resolutions WHA33.35, WHA39.14, WHA43.16 and WHA45.20, all calling for comprehensive multisectoral, long-term tobacco strategies and outlining the most important aspects of national, regional and international policies and strategies in this field;
>
> Recognizing the work carried out by the Organization in the field of tobacco or health, and noting that the plan of action of the "tobacco or health" programme for 1988-1995 comes to an end this year;
>
> Noting that the Director-General and the Secretariat contributed to the success of the Ninth World Conference on Tobacco and Health (Paris, October 1994) at which an international strategy for tobacco control was adopted covering the essential aspects of WHO policy in this field: curbing of the promotion of tobacco products, demand reduction particularly among women and young people, smoking cessation programmes, economic policies, health warnings, regulation of tar and nicotine content of tobacco products, smoke-free environments, and marketing and monitoring,
>
> 1. COMMENDS the International Civil Aviation Organization response to ban smoking on all international flights as of 1 July 1996;
>
> 2. URGES those Member States that have already successfully implemented all or most of a comprehensive strategy for tobacco control to provide assistance to WHO, working with the United Nations system focal point on Tobacco or Health (located in United Nations Conference on Trade and Development), so that these bodies can effectively coordinate the provision of timely and effective advice and support to Member States seeking to improve their tobacco control strategies, including health warnings on exported tobacco products;
>
> 3. REQUESTS the Director-General:
>
> (1) to report to the Forty-ninth World Health Assembly on the feasibility of developing an international instrument such as guidelines, a declaration, or an International Convention on Tobacco Control to be adopted by the United Nations, taking into account existing trade and other conventions and treaties;
>
> (2) to inform the Economic and Social Council of the United Nations of this resolution;
>
> (3) to strengthen WHO's role and capacity in the field of "tobacco or health" and submit to the Forty-ninth World Health Assembly a plan of action for the tobacco or health programme for the period 1996-2000.

Dr VIOLAKI-PARASKEVA (Greece) proposed the insertion of the word "advocacy" before the word "role" in subparagraph 3(3).

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

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.11.

Appropriation section 5: Integrated control of disease (resumed)

5.1 Eradication/elimination of specific communicable diseases (resumed)

5.2 Control of other communicable diseases (resumed from page 136)

New, emerging, and re-emerging infectious diseases (Resolutions WHA39.27, WHA44.8, WHA45.35, WHA46.6, WHA46.31, WHA46.32, WHA46.36, EB95.R7 and EB95.R12; Document A48/15[1])

The CHAIRMAN drew the Committee's attention to three draft resolutions. Two had been recommended by the Executive Board: one on the prevention of hearing impairment in its resolution EB95.R7; the other on the prevention and control of new, emerging and re-emerging infectious diseases in its resolution EB95.R12. The third, which was on the revision and updating of the International Health Regulations, was proposed by Bahrain, Oman, Qatar and the United Arab Emirates. It read as follows:

> The Forty-eighth World Health Assembly,
>
> Recalling the adoption of the International Health Regulations by the Twenty-second World Health Assembly in 1969, their amendment by the Twenty-sixth World Health Assembly in 1973 with provisions for cholera, and their further revision by the Thirty-fourth World Health Assembly in 1981 to exclude smallpox in view of its global eradication;
>
> Aware that plague, cholera and yellow fever are designated as diseases subject to the Regulations;
>
> Recognizing that the purpose of the Regulations is to ensure the maximum possible protection against infection with minimum interference in international traffic;
>
> Recognizing further that the Regulations seek to ensure such protection by preventing infection from spreading from countries where it exists or by containing it upon arrival;
>
> Noting that there is a continuous evolution in the public health threat posed by infectious diseases related to the agents themselves, the facilitation of their transmission in changing physical and social environments and to diagnostic and treatment capacities;
>
> Concerned about the threat posed by the considerable increases in international travel, especially commercial air transport, which may serve to disseminate infectious diseases rapidly;
>
> Fully aware that the strengthening of epidemiological surveillance and disease control activities at national level is the main defence against the international spread of communicable diseases,
>
> 1. URGES Member States to participate in revision of the International Health Regulations, contributing national expertise, experience and suggestions;
>
> 2. URGES other specialized agencies and organizations of the United Nations system, nongovernmental organizations and other groups concerned to cooperate in revision of the International Health Regulations;
>
> 3. REQUESTS the Director-General:
>
> (1) to take steps to prepare a revision of the International Health Regulations and to submit it to the Health Assembly in accordance with Article 21 of the Constitution.

Dr HENDERSON (Assistant Director-General) said that the plague outbreak in India in 1994 had brusquely revealed the deficiencies that existed in national and international readiness to respond quickly but rationally to cases of infectious disease which posed, or appeared to pose, a threat to public health. Although the International Health Regulations provided a sound basis for responding to such an outbreak, few were really familiar with them. That situation must be remedied through increased WHO support, in coordination with agencies such as ICAO. That included support for national preparedness for infectious disease

[1] Document WHA48/1995/REC/1, Annex 3.

emergencies, as well as action within WHO itself to ensure more effective responses. As part of that effort, WHO would review the International Health Regulations, and later in the year would hold an informal consultation with ICAO, among other bodies. After that, and in the light of the results of a second consultation with ICAO in 1995, on aircraft disinsection, the Committee on International Surveillance of Communicable Diseases would be convened to consider and propose revisions to the Regulations for adoption by the Health Assembly, probably in 1997 or 1998. The draft resolution to which the Chairman had drawn attention would support revision of the Regulations.

Dr THYLEFORS (Programme for the Prevention of Deafness and Hearing Impairment), referring to the draft resolution proposed in its resolution EB95.R7 by the Executive Board, said that prevention of hearing impairment was a very modest activity in WHO and based almost entirely on extrabudgetary funding and collaboration with an international network of nongovernmental organizations. The action proposed in the draft resolution, should it be adopted, would continue to be managed in that way.

Professor LOUKOU (Côte d'Ivoire) thanked the Director-General for his report on prevention and control of new, emerging and re-emerging diseases (document A48/15), and expressed support for the draft resolution on the subject recommended in resolution EB95.R12. He drew attention to the incidence of Ebola virus infection among Liberian refugees in Côte d'Ivoire and to the spread of Burili ulcer for lack of any therapy or knowledge of its epidemiology and physiopathology. He reiterated his country's appeal for WHO support in the prevention and control of those infections.

Dr DURHAM (New Zealand) supported the draft resolution on the prevention of hearing impairment, a subject on which New Zealand was currently preparing its own guidelines. She also supported the draft resolution on the revision and updating of the International Health Regulations.

The draft resolution proposed by the Executive Board on new, emerging and re-emerging diseases was a very important one and it, too, had New Zealand's full support. The frequency of resistance to antimicrobials in bacterial pathogens was increasing alarmingly; to prevent the emergence of resistant pathogens, antimicrobial medication must be readily available, correctly prescribed and dispensed, and correctly and completely consumed by the patient. Errors due to unfamiliarity, ignorance, carelessness, obstructive policies and misunderstandings might interfere with the process at any level. She therefore suggested that in subparagraph 1(4) of the draft resolution contained in resolution EB95.R12 the phrase "prescription and availability" should be replaced by "prescription, availability and administration", in order to reflect the scope of activity that was necessary.

Mrs LORD (Canada) commended WHO on its efforts to draw global attention to new, emerging and re-emerging infectious diseases and to mobilize international energies for improved surveillance, strengthened laboratory services and effective responses. As the human population increased, natural ecological boundaries seemed to disappear and all Member States became vulnerable to new pathogens and the increased virulence of established microbial agents. As a country built on immigration, Canada was particularly concerned by the problem and had therefore made a modest contribution to WHO to enhance programmes on emerging infectious diseases. Through the strengthening of national laboratory services, rapid collection and dissemination of global surveillance information, the effective use of collaborating centres and the coordination of international responses to new and emerging infectious diseases, WHO had a unique and crucial role to play. She strongly supported the draft resolution proposed by the Executive Board in resolution EB95.R12.

She also expressed her strong support for the draft resolution contained in resolution EB95.R7. New evidence suggested that the global burden resulting from hearing impairment was higher than previously thought and that much of the problem was preventable. She welcomed the interest shown by nongovernmental organizations in supporting WHO and country activities in that area, in particular the International Federation of Otolaryngological Societies.

Mr ORDING (Sweden) endorsed the draft resolution on the revision and updating of the International Health Regulations; such a revision would be appropriate and timely.

Dr KHOJA (Saudi Arabia) thanked the Director-General for the preparation of documents A48/13 and A48/15. Saudi Arabia had undertaken to establish a communicable disease prevention programme, and in 1994 there had been no cases of diseases such as cholera in the country. The tuberculosis vaccination campaign was continuing. Saudi Arabia was fully informed on the situation in neighbouring countries with respect to communicable diseases, including emerging and re-emerging diseases, thanks to a regional and international system for the exchange of information. A programme had been put in place to prevent the transmission of communicable diseases, and particularly of cholera during the pilgrimage period. It was based on extensive cooperation between various ministries, WHO and other international organizations concerned; water treatment and measures to clean up the environment; greater emphasis on clinical and preventive treatment; improved cooperation between Saudi Arabia and the Centers for Disease Control and Prevention in the United States of America; and measures to control dengue.

Despite the best efforts of the international community, including WHO, tuberculosis had become a global emergency and was the main cause of mortality in many countries. He therefore stressed the importance of integrated health programmes, especially for primary health care.

He proposed three additions to the draft resolution contained in resolution EB95.R12: the words "early notification" after "disease detection" in paragraph 1(3); the words "and promotion in such specialization" at the end of paragraph 1(5) and the words "case definition," before "surveillance information" in paragraph 3(2). With those amendments, he supported the draft resolution.

Dr MUKHERJEE (India) recalled that in September-October 1994 a focal outbreak of plague had occurred in western India, with a few satellite cases elsewhere in the country. Such incidents occurred regularly in all parts of the world. The situation had been quickly brought under control through the intensive efforts of the Government and all the agencies concerned. Yet India had faced serious difficulties when many countries had over-reacted by stopping airline flights without notice and discontinuing the import of goods, even though India was implementing the statutory International Health Regulations. He thanked WHO, the United States of America and the Russian Federation for their timely support.

To prevent a similar situation from arising in the future, he proposed that in the draft resolution contained in resolution EB95.R12 the words "and prompt dissemination of relevant information among all Member States" should be added at the end of subparagraph 3(1), and that in subparagraph 3(2) the final clause be amended to read: "to coordinate their implementation among interested Member States, agencies and other groups". With those amendments, he expressed support for the draft resolution.

Dr MAHJOUR (Morocco) said he supported the draft resolution contained in resolution EB95.R7, given the importance of deafness prevention, particularly among children. Morocco, with the assistance of WHO, had just set up a national programme which aimed to integrate deafness control into primary health care services.

Strongly supporting the draft resolution contained in resolution EB95.R12, he suggested that, if the reference to "outbreaks" were omitted from subparagraphs 1(1) and 1(2), the text could apply to isolated cases as well as to outbreaks.

Referring to paragraph 389 of document PB/96-97, he said that research was an important priority for developing countries in the prevention and control of tropical diseases.

Ms MIDDELHOFF (Netherlands) welcomed and strongly supported document A48/15. With regard to the steps to be taken to establish a global plan to combat emerging infectious diseases, she felt the focus should be on a global surveillance network aiming at early warning, and thus on the first and the second of the four specific goals proposed in paragraph 7 of the document. A strong and stimulating approach by WHO in that area was much needed. WHO should also coordinate with other international organizations such as the European Union, and should conduct prevention, treatment and research activities within existing programmes and budgets. She supported the draft resolution contained in resolution EB95.R12.

With regard to the draft resolution on the revision and updating of the International Health Regulations, she proposed the insertion after the fifth preambular paragraph of a new paragraph reading: "Noting that regulations should be based on sound epidemiological and public health expertise".

Dr BASHI ASTANEH (Islamic Republic of Iran) said that all the steps for future action proposed in document A48/15 seemed meaningful and practical. The first priority was the strengthening of global surveillance, and for that a system must be set up the most important component of which was notification. The Islamic Republic of Iran had recently introduced a community-based surveillance approach within the national disease surveillance system. He felt that legislation on the obligatory notification of diseases should be reformed.

The focus should be on training public health officers to deal competently with communicable diseases rather than on training increasing numbers of specialists, and the control of communicable diseases should be community-based. He fully agreed with the draft resolution recommended in resolution EB95.R12.

Regarding the draft resolution recommended in resolution EB95.R7, greater importance should be attached to the prevention of deafness of congenital etiology, which required long-term rehabilitative care including the provision of special education.

Dr VIOLAKI-PARASKEVA (Greece) suggested that in subparagraph 1(1) of the draft resolution proposed by the Executive Board in resolution EB95.R7, the words "as well as in the elderly" should be inserted after "early detection in children,".

Turning to paragraphs 392 and 442 of the proposed programme budget (document PB/96-97), she drew attention to the prevalence of several major zoonoses in the Mediterranean area and outlined some of the control measures being undertaken.

Regarding new and emerging infectious diseases, she agreed that it was essential to strengthen international capacity for their prevention and control. Accordingly, she suggested three amendments to the draft resolution proposed by the Executive Board in resolution EB95.R12: in subparagraph 1(1) the prompt identification of outbreaks should be mentioned; a new subparagraph 1(7) should be inserted, reading: "to control outbreaks and promote accurate and timely reporting of cases at national and international levels"; and a new subparagraph 3(5) should be inserted, reading:

to improve programme monitoring and evaluation at national, regional and global levels

the current subparagraph 3(5) becoming subparagraph 3(6).

Dr HAMDAN (United Arab Emirates) said that in an age of rapidly advancing technology and even more rapid communications and international travel, new methods were needed to prevent and control the spread of communicable diseases. Member States had a duty to prevent both their exportation and their importation. The draft resolution on the revision of the International Health Regulations, whose sponsors had been joined by Canada and Saudi Arabia, was intended to contribute to that end.

Turning to document A48/15, he considered the affirmation in paragraph 2 that the Indian plague outbreak had threatened other countries in South-East Asia to be an understatement; modern travel facilities were such that it had threatened all countries.

Dr MAREY (Egypt) regretted that document A48/15 did not list the causes or vectors of infectious diseases, proposed no action to combat their transmission, and suggested no measures to ensure they did not recur within a particular region. The programme for communicable disease control in Egypt embraced zoonoses control and measures had been taken governing the import of animals. He supported the draft resolutions contained in resolutions EB95.R7 and EB95.R12.

Mr HALIM (Bangladesh) said that the largely preventable problem of hearing impairment was growing: about 112 million people in the world were estimated to suffer from moderate to serious hearing loss. The draft resolution contained in resolution EB95.R7 reflected the worldwide concern about the problem and proposed useful measures to deal with it. In line with those proposals, a project had been begun in Bangladesh to train personnel in primary ear care and the elimination of preventable causes of deafness and to create public awareness about disabilities and handicaps.

Dr KEY (United Kingdom of Great Britain and Northern Ireland) commented that document A48/15 was useful in raising public awareness about the continuing threat that infectious diseases represented for public health and about the importance of maintaining measures to control them. The United Kingdom supported many of the proposals contained in the draft resolution recommended in resolution EB95.R12 but

suggested that they should be looked at carefully in the context of the available resources and that any ensuing action should be taken as part of other initiatives in the field of communicable diseases.

Professor DIF (Algeria) also supported the draft resolution contained in resolution EB95.R12, which dealt with matters directly affecting his country. Implementation of the expanded programme on immunization over the preceding 20 years had resulted in decreased prevalence and even elimination of certain diseases, such as diphtheria, measles and poliomyelitis. Within the last three years, however, diphtheria had re-emerged owing to the fact that 5-15% of people had missed being vaccinated over the previous 20 years and to inadequacies in the cold chain. In addition, the economic crisis had interrupted the supply of vaccine. A plan to revitalize the expanded programme on immunization was being implemented, based primarily on regular delivery of vaccine supplies through WHO and UNICEF and on strengthening the cold chain and the intervention capacity of the mobile teams.

An epidemic of brucellosis had affected livestock-raising areas over the previous three years, and the disease was becoming the second public health problem in Algeria. A programme to combat zoonoses, including brucellosis, was in progress, under the leadership of the Ministries of Health and Agriculture and local communities. As other diseases, such as malaria, sexually transmitted diseases and AIDS, were likely to be introduced or reintroduced owing to population movements in the south of the country, epidemiological monitoring stations, to which mobile teams were attached for local intervention, had been set up under a cooperative programme with UNDP.

Mr CHAUDHRY (Pakistan) said that a possible cause of the emergence and re-emergence of diseases was changing lifestyles, including overcrowding and unhygienic ways of living. Pakistan supported the draft resolution contained in resolution EB95.R12, but considered it might be improved by a mention of action to change that situation. Thus a new subparagraph 1(7) might be added, reading:

> to develop plans for the promotion of productive lifestyles, stressing protection of the environment, use of religious teaching and principles of public health.

Ms GIBB (United States of America) applauded the commitment in document A48/17 to developing a plan of action against emerging and re-emerging infectious diseases. The current outbreak of a haemorrhagic fever in Zaire showed that such a plan should be drawn up and implemented as soon as possible. The draft resolution contained in resolution EB95.R12 indicated that the importance of enhanced global surveillance had been well understood, that every effort must be made to ensure prudent, rational use of antibiotics in order to avoid widespread microbial resistance, and that rapid diagnostic tests should be developed and made available to all countries. The ability of countries to defend themselves against microbes was closely related to the global state of biomedical research; the plan that was being developed should include provision for research and training that would allow an effective, rapid response to infectious disease emergencies. In order to ensure that the essential supplies needed for prevention, diagnosis and treatment were available, she proposed that the words "accurate laboratory diagnosis and" should be added in subparagraph 3(2) of the draft resolution before the words "prompt dissemination". She also proposed the addition of a new subparagraph 3(4) reading:

> to establish strategies enabling rapid national and international responses to investigate and to combat infectious disease outbreaks and epidemics including identifying available sources of diagnostic, preventive and therapeutic products meeting relevant international standards. Such strategies should involve active cooperation and coordination among pertinent organizational programmes and activities including those of the Global Programme for Vaccines and Immunization, the Action Programme on Essential Drugs and the Division of Drug Management and Policies;.

The following subparagraphs would be renumbered accordingly.

Dr CICOGNA (Italy) noted that malaria was not specifically mentioned in the annotated list of programme budget headings contained in Annex 1 of document A48/17, although as a major scourge of mankind it was considered a priority in the Ninth General Programme of Work. It was not clear whether malaria was subsumed under heading 5.2 as a "vaccine-preventable" disease, which would be an over-optimistic view, or under "activities in vector control"; if the latter were the case, it should be recalled that vector control was only one component of the strategy for malaria control. He commended the global

malaria control strategy, mentioned in paragraph 427 of document PB/96-97, and noted that implementation might begin in areas of unstable malaria, where intervention was more likely to be successful. Strengthening of local health services, operational research and the provision of technical support for planning, implementing and evaluating country programmes were all important activities, provided that capacity was developed at the national level through effective training of health personnel. Training at all levels, from laboratory staff to senior managerial personnel, was a fundamental element in malaria control, as had been pointed out by the Executive Board.

He expressed deep concern about the lack of detail in the proposed programme budget. Exactly how much, for example, was to be allocated to the control of malaria among the large number of communicable diseases included under heading 5.2? He for his part wanted to be able to inform his Minister of Health how much was allocated to priorities in which Italy was particularly interested and to which it contributed financially each year. With regard to tuberculosis, which was becoming more prevalent in industrialized and developing countries alike, he asked how much of the budget under the wide-ranging heading 5.2 would be allocated to that disease and whether part of the 5% of the regular budget that was to be reallocated would be made available for the programme on tuberculosis.

Noting that the veterinary public health activities of WHO relied on a network of specialized centres, he inquired with which other international organizations the Organization collaborated, why there was concentration on only a few zoonoses (for instance, limiting the work on food hygiene to salmonelloses and ignoring problems relating to environmental hygiene), what were the activities of the Mediterranean Zoonoses Control Centre, in Athens, in which Italy was particularly interested, and which countries participated in its programme. In Italy, the Ministry of Health was responsible for veterinary services, including veterinary public health, animal health and well-being, and animal experimentation. Italy supported the veterinary public health activities of WHO and hoped that they would be strengthened.

Dr MBAROUK (United Republic of Tanzania) said that lymphatic filariasis was a major cause of ill health in many parts of his country. Although no recent data were available on the endemicity of the disease, information from the mid-1970s showed infection rates of at least 20% in the areas that had been studied. In endemic areas, lymphangitis, lymphoedema and hydrocele were very common and became more so with age. In some areas of high endemicity, very high parasite densities were accompanied by very high morbidity. Recent studies in some parts of Dar-es-Salaam had shown high infection rates in areas where the population had recently increased considerably.

Dwelling in some detail on the problem of Bancroftian filariasis, he said that a tradition in health research had been established in the United Republic of Tanzania that went beyond gathering data on prevalence and related epidemiological parameters. Field research in endemic areas had established that Bancroftian filariasis could be controlled by two safe, acceptable, affordable interventions: polystyrene beads and cooking salt supplemented with diethylcarbamazine. The new interventions had now to be linked to existing infrastructures so that feasible control measures could be developed. He hoped that WHO could assist in planning and implementing programmes for the control of lymphatic filariasis in his country. He supported the draft resolution contained in resolution EB95.R12.

Professor LEOWSKI (Poland) remarked that the report in document A48/15 indicated that the problem of new, emerging and re-emerging infectious diseases would persist for many decades to come. Table 4 of document A48/17 showed that some US$ 10 million was to be reallocated to heading 5.2, as part of the 5% shift. He understood that a large portion of the funds would be devoted to the control of diseases that had been neglected in the past and were re-emerging as public health problems of worldwide importance, such as tuberculosis. He sought the assurance that the tuberculosis control programme would indeed receive more funds, so that it could be strengthened in accordance with resolutions WHA44.8 and WHA46.36.

Poland supported the three draft resolutions currently under discussion.

Dr YAO SIK CHI (Malaysia) said that Malaysia, like many other countries faced with a changing economic situation, rapid industrialization, rapid increases in international travel and threats to the environment, was concerned about the new, emerging and re-emerging diseases. As a significant proportion of the cases of those diseases seen in Malaysia were imported, disease control and surveillance and

intervention measures had been further strengthened. Malaysia therefore supported the draft resolution in resolution EB95.R12 and the draft resolution on prevention of hearing impairment in resolution EB95.R7.

Dr WINT (Jamaica) said that a world health organization could not be seen as losing the war against microbes, old and new, as it approached the year 2000. That appeared to be the case, however, as resurgences of tuberculosis, plague and cholera had been seen recently, alongside the emergence of highly resistant strains of familiar bacteria. The redoubling of efforts outlined in document A48/15 was therefore both urgent and welcome and would be required in order to strengthen laboratory capabilities, to upgrade surveillance systems and networks and to improve clinical control of infectious diseases at all levels. Jamaica supported the draft resolution recommended by the Executive Board in resolution EB95.R12.

Mrs HERZOG (Israel) congratulated the Director-General for sensitizing the Health Assembly to the problem of hearing impairment and for developing a uniform method for assessment and guidelines for prevention. Early detection was most important for secondary and tertiary prevention and should begin as soon as possible after birth. Genetic counselling was another important factor in prevention. She proposed that the draft resolution contained in resolution EB95.R7 should be amended by adding the words "babies, toddlers and" before the word "children" in subparagraph 1(1), as "children" might be understood to refer only to those over 4 years of age. She further proposed that subparagraph 1(4) should be amended by the addition after the words "at country level" of a comma and the words "including the detection of hereditary factors, by genetic counselling".

Israel shared the concern expressed in document A48/15 about the new, emerging and re-emerging infectious diseases that posed a threat to the international community. The truism that disease knew no political differences and no geographical boundaries applied in particular to communicable diseases, which spread easily, particularly between populations in neighbouring countries. She proposed an amendment to subparagraph 3(2) of the draft resolution contained in resolution EB95.R12, namely the insertion of a comma and the words "bilateral, regional" after the word "national". With those amendments, Israel supported both the draft resolution contained in resolution EB95.R12 and that in resolution EB95.R7.

Dr OUEDRAOGO (Burkina Faso), referring to the report contained in document A48/15, said that control of infectious diseases in Burkina Faso was a matter of priority, particular emphasis being placed on extending the vaccination programme. For the past three years, training of specialists in epidemiology had been undertaken with the goal of setting up an early warning system. The proposals contained in paragraph 7 of document A48/15 were welcomed and he hoped that they could be implemented as quickly as possible. He supported the draft resolution contained in resolution EB95.R12, with the proposed amendments, as well as that contained in resolution EB95.R7.

Dr ASHLEY-DEJO (Nigeria) said that the Director-General's report (document A48/15) was a timely warning that serious attention must be paid to the re-emergence of infectious diseases, and especially to the threat of drug-resistant strains of *Mycobacterium tuberculosis*. With the spread of HIV/AIDS, cases of latent tuberculosis and quiescent foci were being reactivated, causing a considerable increase in morbidity and mortality rates throughout the world. Many developing countries offered a pattern of health care services which incorporated very few laboratory diagnostic facilities; malaria continued to kill children or cause the loss of many person-hours owing to its debilitating effects. In Nigeria, people obtained drugs, including injections, over the counter without visiting a hospital for examination or diagnosis. Few countries had given consideration to including laboratory services within their basic health care services.

Global surveillance, under WHO coordination, which could respond to new, emerging and re-emerging infectious diseases would be a very timely development. The Government of Nigeria would welcome any support to improve its routine diagnostic capability and to train personnel in both epidemiological and laboratory investigations. He fully endorsed the draft resolution contained in resolution EB95.R12.

Professor ALBERTI (International Federation of Oto-Rhino-Laryngological Societies), speaking at the invitation of the CHAIRMAN and referring to the draft resolution on prevention of hearing impairment, said that new epidemiological data strongly suggested that more than 120 million people in the world had a hearing loss of at least 40 decibels in the better hearing ear: in children, that prevented acquisition of

language; in adults, it prevented the achievement of full economic potential; in the elderly, it led to loneliness and neglect. In the least-developed countries, respiratory infections frequently led to chronic middle-ear damage which produced disabling hearing loss and, very often, severe complications. Rubella and meningitis continued to cause severe deafness despite the fact that both diseases were preventable by vaccination. In fact, more than half of the global burden of hearing loss could be prevented by primary means. Counselling, vaccination, education about ototoxic medication, appropriate acute respiratory infection management, and hearing conservation in industry could dramatically diminish the burden of handicapping hearing loss and its complications, and at relatively low cost.

Hearing International, a recently established nongovernmental organization, had already sponsored projects in India and Sri Lanka and was mobilizing further resources for its activities in the field of prevention. The WHO programme had been an essential catalyst to that work, acting as a global nexus of information and advice. The regional offices, particularly those for the South-East Asia, Eastern Mediterranean and the Western Pacific, had also contributed both leadership and help. The International Federation of Oto-Rhino-Laryngological Societies strongly urged WHO to continue supporting and expanding its programme on prevention of hearing impairment.

Professor BERTAN (representative of the Executive Board) said that the Board, in considering heading 5.2 of the proposed programme budget for 1996-1997, had noted the importance of controlling tuberculosis as a major killer of adults in both industrialized and developing countries. The Organization had developed a cost-effective control strategy that had been successfully implemented in more than 20 countries. However, unless many more Member States adopted the strategy, the global tuberculosis epidemic would continue to wax and become more dangerous. The tuberculosis programme was strengthening its collaboration with donor agencies, such as the World Bank, to mobilize resources in its efforts to control the global spread of the disease.

With regard to tropical diseases, the Executive Board had stressed the burden attributable, mainly in the least-developed countries, to that cause, which resulted in incapacity, disfigurement and death and also affected socioeconomic development. The Board had identified the three priorities as being control, training and research. It had recommended that the tropical disease programme should continue to be at the forefront in promoting closer and stronger intersectoral cooperation at the national level and that research into preventive measures should be further encouraged.

With regard to the elimination of leprosy by the year 2000, the Executive Board had concluded that, despite successes, WHO support would still be needed to implement plans at the country level if the target was to be attained.

The Board had noted that new, emerging and re-emerging infectious diseases were an increasing threat to global public health and that it was essential to strengthen active surveillance at country level in order to devise and implement control measures before those diseases reached epidemic proportions. Renewed efforts in the fight against the spread of infectious diseases must include the strengthening of diagnostic facilities, the improvement of communications, more rapid response capabilities and intensified research. In order to focus attention and action on the worldwide threat of infectious diseases, the Board had decided to recommend to the World Health Assembly the adoption of the draft resolution contained in resolution EB95.R12.

Concerning the prevention of hearing impairment, the Board had noted with concern the growing number of people - estimated at some 120 million in the world - who now suffered from that largely preventable condition. Given the significant public health implications of avoidable hearing loss, the Board had decided to recommend to the World Health Assembly the adoption of the draft resolution contained in resolution EB95.R7.

Dr HENDERSON (Assistant Director-General), responding to the Italian delegation's comments on the coverage of malaria in document A48/17, said that document A48/17 Corr.2 reinstated the reference to malaria. Referring to requests by some delegations for specific information on programme allocations under budget heading 5.2, he said that the figures in the programme budget for the 1994-1995 biennium gave a very fair indication of the situation in 1996-1997. Very few changes had been made to the budget allocations between those bienniums, with the exception of an increase of a little over US$ 500 000 for the tuberculosis programme. However, a number of other programmes had suffered reductions, though of only 2-3%. In

answer to the delegate of Poland's question about the reallocation of approximately US$ 10 million as a result of the transfer of 5% of funds, none of that money had been channelled into the tuberculosis programme at headquarters level. Most of it went to regional and country programmes and it was certain that many of the priorities mentioned by delegates, such as tuberculosis and malaria, would be adequately covered with the reallocations.

Resources for activities in veterinary public health were limited but WHO enjoyed close cooperation with a number of other organizations. It was of some concern to WHO that FAO, one of its main partners, might have to reduce its investment in rabies control. He assured the Committee, however, that in addressing the priorities within the veterinary public health programme the resources of WHO had been used effectively. Referring to the Mediterranean Zoonoses Control Centre, he said that its general goal was to reduce the impact of zoonoses on human health. Its main activities related to workshops, consultancies, training and research, and the Director-General had extended a cordial invitation to all countries in the Mediterranean area to participate in its activities.

In conclusion, he recalled the delegate of Pakistan's suggestion that the draft resolution on the prevention and control of new, emerging and re-emerging infectious diseases, recommended by the Executive Board in its resolution EB95.R12, should carry a new paragraph on the promotion of healthy lifestyles. He wondered whether the acceptability of the resolution would not be diminished by offering more than programme activities on infectious disease control could accomplish.

The CHAIRMAN, noting that there were no further comments, invited the Committee to approve the draft resolution on the revision of the International Health Regulations, with the Netherlands' amendment.

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

The CHAIRMAN then invited the Committee to approve the draft resolution on prevention of hearing impairment recommended by the Executive Board in resolution EB95.R7, with the amendments proposed by Greece and Israel.

The draft resolution, as amended, was approved.[2]

The CHAIRMAN proposed that further discussion of the draft resolution recommended by the Executive Board in its resolution EB95.R12 should be deferred until a revised text incorporating all the amendments could be distributed.

It was so agreed. (For continuation, see summary record of the eleventh meeting, page 154.)

Appropriation section 3: Health services development (resumed)

3.2 Human resources for health (Resolution EB95.R6) (resumed from page 138)

The CHAIRMAN invited the Secretary to report on the consultations of the informal working group on the text of the draft resolution recommended by the Executive Board in its resolution EB95.R6.

Dr THYLEFORS (Secretary) said that the working group proposed two new amendments. The first consisted in the expansion of the second preambular paragraph to read:

> Mindful of the importance of an adequate number and mix of health care providers to achieve optimal health care delivery and the reorientation of the education and practice of all health care providers for health for all and the need to begin systematic consideration of each;.

The second proposal was to replace paragraph 2(6) by a text reading:

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[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.7.

[2] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.9.

(6) to present to the Executive Board at its ninety-seventh session a report on the reorientation of education and practice of nurses and midwives, and at its ninety-ninth session a similar report relating to other health care providers for health for all, complementary to the reorientation of medical education and practice in this resolution, and to request the Executive Board to present its recommendations on the reorientations of nurses and midwives and other health care providers to the Forty-ninth and Fiftieth World Health Assemblies.

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

The meeting rose at 13:00.

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.8.

ELEVENTH MEETING

Thursday, 11 May 1995, at 14:30

Chairman: Dr Fatma H. MRISHO (United Republic of Tanzania)

PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

GENERAL REVIEW:[1] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58) (continued)

Appropriation section 5: Integrated control of disease (continued)

5.3 Control of noncommunicable diseases

Professor BERTAN (representative of the Executive Board) said that the Board had noted the increase in noncommunicable diseases in both developing and industrialized countries and had emphasized the need for affordable prevention, better integration of preventive and curative services and a more integrated approach to noncommunicable disease programmes, as seen in such WHO initiatives as INTERHEALTH, MONICA and CINDI. More informational input into advocacy in relation to noncommunicable diseases had also been called for. The Board had expressed concern about the funds available for cancer control and oral health and had stressed the importance of activities in those two areas and also for the control of cardiovascular diseases, diabetes, hereditary diseases and rheumatic fever. National cancer control programmes should be more action-oriented and better coordinated with the activities of WHO collaborating centres. The existing process of internal restructuring had been cited as an effective way of dealing with such concerns. The Board had also been informed of the possibility of the cancer programme being transferred from WHO headquarters to the International Agency for Research on Cancer in Lyons. Physical activity for health was discussed in connection with the world forum to be held in May 1995. There had been general satisfaction with the progress made in improving the status of oral health and promoting fluoride use, as well as with the progress made in diabetes prevention techniques, given the epidemic proportions of the disease in some developing countries and the lack of multistage prevention and linked treatment services. The Board had also discussed the availability of essential medications and care for diabetes sufferers at reasonable prices and collaborative ventures in the treatment of diabetes and other noncommunicable diseases.

Ms ALEXANDER (Seychelles) affirmed that WHO should continue to regard the control of noncommunicable diseases as a priority area, particularly in developing countries, and to provide adequate resources. In addition to the already heavy burden of communicable diseases, many developing countries were facing an increase in cancers, cardiovascular diseases, and diabetes. All developing countries would eventually see a rise in noncommunicable diseases as a result of epidemiological transition. Seychelles favoured a coordinated approach to the control of diseases; for example, cardiovascular diseases were tackled through an integrated primary health care approach. Emphasis had been placed on health education, the provision of diagnostic and treatment facilities, the promotion of better nutrition and physical activities, collaboration with the commercial and other sectors, and tobacco legislation. The high level of awareness stimulated through the cardiovascular disease control programme, in which WHO had been an influential

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

partner, had not only been instrumental in achieving tobacco legislation but had also become an important element in national development by highlighting the importance of economic and social issues.

Dr BRUMMER (Germany) expressed concern that the regular budget allocation for noncommunicable diseases in the European Region in 1996-1997 would be reduced by about one-third compared to that for 1994-1995 (document PB/96-97, page 168), and that no extrabudgetary funding was envisaged. Such a reduction would seriously lessen the direct importance of the WHO programme for the European Region and, specifically, for Germany unless close coordination and cooperation with European Union activities had already been agreed upon. Further, no details were given of the proposed allocations of resources to specific groups of diseases, which made it impossible to identify the priority given to, for example, cardiovascular diseases or cancer or to assess whether or not the activities envisaged could be implemented.

Dr PAVLOV (Russian Federation) said that, despite WHO's commendable efforts to control noncommunicable diseases, they were an increasing cause of morbidity and mortality in many countries. A lack of human and financial resources was hampering WHO activities; in view of the global impact of noncommunicable diseases, those activities must receive adequate support.

A genetic approach in the treatment of noncommunicable and other diseases was becoming more widespread and the human genome project had already provided considerable information on the influence of genetic factors on human health. The use of genetic technology and methods of diagnosis was becoming more common in the prophylaxis and treatment of inherited diseases as well as other diseases such as cancer, cardiovascular diseases and diabetes. WHO should give support to countries and nongovernmental organizations for the development of national programmes in that area. Genetic counselling and therapy raised serious ethical and social problems which called for far-reaching consultations at all levels. WHO should be involved in those discussions and in the development of appropriate guidelines on research and treatment.

Dr DURHAM (New Zealand), expressing concern about WHO activities relating to the control of noncommunicable diseases in the 1996-1997 biennium, regretted that many of them were in fact the continuation or maintenance of existing activities. Given the health impact of noncommunicable diseases indicated in *The world health report 1995*, she urged the Director-General to take a strategic approach and to propose guidelines for framing policies to control noncommunicable diseases in the twenty-first century. That area of activity needed revitalizing so that sustainable programmes for the prevention and control of noncommunicable diseases were in place at the global, regional and country level.

Dr SKUPNJAK (Croatia) said that a unified programme of health promotion for the control and prevention of noncommunicable diseases, based on the CINDI programme, the healthy cities project and the health-promoting-schools initiative, had been established in Croatia in collaboration with the WHO Regional Office for Europe and the World Bank.

Dr ABELA-HYZLER (Malta) said that while the proposed shifts of regular budget resources to specific priority areas (document PB/96-97, page 134) were acceptable, he felt that WHO's role in the control of noncommunicable diseases was being marginalized. Few new initiatives had been proposed for controlling diabetes, which according to WHO's own estimates was expected to affect over one million people by the year 2000. He therefore endorsed the views expressed by the delegate of New Zealand and urged the Director-General to assign greater priority to the area than was the case in the proposed programme budget. Moreover, the progress currently being made in genetics indicated that in the twenty-first century it would be a leading science capable of radically changing approaches to treating and preventing many intractable diseases. He agreed with the delegate of the Russian Federation that WHO should play a leading role in these activities in order to be in a position to exploit all the possibilities that would emerge from scientific progress in the field.

Dr SKAČKOVÁ (Slovakia) reported that cardiovascular diseases and cancer were responsible for 80% of deaths in Slovakia and that diabetes, respiratory diseases (including asthma) and rheumatological diseases were also on the increase. Other countries of central and eastern Europe were similarly afflicted and were

also experiencing the same economic effects of noncommunicable diseases as Slovakia and, indeed, western Europe. No cost-effective preventive measures had been found by which to halt the trend. Nevertheless, integrated approaches such as the CINDI and INTERHEALTH programmes were valuable in controlling and preventing noncommunicable diseases globally. She agreed with the delegate of Germany and advocated an increase in the proposed funding for noncommunicable diseases in the regular budget allocated to Europe. INTERHEALTH and MONICA methodology should also be made generally available.

Dr SULEIMAN (Oman) said that since noncommunicable diseases were becoming as widespread as communicable diseases in many countries, it was essential to devise a prioritizing system in view of the limited resources available. The fact that resources for noncommunicable diseases had decreased would have a negative impact on the health of many people, especially those suffering from diabetes, cancer and hereditary diseases. Activities aimed at combating such diseases deserved increased and sustained support in order to facilitate the formulation of control and prevention programmes.

Dr KHOJA (Saudi Arabia) said that research in the last five years had shown that noncommunicable diseases were increasing in Saudi Arabia and most other Eastern Mediterranean countries. The effects of those diseases were psychological and social as well as physical, and a programme for controlling them was of the utmost importance. He urged the Organization to allocate the same resources to asthma as it did to cardiovascular diseases and diabetes. Asthma morbidity and mortality were rising at an alarming rate in Saudi Arabia; 1995 had been designated as asthma control year and a special programme had been set up. WHO should give priority to activities for the prevention and control of a number of noncommunicable diseases, especially cancer. He asked the Director-General to reconsider the proposed reduction in allocations for the Eastern Mediterranean Region so that resources would be available for expanding efforts to control noncommunicable diseases in the Region.

Mrs DUPUY (Uruguay) also believed that, given the high levels of morbidity and mortality due to cancer and cardiovascular diseases worldwide, activities for their prevention and control should be a priority for WHO. She therefore urged the Director-General to increase the funding for such activities in all regions.

Mrs VOGEL (United States of America) reaffirmed the need to prioritize but at the same time stressed the importance of linking activities under programme budget heading 5.3 with those under programme budget heading 4.2, since it was clear that noncommunicable diseases such as cardiovascular disorders and cancers of certain sites were connected with lifestyles.

Professor SHAIKH (Pakistan) endorsed the views of previous speakers. In Pakistan, 10%-15% of the population suffered from diabetes, and a cancer control programme had just been set up. He therefore viewed the proposed reduction in the regular budget allocations with dismay, since they would undoubtedly have a negative impact on noncommunicable disease programmes. He supported WHO's involvement in the field of genetics.

Dr SAMBA (Regional Director for Africa) said that in most African countries communicable diseases were still the main problem but noncommunicable diseases, especially cardiovascular disorders, diabetes and cancers, were on the increase, and had overtaken the communicable diseases in three or four countries. It was therefore essential to increase both regular budget and extrabudgetary funding in order to deal with a rapidly growing number of priority areas.

Ms MURPHY (Regional Office for Europe), replying to the delegate of Germany, said that the European Region had undertaken a very thorough process of prioritization for the 1996-1997 programme budget which had been approved by the Regional Committee. The cancer programme was one of the "posteriorities" that had accounted for a reduction in the area under discussion in the European programme budget. Staff and funds had thus been released for reallocation to the country programme. She stressed that the priorities had been set for the 1996-1997 programme budget and would be reviewed for the following biennium.

Dr NAPALKOV (Assistant Director-General) said that, as one who had devoted the better part of his professional life to the control of noncommunicable diseases, he, like many delegates, was seriously concerned at the proposed reduction in the budget for 1996-1997 under programme budget heading 5.3. However, it was very difficult to imagine how prioritization was possible under the umbrella of a zero-growth budget without transferring funds from one area to another. There were nevertheless possibilities of reinforcing activities in the field of noncommunicable diseases. Various programmes, for example INTERHEALTH, MONICA, and CINDI, attempted to unite the different multidisciplinary approaches within the complex of noncommunicable diseases at community level.

The problems of normative functions and expertise at all stages of control of noncommunicable diseases - prevention, diagnosis and detection, treatment and rehabilitation - were closely related. Activities for the primary prevention of the majority of noncommunicable diseases were in fact to be found under such headings as 4.2, Healthy lifestyles; 4.3, Nutrition; and 4.4, Environmental health. Problems relating to the rehabilitation of patients suffering from noncommunicable diseases must be taken into account in considering the allocations for the appropriation section. The budget for noncommunicable disease control programmes for 1996-1997 was more or less equally divided between cancer and palliative care, cardiovascular diseases, and all other noncommunicable diseases plus oral health. A substantial part of the funding for such programmes must come from extrabudgetary resources. For example, in order to continue and complete the current stage of the MONICA project, extrabudgetary funds were undoubtedly necessary as they were the only source of financial support for the initiative, which had been so highly commended at the technical briefing held during the Health Assembly.

The view had been expressed by several speakers that WHO should reinforce its activities in the field of medical genetics and hereditary diseases. Several programmes were currently under consideration with a view to further development; however, that would inevitably call for additional funding. The subject of noncommunicable diseases was very closely related to a whole series of questions concerning bioethics and medical deontology. If such questions were considered together with reproductive health, medical genetics and hereditary diseases, it was clear that an integrated approach was essential. It was hoped that all the ideas put forward would be utilized in the Organization's strategic planning for the twenty-first century. The Director-General was giving serious consideration to the organizational structure of the Division of Noncommunicable Diseases with a view to making changes that would allow greater flexibility, use the scarce resources better, and permit more effective implementation of the programme.

5.2 Control of other communicable diseases (continued)

New, emerging, and re-emerging infectious diseases (Resolutions WHA39.27, WHA44.8, WHA45.35, WHA46.6, WHA46.31, WHA46.32, WHA46.36 and EB95.R12; Document A48/15[1]) (continued from page 149)

Dr THYLEFORS (Secretary) drew the attention of the Committee to the revised text of the draft resolution recommended by the Executive Board in resolution EB95.R12, incorporating the amendments proposed at the previous meeting by the delegates of Greece, India, New Zealand and Saudi Arabia and taking account of the points raised by the delegates of Morocco and Pakistan.

The draft resolution, as amended, was approved.[2]

Dr ABELA-HYZLER (Malta) proposed that the Executive Board should be requested to evaluate the Health Assembly's discussions on the proposed programme budget, which was the first to be prepared using the new strategic approach. Although some delegates had expressed concern at the way in which some of the proposed activities had been grouped, the new format had generally been well received and was more user-friendly. However, the various sections of the proposed programme budget, which provided a prospective view, had been considered in conjunction with a number of progress reports on the

[1] Document WHA48/1995/REC/1, Annex 3.

[2] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.13.

implementation of resolutions, which were retrospective. The discussions on each budget section had focused on the programme activities covered by the progress reports and, as a consequence, other activities outlined in the proposed programme budget had been neglected. Further, there had been a tendency to concentrate on individual programme details - the former method of examination of programme budgets - rather than the strategic approach now required. Thus, although the new budget format was a step in the right direction, the way in which the proposals had been discussed had not been appropriate. The Executive Board should therefore be asked to consider the matter further and provide guidance for the examination of the next proposed programme budget in 1997.

The CHAIRMAN requested the Director-General to take note of that proposal.

(For discussion on the proposed programme budget, appropriation section 6: Administrative Services, see summary record of Committee B, eighth meeting, section 2.)

FINANCIAL REVIEW: Item 18.3 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, and A48/17 Add.1)

The CHAIRMAN drew attention to the proposed appropriation resolution for the financial period 1996-1997 contained in the Annex to document A48/17 Add.1. The delegations of Australia, Austria, Belgium, Canada, Netherlands and Switzerland had submitted two proposed amendments to that draft resolution. First, subparagraph E should be amended to read:

> E. The maximum net level of the exchange rate facility provided for under Article 4.6 of the Financial Regulations is established at US$ 31 000 000 for the biennium 1996-1997, on the basis of the United Nations/WHO accounting rates of exchange (for all regions and at the global level) prevailing during May 1995.

Secondly, a new paragraph should be added, reading:

> 2. REQUESTS the Director-General, in preparing future programme budgets, to present data from authoritative sources, *inter alia* international financial institutions and regional economic cooperation bodies, on estimated inflation rates.

The delegations of Finland, Georgia, Greece, Hungary, Ireland, Malta, Poland and Slovakia had submitted a proposal to amend the draft resolution by the addition of a new subparagraph B reading:

> B. Within the overall appropriation of US$ 963 651 000, the operating budgets for 1996-1997 for the six regional offices shall be calculated in accordance with established principles of equity, and on the basis of the prevailing United Nations/WHO accounting rates of exchange, effective May 1995, for all regional offices' currencies *vis-à-vis* the US dollar.

Subparagraphs C-E would therefore become subparagraphs D-F.

Mr AITKEN (Assistant Director-General), introducing the item with the aid of a series of overhead projections, said that it was a new item resulting from the budgetary reform process. Inevitably much of what he would say would be relevant to the forthcoming debate on the proposed appropriation resolution for the financial period 1996-1997. In 1994-1995 the budget for the whole of the Organization had stood at US$ 822 million. The first stage in the process of establishing how much should be allowed for inflation in the budget had been to request Regional Offices and countries to give estimates of their inflation requirement. All the figures provided had been calculated for a two-year period and should not therefore be aligned upon annual inflation figures for individual countries. For the European Regional Office the requirement was 7% over a two-year period. That was the lowest figure and compared with the maximum figure of 17% for South-East Asia. When inflation was weighted by the size of the budget available to various parts of the Organization, the total inflation requirement to maintain zero real growth was 11.54%.

The other major increase in the budget was due to exchange rate fluctuations, for which the differences were more marked and much less predictable in terms of providing an exact figure. While the inflation figure was likely to be within the correct range, for differences resulting from exchange rate fluctuations estimates had to be made for real needs based on rates currently in force. The Regional Office for the Americas was completely dollar-based so that no exchange rate was applicable as WHO's budget was expressed in US dollars. The Swiss franc had been extremely strong against the dollar and consequently programmes implemented from Geneva were particularly susceptible, so that a currency adjustment increase of 16% was required to compensate for exchange rate changes. The Danish krone had also been particularly susceptible, so that an 11% increase was required for the European Region. Conversely, the CFA franc had been devalued, giving a currency adjustment decrease in the African Region. The requirement for the South-East Asia Region was also down, while the figures for the Western Pacific and Eastern Mediterranean Regions would remain about the same. The Organization's expenditures were in many different currencies, but primarily in seven, namely the Swiss franc and the currencies of the six Regional Offices. Of those, the six subject to exchange rate fluctuations were under consideration.

The combined effect of real needs produced a total budget figure of US$ 822 million plus an increase of 16.24%. In discussions most Member States had said they could not afford such an increase on a biennial basis. The Director-General had therefore decided to reduce the proposed increase by more than half, to 7.49%. The figure might seem over-precise but was based on a particular calculation. The basic principle of the calculation was outlined in the Director-General's final proposal, given in document A48/17 Add.1.

The question of how the figure of 7.49% was broken down had been the subject of considerable discussion. There were two pertinent factors: how much of the US$ 62 million, i.e. 7.49%, should be related to the exchange rate and how much should be allocated for inflation. In monetary terms the two appeared to be the same. However, they differed greatly in terms of impact on the Organization's ability to manage its programmes. The reason was that a separate exchange rate facility was available that allowed the Organization some risk management for exchange rates outside the budget. However, it was necessary to build inflation into the budget.

The three variants of the appropriation resolution, that submitted by the Director-General (document A48/17 Add.1, Annex) and the two amended texts mentioned by the Chairman, were all based on the same total increase in the budget, 7.49%. The differences between them related to how much of the 7.49% increase was used to compensate for inflation and how much for exchange rate changes, which in turn depended on what assumptions were made for the exchange rate. The Director-General's original proposal took a greater risk with the exchange rate than either of the others. An exchange rate further away from the current rate had been chosen since an exchange rate facility was available outside the budget to cover that risk. That enabled the inflation figure to be kept as high as possible in order to minimize programme cuts. The actual increase needed to compensate for inflation was 11.5%; the Director-General's proposal was based on a figure of 9%, so some programme cuts would still be necessary. That would assume an accounting rate of exchange of 1.49 Swiss francs per US dollar, the figure used for the current biennium. In fact the exchange rate for May 1995 was 1.14 Swiss francs per US dollar. The Director-General's proposal also assumed the May 1993 rate for the Danish krone.

Considerable concern had been expressed by the Members of the European Region, some of which - Finland, Georgia, Greece, Hungary, Ireland, Malta, Poland and Slovakia - had submitted a proposal that it should be treated in the same way as the other regions. On reflection, he agreed with that approach for the biennium under consideration. The draft resolution as amended by them contained no direct reference to the accounting rate of exchange to be used for the Swiss franc but, if it were adopted, he would presume that the Director-General's proposal was taken into account and that the rate of 1.49 Swiss francs per US dollar was to be approved. That proposal would still result in a total increase of 7.49%, but a slightly lesser risk was being taken with the exchange rate, an inflation rate of 8.3% could be applied across the Organization, and programme cuts would be less than would result were the possibility set out in the amended draft resolution sponsored by the delegations of Australia, Austria, Belgium, Canada, Netherlands and Switzerland to be applied. The latter proposal suggested using the current rates of exchange throughout the Organization; the exchange rate component of the budget increase would then be much higher (4.39%) and the inflation component much lower (3.1%), which would mean greater cuts in programmes in order to deliver the programme budget.

The difference between the three proposals thus lay in the extent to which monies outside the budget would have to be used, namely, the exchange rate facility consisting of casual income, drawn on when needed - the further from current exchange rates, the greater the risk that the facility would have to be drawn on, and the less the likelihood of the money being returned to Member States or their being able to decide on how to use the amount. Therefore, the proposals made by the Director-General and by Finland and others entailed a higher risk in return for lower programme cuts, but also reduced the possibility of returning casual income to Member States.

It might be noted that the casual income generated at present was primarily due to countries' inability to pay WHO; when they failed to pay on time but paid eventually, the contributions were credited to casual income. For that reason, programmes had already been cut in the present and previous bienniums. The Director-General had considered that the best use for the casual income in the forthcoming biennium was to maximise the ability to deliver programmes in that biennium, by using it to keep exchange rate costs out of the budget.

It was important for delegates to understand the matter thoroughly so that they could take a clear decision.

Dr TIERNEY (Ireland) stressed the insistence by European Member States that the accounting rates of exchange for May 1995 should be applied equitably to all Regional Offices, including that for Europe, for the 1996-1997 programme budget, in accordance with established practice. He understood that the Director-General had changed his position from that set out in document A48/17 Add.1, so that the European Region would indeed start the next budgeting cycle from the same adjusted base as other regions. Nevertheless, he wished to inform the Committee of the serious reservations the European Member States had had about the Director-General's original proposal: they had discussed the matter several times, seeing the question as essentially one of principle, and had been unanimous on the need to insist that all regions should begin on the same base. He stressed, furthermore, that European Member States contributed 47% of the global regular budget of WHO, while receiving only 5.96%, notwithstanding the fact that several of the 20 new States in the Region were classified as least developed countries. He had been authorized, in his capacity as Chairman of the Standing Committee of the Regional Committee for Europe, to inform the Committee that, unless the change had been made, the European Member States would have voted against the appropriation resolution.

The amendment to the draft appropriation resolution proposed by Finland, Georgia, Greece, Hungary, Ireland, Malta, Poland and Slovakia pertained only to subparagraph B, and would introduce the principle of equity between all the regional offices of the Organization in budget preparation, setting a useful precedent on the matter. The following delegations had requested that their names should be added as proposers of the amendment: Belarus, Bulgaria, Croatia, France, Luxembourg, Turkey and the Russian Federation.

Mr SPIEGEL (United States of America) expressed his satisfaction that, as requested by the Executive Board, 5% of budget resources had been shifted to ensure greater attention to higher-priority activities. He hoped that the governing bodies of the Organization would continue to play a strong role in setting priorities.

He recognized the great value of WHO programmes to all Member States and it was his country's aim to ensure programme effectiveness and success. However, WHO was facing serious financial challenges, with reductions in payments of assessed contributions and in extrabudgetary funding, and its expenditure must be reduced by running programmes more cost-effectively and curtailing those of marginal utility. In that regard, Member States must help in establishing priorities. He stressed that there was no organization anywhere that could not withstand a tightening of the budget and still operate effectively. However, it was not easy to operate within a zero-growth budget: hard work was required by everyone.

The United States of America, like many other countries, was confronted with the need for major reductions in its budget. The outlook for United States contributions to international organizations was grim and, while the current Administration would strongly resist reductions in payments to the United Nations and affiliated agencies, it was not clear that it would have the funds available to pay its full assessed contributions. It would therefore be irresponsible for him to vote in favour of the proposed budget. The United States Government could only support a WHO budget for 1996-1997 at exactly the same level as that for 1994-1995. Because the proposed level was not acceptable to his Government, he must call for a vote on the budget and would vote against all three of the proposals currently before the Committee. He stressed that

his country would adopt a similar position in other agencies of the United Nations system. The United States was facing a serious budgetary problem and must adapt to financial realities.

Mr KNOTT (Australia) said that he fully supported the comments on equity made by Ireland; the proposed course of action was in keeping with standard United Nations budgetary and financial practice.

He introduced the amendments proposed by Australia, Austria, Belgium, Canada, Netherlands and Switzerland, to the draft appropriation resolution contained in the annex to document A48/17 Add.1, noting that Brazil and Mexico wished to join the proposers. He and the other proposers had been disappointed with the quality of the data provided to support what they had considered excessive cost increases in the proposed programme budget for 1996-1997. The origin of the figures appeared obscure, their manipulation difficult to follow and their computation suspect: in short, it was not clear how the requested level of increase could be justified. Nevertheless, although they were still not convinced that the current level of the budget was necessary to cover cost increases, they were prepared to approve the figures set out in subparagraph 1A. However, they were not prepared to gamble with exchange rates, since adequate mechanisms already existed within the United Nations system to manage exchange rate fluctuations.

The amendment introduced by the delegate of Ireland was, in effect, an elaboration of part of the amended version of subparagraph E proposed by his delegation and others and would therefore be acceptable to the proposers. The proposal was to add a phrase to subparagraph E to the effect that the budget should be based on current exchange rates throughout the Organization at both regional and global levels, in line with standard United Nations practice. The effect of that change would, naturally, depend on the United States dollar exchange rate over the next biennium. If the rate stayed unchanged, the effective working budget would remain unchanged at US$ 883 million. If the dollar weakened, the exchange rate facility of US$ 31 million would be used to make up the deficit; the exchange rate facility had been set at the same level as in the previous biennium because, at current rates, that would be more than adequate. If the dollar became stronger, the surplus would be added to the casual income account and its use would be decided by the Health Assembly in 1996.

The proposed paragraph 2 of the draft resolution asked for data on estimated inflation rates to be provided from authoritative sources for future programme budgets, in the hope that the current problem would not occur again.

The proposers considered that the question at issue was not one of finance or economics, but one of governance. The proposed amendments would ensure that the budget remained free of exchange rate risk, using WHO's tried and proven mechanisms, as set out in the Financial Regulations, as well as a lower exchange rate facility, conforming with the United Nations standard exchange rate practice and exercising greater control over the likely benefits of exchange rate movements in the Organization's favour. The proposers considered that such a procedure was simple and beneficial for all concerned and upheld the proper governing role of the Health Assembly. He hoped that all delegations would support it.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) said that the United Kingdom wished to join Australia and others in proposing the amendments just introduced.

At a time when many Member States and international organizations were facing budgetary constraints, WHO must also accept financial stringency. He therefore favoured a maximum net level of exchange rate facility of US$ 31 million for the biennium 1996-1997, as indicated in the proposed amendment to subparagraph E.

He also supported the incorporation of the amendment introduced by Ireland in the draft resolution as amended by Australia and others, believing that there was no inconsistency between the two and that it was important to introduce the principle of equity. Considering the financial situation facing national governments, the proposals in the draft resolution as amended by Australia and others were generous.

Mr MUYLLE (Belgium) congratulated the Director-General on his sense of realism and said that Belgium could accept the proposed increase of 7.49%, if the Health Assembly so decided, provided that that was the final figure. However, he agreed that the six regions should be treated identically in the budgetary as in other spheres, as a matter of principle. He therefore supported the draft resolution with all the amendments proposed.

Mr VAN REENEN (Netherlands) said that in assessing the succession of figures for attaining zero growth in real terms proposed by the Director-General in recent months, ranging from 12.75%, through 14% to 16.24%, and the final proposal of 7.49%, his main concern had been the lack of data from authoritative sources on estimated inflation to justify the increases.

He expressed grave doubts about how the latest proposal had been reached, as the cost increase figure proper was still a hefty 9% and compensation was sought in a lower overall currency adjustment which, according to the Director-General, would result in a budgetary saving of 1.51% and a simultaneous increase in the amount of the exchange rate facility. Paragraph 6 of document A48/17 Add.1 stated that the full WHO programme could not be implemented with an overall increase of 7.49%. He was not convinced that that was true and requested additional authoritative data to justify that statement. In the light of those views, he had joined others in proposing the amendments to the draft resolution introduced by the delegate of Australia, which accommodated most of his concerns, and supported the amendment introduced by the delegate of Ireland.

Dr LARIVIÈRE (Canada) said that Canada, which adhered to the concept of zero real growth, with maximum absorption of cost increases, had expressed its serious concern about the initial proposals for cost increases in the proposed programme budget. His Government was itself cutting costs, and nominal budget increases of the order of 7% for international organizations attracted ever greater scrutiny and were increasingly difficult to accept. Canada did not consider as legitimate some of the elements included in calculating the cost increases, such as biennialization, professional salary increases that had not yet been recommended or approved by the United Nations General Assembly, within-grade step increments, and reclassification of posts. WHO had created 350 new posts, financed from regular budget funds, over the past six years, which was inconsistent with the principle of zero real growth.

Some international organizations, particularly the United Nations, were doing more to absorb cost increases. The proposed United Nations programme budget had been cut by 4% in real terms, by means of efficiency savings and productivity gains, before cost increases had been applied. Even so, it had proved possible to increase the resources allocated to several high-priority programme areas. WHO should adopt similar efficiency and productivity goals for the next biennium, with full absorption of cost increases - in other words, zero-nominal growth. It was not too soon to begin identifying cost savings that could be implemented during the current and the next biennium. Rigorous priority-setting would ensure that WHO's most important programmes received the resources they needed.

His delegation was a proposer of the amendments to the appropriation resolution introduced by Australia, and endorsed the remarks made by the Australian delegate. Canada could not accept the calculation methods used by the Director-General in drawing up the proposed appropriation resolution and could therefore support the appropriation resolution only with those amendments. He also supported the amendment introduced by Ireland.

Mr NUNLIST (Switzerland) endorsed the comments made by the delegate of Australia. The presentation of the WHO programme budget was not a simple matter: on the one hand there was a constant increase in the tasks to be undertaken, and on the other the financial resources were limited. A system of priorities had to be established regarding programme activities. He commended the Director-General's efforts in producing the proposed programme budget.

Switzerland would have had great difficulty in accepting a 12%-14% increase in the budget, as initially proposed. A 7.49% increase was acceptable on two conditions: that all regions and headquarters were treated on an equal basis, and that precise data on cost increases and exchange rate adjustments were determined on a scientific basis. Switzerland therefore joined in proposing the amendments introduced by the delegate of Australia.

Dr WETZ (Germany) strongly supported the amendments introduced by the delegates of Ireland and Australia and endorsed Australia's request for reliable data on worldwide inflation rates in future, which should be comparable to figures issued by international financial organizations. Germany was prepared to accept an increase of 7.49%, though it would have preferred a lower figure and greater absorption of cost increases within the budget.

Regarding the exchange rates upon which the budget was calculated, he could not accept an arbitrary choice of rates for some regions: the official United Nations exchange rates for May 1995 should be used throughout the whole Organization, including all regions and headquarters, as was the standard practice in the United Nations system. He agreed that the WHO budget was no place to gamble on exchange rates. If the exchange rate of 1.49 Swiss francs per US dollar for May 1993 was used instead of the 1.14 Swiss francs per US dollar for May 1995, it would have to be hoped that the dollar would rise to an exchange rate of at least 1.49 by January 1996. If not, WHO would suffer exchange losses as from the beginning of the new biennium and would therefore have to draw upon the exchange rate facility. But the exchange rate facility should not be used in that way; it was intended to cover unforeseeable exchange rate fluctuations, which was impossible if its use was already predetermined in the original budget. If realistic exchange rates were used the exchange rate facility could be set aside for unforeseen emergencies, and there would be no need to raise the exchange rate facility to US$ 41 million. If the amendments introduced by Ireland and Australia were not included, his delegation would be unable to vote in favour of the draft resolution.

Dr TIERNEY (Ireland) supported the Australian proposal, which meant that there was now a common position on the amendments proposed by Australia and others and by Finland and others.

Dr BENÍTEZ (Argentina) expressed concern over the deficits and levels of arrears in contributions which prevailed throughout the United Nations system, including WHO, and which placed a great burden on budgets. Governments could not assume responsibilities and commitments they were unable to meet, as that would compromise the entire viability of the system. National economies were facing exceptionally difficult situations on account of fluctuations in the world financial markets, which required stringent adjustment measures. For example, in Argentina public service salaries had recently been cut by 15%, and there had been similar cutbacks in the private sector. He therefore wished to see similar criteria applied to international organizations, in order to achieve financial and budgetary discipline. He welcomed the proposals to reformulate the budget on the basis of more realistic exchange rates. Unfortunately that still involved an increase in assessments for countries, with which his Government was not in agreement. Although in the interest of consensus, his delegation had been willing to accept a small budgetary increase, it could on no account approve the proposed increase of 7.49% and regretted that it was therefore unable to support any of the proposals before the Committee.

Professor GIRARD (France) said that agreement seemed to have been reached on three points, namely: the possibility of shifting 5% of the budget, on the recommendation of the Executive Board, to selected priority activities; the need to apply the principle of equity between regions; and the need for transparency in application of exchange rates. Regarding zero real growth, he observed that in the field of health that was a constraint and not a dogma. His delegation therefore supported the draft appropriation resolution, which entailed an increase of 7.49%, provided that all the amendments proposed were incorporated.

Dr FREIRE (Spain) supported the draft proposal as amended. Since there was no universally accepted calculation method to determine the level of inflation, he urged the Director-General to ensure that in future reliable figures were produced that would be less subject to apparently arbitrary fluctuations. Cost increases should reflect the additional costs arising for reasons outside the control of the Organization. He stressed the importance of basing budgetary allocations and exchange rates on the principle of equity, to avoid any discrimination between the regions.

Dr SAVEL'EV (Russian Federation) said that the Russian Federation maintained the position it had taken for many years calling for zero real growth in the budget and urging that any increases due to inflation or exchange rate fluctuations should be absorbed as far as possible. He agreed that all regions should be treated equally with regard to exchange rate implications. The Director-General's proposals to limit budget growth to 7.49% and to shift 5% of resources to high-priority areas were a step in the right direction. However, the Russian Federation, like many other countries, including those with transitional economies, was experiencing severe economic difficulties, despite which his Government was taking energetic steps to pay off the arrears on its assessed contributions to the budget. He therefore considered that the figure of 7.49% was still too high and would abstain in the vote.

Dr CICOGNA (Italy) endorsed the views expressed by the delegate of Australia and wished to be included as a proposer of the amendments before the Committee.

Dr ABELA-HYZLER (Malta), clarifying his delegation's position, said that it had supported the amendment introduced by the Irish delegation but had not in fact cosponsored the whole of the draft resolution.

Dr DURHAM (New Zealand), reiterating New Zealand's commitment to zero real growth, supported the proposed amendments. If they were not accepted she would be unable to vote for the appropriation resolution.

Dr VIOLAKI-PARASKEVA (Greece) endorsed the views expressed by the delegate of France and supported the draft resolution as amended. She hoped that a much greater proportion of the budget would go to implementation of programmes in the field in future.

Mr AITKEN (Assistant Director-General) said that the inflation figures used by the Organization were based on a breakdown of its expenditure, a considerable part of which related to staff salaries. The salaries of local general service staff in their various places of employment were based on the formula current within the United Nations system, which laid down that they should be paid the best prevailing rates in the locality concerned. In many locations throughout the world, that system was producing salary increases much higher than the average inflationary increase in the country concerned. That was the reason why the inflation-related increases which appeared in the WHO figures were in excess of inflation statistics provided by such institutions as the International Monetary Fund and the World Bank. If Member States were unhappy with the result of following the salary rules set by the United Nations, they would have to seek the remedy in New York.

Turning to the draft appropriation resolution and the proposed amendments that were now before the Committee, he pointed out that one of the amendments had serious implications for the Organization's ability to implement its proposed programme of work. The amendment proposed by Australia and others, with the incorporation of the amendment introduced by Ireland, would lead to a considerable decrease in the additional monies that would become available to the regions in comparison with the monies that would become available as a result of the incorporation of the amendment introduced by Ireland into the Director-General's original proposal. The respective figures were as follows: for the African Region, 4% in the case of the first amendment as opposed to 10% with the second; for the Region of the Americas, 2% as opposed to 7%; in the South-East Asia Region, 4% as opposed to 12%; in the European Region, 2% as opposed to 5%; in the Eastern Mediterranean Region, 4% as opposed to 11%; in the Western Pacific Region, 4% as opposed to 11%; and at headquarters, 2% as opposed to 6%. The overall result would be 3% extra monies if the amendment proposed by Australia and others, incorporating the amendment introduced by Ireland, was accepted, and 8% extra monies if the amendment introduced by Ireland was accepted alone. The differences for monies available resulted from the fact that the exchange rate component was not available in the same way as the inflation component, i.e. it would not assist in improving allocations to programmes or stopping cut-backs in programmes; the exchange rate component would merely enable the Organization to tread water in terms of keeping the books balanced.

Dr TIERNEY (Ireland) said that it was now proposed that the amendment he had introduced should be incorporated in the draft resolution as amended by Australia and others. The Committee therefore had before it two alternatives.

Mr VIGNES (Legal Counsel) agreed that the Committee had two draft texts before it on which a vote was necessary. The first was the original proposed appropriation resolution contained in the Annex to document A48/17 Add.1 with the amendments proposed by Australia and others, and incorporating the amendment introduced by the delegate of Ireland. The second was the original proposed appropriation resolution with the amendment introduced by the delegate of Ireland, which the Director-General had agreed to accept. The Committee would thus be called upon to vote first on the first alternative, acceptance of which would require a two-thirds majority of those present and voting; should that amendment be rejected, and only

then, the Committee would be called upon to vote on the second one, acceptance of which would also require a two-thirds majority.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) said that Mr Aitken had referred to a need for cuts in programmes. There was, however, another option, which was to make efficiency savings, and that had not yet been given serious consideration. Unnecessary and unjustified alarm was created by raising the issue of programme cuts when alternatives might have been considered.

The CHAIRMAN invited the Committee to vote by show of hands on the proposed appropriation resolution contained in the Annex to document A48/17 Add.1, as amended by Australia, Austria, Belgium, Canada, Netherlands and Switzerland and incorporating the amendment proposed by Finland, Georgia, Greece, Hungary, Ireland, Malta, Poland and Slovakia.

The voting being as follows: 42 votes in favour, 23 votes against and 23 abstentions, the amendment was rejected since the necessary two-thirds majority had not been attained.

Dr LARIVIÈRE (Canada), speaking on a point of order, requested that in view of the closeness of the decision a roll-call vote should be taken.

Dr ANTELO PÉREZ (Cuba) said that, in view of the importance of the issue for the future of the Organization, the fact that the countries which voted against represented over 60% of contributions to the Organization's budget, and the difficulties many countries already faced in meeting their current assessments, it might be wise to consider setting up a drafting group to reword the resolution in the light of those realities.

Mr VIGNES (Legal Counsel) said that, since the voting procedure had already begun, consideration of that suggestion would have to be deferred until voting on the two proposals before the Committee had been completed.

Dr MUKHERJEE (India) asked whether it was possible to vote twice on the same proposal.

Dr ANTELO PÉREZ (Cuba) asked whether, if the second vote also resulted in rejection, consideration could then be given to his proposal to set up a drafting group.

Mr VIGNES (Legal Counsel) said that if no agreement was reached, the option proposed by Cuba could be considered: however, the Committee should first proceed with the vote.

Professor LOUKOU (Côte d'Ivoire), on a point of order, asked whether the second vote ought not to be taken by the same procedure as the first.

Mr VIGNES (Legal Counsel) said that the situation in which the Committee now found itself was one he had never encountered before. In view of the fact that the result of the first vote had not been entirely clear, and that on such an important matter it was vital to avoid having a decision that might be open to question, he believed that, should the Committee agree, the Chairman could accede to the Canadian request for a roll-call vote on the first proposal before the Committee, namely the proposed appropriation resolution contained in the Annex to document A48/17 Add.1 as amended by Australia and others and incorporating the amendment introduced by Ireland.

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

The result of the vote was as follows:

In favour: Australia, Austria, Belgium, Brazil, Bulgaria, Canada, Colombia, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Honduras, Hungary, Ireland, Israel, Italy, Jamaica, Luxembourg, Malta, Mexico, Netherlands, New Zealand, Norway, Panama, Poland, San Marino, Slovakia, South Africa,

Spain, Sweden, Switzerland, Tonga, Tuvalu, Uganda, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania.

Against: Algeria, Argentina, Bhutan, Brunei Darussalam, Chile, El Salvador, Guatemala, India, Indonesia, Japan, Kenya, Kiribati, Lebanon, Malawi, Malaysia, Mali, Namibia, Nepal, Nicaragua, Peru, Sri Lanka, Swaziland, Thailand, United States of America, Zimbabwe.

Abstaining: Angola, Barbados, Benin, Botswana, Central African Republic, China, Côte d'Ivoire, Cuba, Eritrea, Ethiopia, Gambia, Ghana, Islamic Republic of Iran, Kuwait, Morocco, Pakistan, Republic of Korea, Romania, Russian Federation, Senegal, Seychelles, Togo, Trinidad and Tobago, Tunisia, Turkey, Uruguay.

Absent: Afghanistan, Albania, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Bolivia, Boznia and Herzegovina, Burundi, Cameroon, Cape Verde, Cook Islands, Costa Rica, Cyprus, Democratic People's Republic of Korea, Djibouti, Ecuador, Egypt, Estonia, Fiji, Gabon, Georgia, Guinea, Iceland, Jordan, Kazakhstan, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lesotho, Libyan Arab Jamahiriya, Lithuania, Madagascar, Maldives, Mauritania, Mauritius, Federated States of Micronesia, Monaco, Mongolia, Mozambique, Myanmar, Nauru, Niger, Nigeria, Oman, Palau, Paraguay, Philippines, Portugal, Qatar, Republic of Moldova, Rwanda, Saint Kitts and Nevis, Samoa, Sao Tome and Principe, Saudi Arabia, Sierra Leone, Singapore, Slovenia, Solomon Islands, Sudan, Surinam, Syrian Arab Republic, The Former Yugoslav Republic of Macedonia, Ukraine, United Arab Emirates, Uzbekistan, Vanuatu, Venezuela, Viet Nam, Zambia.

The voting being as follows: 39 votes in favour, 25 votes against and 26 abstentions, the draft resolution was rejected, since the necessary two-thirds majority had not been attained.

Dr STAMPS (Zimbabwe), on a point of order, said that Rule 70 of the Health Assembly's Rules of Procedure stated that once a vote had been taken on a proposal there should be no re-voting on the same proposal. Many delegates who had been present for the initial vote had been recorded as absent on the roll-call vote, leading to a disparity between the two results.

The CHAIRMAN requested Mr Vignes to proceed to the next step.

Mr VIGNES (Legal Counsel) said that the Committee's next step should be to vote on the second proposal, namely the proposed appropriation resolution contained in the Annex to document A48/17 Add.1, with the amendment proposed by Finland, Georgia, Greece, Hungary, Ireland, Malta, Poland and Slovakia.

Mr VAN REENEN (Netherlands) requested 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 Madagascar, the letter M having been determined by lot in the previous vote.

The result of the vote was as follows:

In favour: Algeria, Benin, Bhutan, Brunei Darussalam, Central African Republic, China, Côte d'Ivoire, Gambia, Ghana, India, Indonesia, Islamic Republic of Iran, Japan, Kiribati, Lebanon, Malawi, Malaysia, Mali, Nepal, Panama, Sri Lanka, Swaziland, Thailand, Togo, Tonga, Tunisia, Turkey, Zimbabwe.

Against: Argentina, Australia, Austria, Belgium, Bulgaria, Canada, Chile, Cuba, Czech Republic, Denmark, El Salvador, Finland, France, Germany, Greece, Guatemala, Hungary, Ireland, Italy, Luxembourg, Malta, Mauritius, Netherlands, New Zealand, Nicaragua, Norway, Peru, Slovakia, South Africa, Spain, Sweden, Switzerland, Uganda, United Kingdom of Great Britain and Northern Ireland, United States of America, Uruguay.

Abstaining: Angola, Botswana, Brazil, Colombia, Eritrea, Ethiopia, Honduras, Israel, Jamaica, Kuwait, Republic of Korea, Romania, Russian Federation, San Marino, Senegal, Seychelles, Trinidad and Tobago, Tuvalu.

Absent: Afghanistan, Albania, Armenia, Azerbaijan, Bahrain, Bangladesh, Barbados, Belarus, Belize, Bolivia, Bosnia and Herzegovina, Burundi, Cameroon, Cape Verde, Cook Islands, Costa Rica, Croatia,

Cyprus, Democratic People's Republic of Korea, Djibouti, Ecuador, Egypt, Estonia, Fiji, Gabon, Georgia, Guinea, Iceland, Jordan, Kazakhstan, Kenya, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lesotho Libyan Arab Jamahiriya, Lithuania, Madagascar, Maldives, Mauritania, Mauritius, Federated States of Micronesia, Monaco, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Niger, Nigeria, Oman, Pakistan, Palau, Paraguay, Philippines, Poland, Portugal, Qatar, Republic of Moldova, Rwanda, Saint Kitts and Nevis, Samoa, Sao Tome and Principe, Saudi Arabia, Sierra Leone, Singapore, Slovenia, Solomon Islands, Sudan, Surinam, Syrian Arab Republic, The Former Yugoslav Republic of Macedonia, Ukraine, United Arab Emirates, United Republic of Tanzania, Uzbekistan, Vanuatu, Venezuela, Viet Nam, Zambia.

The proposal was therefore rejected by 36 votes to 28, with 18 abstentions.

Mr AITKEN (Assistant Director-General) suggested that the Committee had two options open to it: it could either follow Cuba's suggestion to establish a drafting group which would meet that evening in an attempt to establish a consensus and would report the following morning; or the full Committee could find some compromise between the two proposals which would reflect the weight of the voting. There had been a clear move, in terms of numbers, towards voting in favour of the first proposal: it had attracted a clear majority, albeit not a two-thirds majority. The second proposal had been defeated. The Committee would have to consider how it wished to proceed.

Ms WENSLEY (Australia) said that the difficulty with the second option was that it would be impossible for delegates to react immediately; they needed time to consider any compromise proposal and possibly to consult. Australia therefore favoured the establishment of a drafting group.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland), Dr WETZ (Germany) and Dr TIERNEY (Ireland) supported that view.

Mr AITKEN (Assistant Director-General) suggested that the drafting group should comprise the delegations of Argentina, Australia, Benin, Canada, China, Cuba, India, Ireland, Japan, United States of America and any others interested.

It was so agreed.

The meeting rose at 19:05.

TWELFTH MEETING

Friday, 12 May 1995, at 9:00

Chairman: Dr Fatma H. MRISHO (United Republic of Tanzania)

1. SECOND REPORT OF COMMITTEE A (Document A48/55)

Dr HANSEN-KOENIG (Luxembourg), Rapporteur, read out the draft second report of Committee A.

The report was adopted.[1]

2. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

FINANCIAL REVIEW: Item 18.3 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, and A48/17 Add.1) (continued)

The CHAIRMAN said that, as delegates were aware, it had not been possible at the preceding meeting to achieve consensus on the proposed appropriation resolution for the financial period 1996-1997. A drafting group had therefore met under the chairmanship of the delegate of Australia and had produced the following revised version for the Committee's consideration:

The Forty-eighth World Health Assembly

1. RESOLVES to appropriate for the financial period 1996-1997 an amount of US$ 922 654 000 as follows:

A.

Appropriation section	Purpose of appropriation	Amount US$
1.	Governing bodies	21 600 000
2.	Health policy and management	261 464 000
3.	Health services development	162 871 000
4.	Promotion and protection of health	131 146 000
5.	Integrated control of disease	120 756 000
6.	Administrative services	144 817 000
	Effective working budget	842 654 000
7.	Transfer to Tax Equalization Fund	80 000 000
	Total	922 654 000

[1] See page 275.

B. Within the overall appropriation of US$ 842 654 000, the operating budgets for 1996-1997 for the six regional offices shall be calculated in accordance with established principles of equity, and on the basis of the prevailing United Nations/WHO accounting rates of exchange, effective May 1995, for all regional offices' currencies *vis-à-vis* the US dollar.

C. Amounts not exceeding the appropriations voted under paragraph A shall be available for the payment of obligations incurred during the financial period 1 January 1996 - 31 December 1997 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 1996-1997 to sections 1-6.

D. Notwithstanding the provisions of Financial Regulation 4.5, the Director-General is authorized to make transfers between those appropriation sections that constitute the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made, this percentage being established in respect of section 2 exclusive of the provision made for the Director-General's and Regional Directors' Development Programme (US$ 6 643 000). The Director-General is also authorized to apply amounts not exceeding the provision for the Director-General's and Regional Directors' Development Programme to those sections of the effective working budget under which the programme expenditure will be incurred. All such transfers shall be reported in the financial report for the financial period 1996-1997. Any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.5.

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

		US$
(i)	reimbursement of programme support costs by the United Nations Development Programme in the estimated amount of .	3 600 000
(ii)	casual income (other than interest earned)	7 594 300
		11 194 300

thus resulting in assessments on Members of US$ 911 459 700. In establishing the amounts of contributions to be paid by individual Members, their assessments shall be reduced further by (a) the amount standing to their credit in the Tax Equalization Fund, except that the credits of those Members that require staff members of WHO to pay taxes on their WHO emoluments shall be reduced by the estimated amounts of such tax reimbursements to be made by the Organization, and (b) the amount of interest earned and available for appropriation (US$ 3 352 700) credited to them in accordance with the incentive scheme adopted by the Health Assembly in resolution WHA41.12.

F. The maximum net level of the exchange rate facility provided for under Article 4.6 of the Financial Regulations is established at US$ 31 000 000 for the biennium 1996-1997, on the basis of the United Nations/WHO accounting rates of exchange (for all regions and at the global level) prevailing during May 1995.

2. APPROVES the use of casual income, if available, up to the amount of US$ 10 000 000 in each of the years 1996-1997 for expenditure on priority country programmes, such expenditure to be approved by the Executive Board at its ninety-seventh session in January 1996;

3. URGES Member States to make every possible effort to pay their annual assessments in full and on time in order to ensure effective programme delivery;

4. REQUESTS the Director-General, in preparing future programme budgets, to present data from authoritative sources, *inter alia* international financial institutions and regional economic cooperation bodies, on estimated inflation rates.

Mr KNOTT (Australia), introducing the draft resolution, said that the drafting group had worked long and hard to produce its final version, for two reasons. First, a wide range of views on the issue were represented and those views had been fully expressed. Secondly, the group had been committed to preparing a proposal with the potential to achieve consensus. The version it had produced contained two changes in the financial arrangements: those were a much lower cost increase than in the previous version, together with better targeted and increased (but non-assessable) spending at country level, with resulting improvements in programme delivery. The drafting group proposed an increase over the preceding biennium's budget of 2.5%, which meant that the budget would increase from US$ 822 million in 1994-1995 to US$ 842 million in 1996-1997. That was 5% lower than either of the proposals on which the Committee had voted at its preceding meeting. It responded to the concern of many Members about trends in their own budgets considering current economic conditions.

The other major change was an approval of the use, from casual income, of US$ 10 million, in each of the years 1996 and 1997, for priority country programmes, such expenditure being decided by the Executive Board. That was the equivalent of a 2.5% increase in the budget, but one that did not increase assessed contributions. The change responded to Members' concern that support for country programmes should not automatically suffer as a result of tighter budgetary control. Indeed, somewhat paradoxically, the rigour imposed by a leaner budget and improved methods of work should improve efficiency both at headquarters and at regional level, which would further increase the availability of funds for those programmes.

In addition to those two changes, the proposal contained a new paragraph urging all Members to make every possible effort to pay their annual assessed contributions.

He urged the Committee to approve the revised appropriation resolution by consensus.

Dr ANTELO PÉREZ (Cuba) said that the drafting group had been faced by two problems. The first was that in fact countries were not going to be able to pay the contributions that would be imposed on them by the budget. Indeed, in document A48/20 the Administration, Budget and Finance Committee of the Executive Board expressed serious concern at the increasingly large number of Members that had been in arrears in the payment of their contributions in recent years to an extent which would justify invoking Article 7 of the Constitution. On the other hand, the developed countries were also unhappy with the proposals made to ensure approval of the programme budget. Thus, both rich and poor were agreed that a budgetary increase, even though intended to combat inflationary and exchange problems, would have an undesirable effect on the contributions to be made by each country, and it was essential that a solution should be found that would ensure approval. The Director-General was committed to increasing support to country programmes through allocations to be decided by the Executive Board. He, too, urged delegates to reach consensus on the proposal.

Miss TOSONOTTI (Argentina) strongly supported the draft resolution, considering it capable of securing a consensus. It had the advantages of reducing the proposed budget to a level commensurate with countries' ability to pay their assessments, and of providing for US$ 10 million to be available for expenditure on priority country programmes approved by the Executive Board.

Dr DOSSOU-TOGBE (Benin) said that the rejection of two draft appropriation resolutions the previous day and the intensive work that had gone into preparing a new draft indicated that the Organization continued to believe in the importance of reaching decisions by consensus. He was confident that the present text would secure general agreement.

Dr SAVEL'EV (Russian Federation) supported the draft resolution as a proposal which, as far as possible, took account of all the interests of Member States.

Dr BOUFFORD (United States of America) welcomed the proposal because it reduced the overall level of the budget from that of the previous proposals, a step which went a long way towards meeting the concern of a number of countries, including her own, about their ability to pay their assessments. The proposal also sought to encourage greater efficiency and less bureaucracy and so improve WHO's performance. She believed that the allocation of casual income to country-level programmes in accordance with Executive Board priorities was consistent with the generally shared goal of putting maximum resources into programmes of that kind. The Executive Board would need to be vigilant to ensure that outcome. Despite its favourable view of the new proposal, her Government might nevertheless find itself unable, for national budgetary reasons, to pay its assessment in full. Consequently, she could not join the consensus on the draft, but would not oppose it.

Dr MUKHERJEE (India) supported the draft resolution as a compromise formula which would help both developed and developing countries.

Dr AL-JABER (Qatar) also welcomed the draft.

Mr KASTBERG (Sweden) approved the draft resolution and expressed the hope that its adoption would lead to a higher level of contribution payments.

Mr NGEDUP (Bhutan) supported the draft resolution as a well-balanced and objective document.

Professor LI Shichuo (China) said that although the proposed appropriation resolution was not ideal, it represented a compromise which he would support.

Dr SEIXAS (Brazil), expressing strong support for consensus, said that his country wished to join the list of sponsors.

Mr ILABACA (Chile) said that he associated himself with the expressed desire for consensus.

Mr CHAUDHRY (Pakistan) approved the revised draft appropriation resolution.

Mr DENGO BENAVIDES (Costa Rica) associated himself with the appeal for consensus.

Ms ARIAS (Colombia) said that she too would welcome consensus in a spirit of compromise. Her country wished to join the list of sponsors of the resolution.

Dr TIERNEY (Ireland) supported the draft resolution. He welcomed in particular the provision that US$ 20 million of casual income should be spent on country programmes in the biennium. He asked for his country to be added to the list of sponsors.

Mr SATA (Zambia) felt that the compromise reached was workable and expressed his support for the draft resolution. The previous proposal would have increased the contributions also of countries that had only poverty and integrity. He hoped that the appropriations would be put to good use, but warned that, unless the running of the Organization came up to expectations, even more reductions might be the consequence.

Dr BASHI ASTANEH (Islamic Republic of Iran) supported the draft resolution.

Ms RIVERO (Uruguay) expressed her satisfaction at the prospect of consensus. She thanked the working group for its efforts and hoped that the exercise would serve as a guide for preparing future programme budgets. She hoped, too, that the work of the bodies concerned with the programme budget

would be more transparent, and that adjustments in the management field would continue to be made without affecting programmes.

The draft resolution was approved.[1]

3. THIRD REPORT OF COMMITTEE A (Document A48/56)

Dr HANSEN-KOENIG (Luxembourg), Rapporteur, read out the draft third report of Committee A.

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 10:10.

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA48.32.

[2] See page 276.

COMMITTEE B

FIRST MEETING

Wednesday, 3 May 1995, at 14:30

Chairman: Professor A. WOJTCZAK (Poland)

1. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 20 of the Agenda (Document A48/42)

The CHAIRMAN expressed gratitude for his election and welcomed all present, in particular the delegate of the new Member State, Palau.

He drew attention to the third report of the Committee on Nominations (document A48/42)[1] in which Mr M.S. Dayal (India) and Dr E. Samayoa (Honduras) were nominated for the offices of Vice-Chairmen of Committee B and Dr H. El Kala (Egypt) for that of Rapporteur.

Decision: Committee B elected Mr M. S. Dayal (India) and Dr E. Samayoa (Honduras) as Vice-Chairmen and Dr H. El Kala (Egypt) as Rapporteur.[2]

2. ORGANIZATION OF WORK

The CHAIRMAN, recalling the problems caused by the late introduction of draft resolutions during the Health Assembly in previous years, drew attention to resolution WHA47.14 which contained *inter alia* the request that when a resolution was first initiated and presented at the Health Assembly without prior review by the Executive Board, the Chairmen of Committees A and B, supported by the Director-General, should determine whether the committee concerned had sufficient information and whether to refer the matter to the General Committee.

The role of the representatives of the Executive Board, who would participate in the work of the Committee in accordance with Rules 44 and 45 of the Rules of Procedure, was to convey the views expressed by the Board and to explain the rationale behind any recommendations made for the Health Assembly's consideration. They did not express the views of their respective governments.

He suggested that the normal working hours should be from 09:00 to 12:30 and from 14:30 to 17:30. To allow full discussion of each item, he proposed that, if necessary, the afternoon meetings should continue until 18:00.

It was so agreed.

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[1] See page 274.

[2] Decision WHA48(4).

3. REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION: Item 21 of the Agenda

Interim financial report on the accounts of WHO for 1994 and comments thereon of the Administration, Budget and Finance Committee of the Executive Board: Item 21.1 of the Agenda (Documents A48/18 and Add.1 and A48/43)

The CHAIRMAN recalled that in January 1994 the Executive Board had adopted resolution EB93.R13 entitled "WHO response to global change: committees of the Executive Board". One of the decisions contained therein related to the establishment of an administration, budget and finance committee, which, *inter alia*, would meet for half a day before the opening of the Health Assembly, replacing the former Committee of the Executive Board to Consider Certain Financial Matters prior to the Health Assembly. The Administration, Budget and Finance Committee of the Executive Board had duly met on the morning of 1 May 1995 and its report was contained in document A48/43.

Mr AITKEN (Assistant Director-General) said that document A48/18 and its addendum contained the interim financial report of WHO for the year 1994, the first year of the biennium 1994-1995, and that a final financial report for the biennium would be submitted to the Health Assembly in 1996. The contents of the interim financial report were similar to those of previous interim reports, with an introduction in document A48/18 summarizing essential features, followed by statements and financial information with relevant explanatory notes. Document A48/18 Add.1 provided information on contributions received and programme activities financed from extrabudgetary resources.

There had been a low rate of collection of assessed contributions during 1994, only 80.3%, caused largely by the delay in payment by one of the largest contributors. Through the operation of the exchange rate facility there had been a net usage of almost US$ 1.9 million during 1994 in respect of the adverse effects of exchange rate fluctuations between the United States dollar and currencies at headquarters and regional offices, in particular the Swiss franc and the Danish krone. Based on the exchange rates in effect at 31 December 1994, it had then been estimated that a further US$ 6 million would be required during 1995, resulting in a total net usage of US$ 7.9 million for 1994-1995. However, with the further decline of the United States dollar over recent months, the current estimate of the amount needed was about US$ 21 million against the approved net level of US$ 31 million for the biennium.

At 31 December 1994, available casual income had amounted to some US$ 18 million. It had been proposed that after providing for a transfer of US$ 7 691 000 to the Real Estate Fund, for certain projects to be discussed later, almost US$ 11 million should be appropriated to help finance the regular programme budget for 1996-1997, currently under consideration in Committee A.

Of the effective working budget of US$ 822.1 million approved under the regular budget for 1994-1995, augmented by net transfers from casual income of US$ 1.9 million in respect of the exchange rate facility, giving a total of US$ 824 million, obligations of US$ 574.8 million or 69.8% had been incurred at 31 December 1994, leaving a balance of US$ 249.2 million available for obligation in 1995. It was normal practice to obligate a much higher percentage of the approved budget in the first year of the biennium, in particular to cover staff salary obligations for the whole of the financial period. Thus, at 31 December 1994, unliquidated obligations amounted to US$ 265.1 million, including US$ 173.1 million in respect of staff salaries and allowances for 1995.

Under extrabudgetary sources of funds, expenditures under the Voluntary Fund for Health Promotion during 1994 amounted to some US$ 149.2 million, compared to US$ 124.3 million in 1992 and US$ 165.4 million in 1993. Under other major extrabudgetary funds, expenditures in 1994 amounted to some US$ 206.1 million, compared to levels of US$ 252.7 million in 1992 and US$ 214.4 million in 1993.

He drew attention to a resolution recommended by the Administration, Budget and Finance Committee for adoption by the Health Assembly.

Mr ORR (Canada), recalling the financial rules, urged all Member States to fulfil their commitment to the Organization and to pay their assessed contributions in full, on time and unconditionally. He also looked forward to the full implementation of United Nations accounting standards for the presentation of future statements.

The interim financial statements for the year ended 31 December 1994 provided a useful summary of the spending of WHO's resources. According to paragraph 4 of document A48/18, the rate of collection of annual assessed contributions at the end of 1994 had amounted to 80.3%, or US$ 326 million which was only a modest improvement on previous years. However, Schedule 1 of the report indicated that some US$ 64.7 million of the outstanding assessments for prior financial periods had also been collected during 1994. Thus, actual cash inflow appeared to have amounted to some US$ 392 million, or 96% of assessed contributions for 1994. The actual cash outflow during the year seemed to have been less than budgeted, although it was difficult to determine that from reading the accounts. Disbursements had been approximately US$ 315 million for current programmes and US$ 51 million to cover deficits from prior years, indicating that during 1994 the Organization had had a positive cash flow of some US$ 25 million. Documents concerning the status of collection of assessed contributions should be modified to reflect actual cash inflow during the period covered, regardless of the financial period to which the contributions actually pertained, to give a more realistic picture of the status of payment of all assessed contributions. In addition, the communication of a quarterly expenditure update to Member States showing amounts expended against amounts collected might be appropriate; Canada had approved the recent adoption by the United Nations of a quarterly reporting format.

Document A48/18 Add.1 was voluminous, but much of the information was not very useful; it was important to remember that the Health Assembly's task was to consider policy and broad programme issues, not the minutiae of accounts. He had, however, observed with concern the indication that a number of accounts, including the technical cooperation funds relating to UNDP, UNEP, UNDCP and UNFPA, had been in negative balance at the end of 1994, and sought the assurance from the Director-General that the situation would be remedied by the end of 1995.

Dr TAPA (Tonga) expressed concern at the increase in the number of Member States failing to pay their assessed contributions on time and the consequent increase in arrears. Unfortunately, the incentive scheme to promote timely payments introduced by resolution WHA41.12 did not appear to be popular with many Member States. His Government, having made use of the scheme from its inception, could vouch for its financial benefits; he therefore urged all Member States that had not yet done so to give the scheme a trial.

He welcomed the report of the Administration, Budget and Finance Committee and endorsed the draft resolution.

Mr BOYER (United States of America) said that he shared the concern about late payment of contributions in 1994 and failure to pay any contributions at all; during the past two years and more, no payments had been received from 43 Member States. Although some 80% of contributions had been collected during the year, that proportion was still insufficient to allow the Organization to deploy its resources appropriately. He asked what measures were envisaged for meeting the shortfall in assessments at the end of 1994, which amounted to US$ 80 million. Borrowing from internal resources to meet such shortfalls, as had happened in the 1992-1993 biennium, was not a desirable practice, even though the US$ 51 million borrowed on that occasion had apparently been repaid in 1994.

Extrabudgetary contributions to WHO also appeared to be declining in almost every programme area and expenditure of those resources had also decreased from US$ 380 million in 1993 to US$ 355 million in 1994.

In the face of the decline in both payment of assessments and receipt of extrabudgetary contributions, the Health Assembly, as a governing body, would have to recognize that the Organization could not continue to operate as though there were no financial difficulties; the problems that a significant number of countries were facing in paying their contributions or providing extrabudgetary funds were unlikely to improve in the future. Serious efforts would have to be made to trim the Organization's programme in order to focus on a reduced number of activities that could be done well. At its session in January 1995, the Executive Board had made progress in recommending shifts of resources into high-priority programme areas, either by cutting back on programme areas of declining importance or by controlling administrative costs. Such action should, however, be a joint effort by all those with the interests of the Organization at heart, including WHO staff.

Because it would describe actual expenditure, the final financial report for the whole biennium, to be considered in 1996, would give more information than any budget estimates could. It was to be hoped that,

in future bienniums, proposed programme budgets would be compared not with the budgets for previous bienniums but with actual expenditure and actual implementation of programmes, since that would provide a more meaningful analysis.

With regard to document A48/18 Add.1, he shared the view that more meaningful summaries could be prepared, especially in relation to the Voluntary Fund for Health Promotion and the Global Programme on AIDS.

Mr VAN REENEN (Netherlands) shared the concern expressed with regard to the rate of collection of contributions, despite the fact that there had been a slight improvement as compared with previous years. Lack of payment discipline prevented WHO from carrying out planned activities and led to borrowing from internal resources. Every effort should be made to improve payment discipline and he therefore endorsed the draft resolution recommended in resolution EB95.R15, which would be considered under item 21.2 of the agenda.

Mr AITKEN (Assistant Director-General), replying to the delegate of Canada, said that the arrears of payments for earlier years received in 1994 could not be regarded as a source of income in that year as they had had to be used to pay back the money borrowed to meet 1992-1993 budget commitments. There was in fact a hierarchy of obligations that had to be met out of any arrears paid: the first was to repay any internal borrowing made necessary as a result of late payment of contributions, the second was to repay any funds taken from the Working Capital Fund, and the third was for casual income. Those calls on any arrears paid were covered in the accounts; however, an effort would be made to give a clearer description of the procedure in future reports.

Reporting of arrears to Member States was in fact done on a monthly basis in WHO. The Organization was also currently focusing on analysis of its own cash flow, including projections on a long-term basis. Although constant efforts were made to foresee the Organization's situation in the years ahead, the uncertainty with respect to prompt payment of contributions caused enormous difficulties.

The details on extrabudgetary contributions provided in document A48/18 Add.1 were necessary to meet the requirements of certain donors and to provide a document for submission to the External Auditor. It was difficult to reconcile those requirements with the need to provide an overall picture that the Health Assembly could consider for purposes of future policy. However, efforts would be made in the next report to develop a more user-friendly summary.

In reply to the delegate of the United States of America, he noted that, although the Organization had not yet had to borrow to meet its obligations for the current biennium, it expected to have to borrow a total of US$ 60 million, taking US$ 30 million from the Working Capital Fund and US$ 30 million from internal resources.

A cut of approximately 2% was currently being made in programme implementation in order to maintain a balance between borrowing funds and reducing activities in meeting the income shortfall. At the start of each biennium, an estimate had to be made as to whether the Organization would receive sufficient money to cover its activities. An analysis of income received in 1994 had shown that the Organization was keeping more or less level with the previous year's extrabudgetary income. It had to be recognized that there was a growth in funds earmarked for emergency operations rather than for regular programmes. The United States comment that there was a need for a close look at the issues of funding was thus a valid one and would no doubt be taken into consideration by Committee A in its review of the proposed programme budget.

Mr BOYER (United States of America) said that a number of large contributors, including his own country, were responsible for a major part of the shortfall in collection of assessments. One Member State in particular was some US$ 42 million in arrears, which would appear to pose a serious constraint on the Organization's activities. Could some information be provided on when those arrears might be paid?

Mr AITKEN (Assistant Director-General) said that WHO was in constant contact with large contributors to the budget who were in arrears. Such contributors had generally been very cooperative in indicating to WHO what they expected the future pattern of their payments to be, which enabled the Organization to estimate its future cash flow and had provided the basis for the current estimate of a borrowing requirement of US$ 60 million for 1994.

The draft resolution contained in document A48/43 was approved.[1]

Status of collection of assessed contributions and status of advances to the Working Capital Fund: Item 21.2 of the Agenda (Resolution EB95.R15; Document A48/19)

Professor KUMATE (representative of the Executive Board) said that the Director-General's report on the status of collection of assessed contributions and status of advances to the Working Capital Fund as at 31 December 1994 had been reviewed during the ninety-fifth session of the Executive Board. The Board had expressed deep concern at the level of outstanding contributions and the impact of the shortfall on the programme of work approved by the Health Assembly. It had noted in particular that, as at 31 December 1994, the rate of collection of contributions to the effective working budget for that year had amounted to 80.32%, resulting in a shortfall of almost US$ 80 million; that only 99 out of the 187 Members contributing to the effective working budget had paid their 1994 contributions in full; that 72 Members had made no payment whatsoever towards the 1994 contributions; that unpaid arrears of contributions to the effective working budget in respect of 1993 and earlier years exceeded US$ 52 million; and that, as a result of the introduction of the incentive scheme to promote the timely payment of assessed contributions instituted by resolution WHA41.12, those Members paying early in the year in which payment was due would have their contributions payable for the subsequent programme budget reduced appreciably, whereas Members paying later would have their subsequent contributions reduced only marginally, or not at all.

The Board had urged Members that were regularly late in the payment of their contributions to take as rapidly as possible all steps necessary to ensure prompt and regular payment. The resolution contained in resolution EB95.R15 was submitted to the Health Assembly for its consideration.

Mr AITKEN (Assistant Director-General), introducing document A48/19, drew attention to the fact that as at 30 April 1995 collections of contributions payable in 1995 in respect of the effective working budget amounted to 41.68% of the assessments on the Members concerned; that figure was substantially higher than the collection rate in 1994 and in line with the figures for 1993 and 1992. Regarding arrears for previous years, the total owing on 1 January 1994 had amounted to some US$ 122 million. The amount owing on 1 January 1995 had stood at US$ 137 million, and by 30 April 1995 at US$ 115 million. By 30 April 1995 as many as 60 Members - more than 30% of the total number - had made no payment at all in respect of the 1994 instalment, some 16 months after it had fallen due. However, he was pleased to report that during the first three days of May 1995, payments in respect of part or all of their 1995 assessments totalling some US$ 1.7 million had been received from 11 Members: Austria, Cook Islands, Federated States of Micronesia, Guinea, Kiribati, Malaysia, San Marino, Slovakia, Tunisia, United Republic of Tanzania, and Vanuatu. In addition, payments totalling more than US$ 300 000 in respect of arrears of contributions had been received from Burundi, Central African Republic, Guinea-Bissau, Suriname, Trinidad and Tobago, and Uruguay.

He expressed particular thanks on behalf of the Director-General to 10 Members which had paid their contributions in advance of the due date and in full in at least three of the last five years: Brunei Darussalam, Canada, Kuwait, Mauritius, Myanmar, New Zealand, Saint Lucia, Sweden, Thailand and Tonga.

Mr ORR (Canada) suggested that the draft resolution should be amended by the insertion of a paragraph requesting the inclusion in documents concerning the status of collection of assessed contributions of information regarding the collection of arrears as well as the collection of current assessed contributions so that a full picture could be given of how much money the Organization was receiving and the extent to which it was thereby able to replenish its reserves.

Dr PAVLOV (Russian Federation) said that his country intended to speed up the payment of its contributions for the current year, and had already paid US$ 8 million; a further US$ 2 million would be paid the following day. By the end of the year, his country's debt would have gradually been reduced to the absolute minimum. He endorsed the draft resolution recommended by the Executive Board in resolution EB95.R15.

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[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA48.4.

Ms INGRAM (Australia) shared the concern expressed regarding outstanding contributions and the effect that delays in payment had on the Organization's work. With such a large shortfall it was impossible for the Director-General to implement the programme budget in an orderly manner, and she wondered whether the Health Assembly would consider establishing priorities within the programme budget.

Dr SOMBIE (Burkina Faso) said that his country had paid about US$ 60 000 of its arrears.

Mrs HERZOG (Israel) shared the concern expressed regarding the late payment of assessed contributions, and asked why Israel had not been included in the list of Members that had paid their contributions in full.

Mr KOVAL (Ukraine) said that his country's delegates at previous Health Assemblies had repeatedly stated that, following the break-up of the Union of Soviet Socialist Republics, the General Assembly of the United Nations at its forty-seventh session had set a rate of assessment for Ukraine that was both unjustifiably high and completely unrealistic in view of the country's economic and financial situation. The decision of the General Assembly of the United Nations at its forty-ninth session to review and reduce Ukraine's rate of assessment had been a recognition of the inappropriateness of the rate of assessment for 1994-1995. A corresponding correction by WHO to Ukraine's rate of assessment for 1996-1997 would also be appropriate.

As a country with an economy "in transition", Ukraine was encountering significant economic difficulties linked partly to market restructuring and partly to the financial repercussions of the consequences of the accident at the Chernobyl nuclear power station. Consequently, Ukraine would not be able to pay its contributions to WHO in full; however, it had transferred US$ 3 million to the Organization in January 1995, thereby demonstrating its goodwill towards and support for WHO, and hoped that that payment would be taken into account when the Organization's technical cooperation programme was drawn up.

Dr LOUME (Senegal) said that his country was one of those in arrears with their contributions. While he did not wish to make excuses, he pointed out that there were often delays within the government system, and that the Ministry of Health had made an effort to resolve the problem.

Dr DY (Cambodia) said that he was pleased to report that his country would be paying all its arrears and the current contribution in the next few days, in spite of the serious budgetary and financial difficulties with which it was faced.

Dr DLAMINI (Swaziland) shared the concerns expressed regarding delays in the payment of contributions, which were often the result of the various economic constraints to which countries were subject. She endorsed the resolution recommended in resolution EB95.R15, as well as the amendment proposed by the delegate of Canada and the proposal that the Organization should "prioritize" activities in its programme budget.

Dr TAPA (Tonga) also expressed support for the draft resolution recommended in resolution EB95.R15, but requested that the amendment proposed by the delegate of Canada should be submitted in writing.

Mr AITKEN (Assistant Director-General) said that a cross-reference in the draft resolution to the accounts might give rise to confusion and he hoped that instead the delegates of Canada and Swaziland would accept his assurance that steps would be taken to draw more attention to payments of arrears of contributions in future documentation. He pointed out to the delegate of Israel that the list to which she had referred was of those Members that had paid their contributions in advance of the due date and in full in at least three of the last five years. The setting of priorities within an approved programme budget, suggested by the delegate of Australia, might prove a double-edged sword because there was a tendency for some Members to think that they did not need to pay for activities that were not given a high priority. He thanked the delegate of Ukraine for his country's payment which had been duly received.

The CHAIRMAN asked the delegate of Canada if he could accept the solution proposed by Mr Aitken.

Mr ORR (Canada) said he would be happy to do so, but wished the situation regarding the collection of arrears to be reflected not only in the annual accounts but also in the monthly document on the status of contributions.

The CHAIRMAN said that that would be done.

The draft resolution recommended by the Executive Board in resolution EB95.R15 was approved.[1]

Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution: Item 21.3 of the Agenda (Decision EB95(12); Document A48/20).

Mr AITKEN (Assistant Director-General), introducing the second report of the Administration, Budget and Finance Committee of the Executive Board (document A48/20), drew attention to the draft resolution contained in it and provided information on the developments which had taken place since that Committee's last meeting on 1 May 1995.

As a result of payments made by Suriname and Uruguay, the unpaid prior years' arrears of contributions due from those Members had now been reduced to a level below the total amount due for the years 1993 and 1994. Hence the following text should be added after the last preambular paragraph of the draft resolution:

> Having been informed that as a result of payments received after the opening of the Forty-eighth World Health Assembly the arrears of contributions of Suriname and Uruguay have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution,

Suriname and Uruguay should also be deleted from the Members named in paragraph 6(1) of the resolution.

The equivalent of US$ 14 989 had been received from Guinea-Bissau, but that amount did not reduce the prior years' arrears to less than two years' contributions and had no impact on the suggested resolution.

Dr LIU Hailin (China) said that, although it was essential for every Member to fulfil its obligations to pay its contributions on time, certain developing countries had financial or political problems causing the arrears in question. In those cases, WHO should adopt a flexible attitude and find a solution which did not deprive those countries of their voting rights.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) said that in the important matter of unpaid arrears WHO should follow well-established procedures rather than try to make changes.

Dr TAPA (Tonga) endorsed the draft resolution recommended in the document, as amended by Mr Aitken.

Mr AITKEN (Assistant Director-General) said that in recent years, the Health Assembly had adopted a policy of depriving Member States which had not paid their contributions of their vote but only subsequent to one year's advance notice. Such a period of delay had been intended to cover some of the concern expressed by the delegate of China. It was up to Member States to decide whether they considered that approach satisfactory.

The draft resolution, as amended, was approved.[2]

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[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA48.5.

[2] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA48.6.

Arrears of contributions of South Africa: Item 21.4 of the Agenda (Documents A48/21 and Add.1)

Mr AITKEN (Assistant Director-General) said that, since no decision had yet been taken by the United Nations, the Director-General had suggested, on the basis of a letter from the Government of South Africa, that further consideration of the subject by the Health Assembly should be deferred until the following year.

In reply to a request for clarification by Mr SALA Vaimili II (Samoa), Mr AITKEN explained that South Africa had paid its contributions in full since its membership had been reactivated.

Mr TOPPING (Office of the Legal Counsel) confirmed that South Africa therefore had full membership rights.

The CHAIRMAN said he took it that the Committee wished to defer the matter until the Forty-ninth World Health Assembly to be held in 1996.

It was so agreed.

Report on casual income: Item 21.5 of the Agenda (Document A48/22)

Professor KUMATE (representative of the Executive Board), introducing the item, said that the Board had been informed that the estimated unobligated balance of casual income available as at 31 December 1994 had been approximately US$ 14 million. After closure of the accounts, however, the final amount stood at US$ 18.6 million. After taking into account the proposal set out in the resolution recommended by the Board in resolution EB95.R18, as revised,[1] that US$ 7.7 million should be appropriated to the Real Estate Fund, the available balance of casual income of US$ 10.9 million could be applied to help reduce Members' assessed contributions for the 1996-1997 biennium. Of that sum, US$ 3.3 million would be used under the financial incentive scheme in accordance with resolution WHA41.12. The balance would be deducted from appropriations prior to the calculation of assessed contributions of Member States for that financial period.

The Committee endorsed the Director-General's proposal to appropriate US$ 10 947 000 of available casual income to help finance the 1996-1997 regular budget.[2]

The meeting rose at 16:55.

[1] See document WHA48/1995/REC/1, Annex 4.

[2] Transmitted to Committee A in the Committee's report to Committee A.

SECOND MEETING

Thursday, 4 May 1995, at 14:30

Chairman: Professor A. WOJTCZAK (Poland)

WHO RESPONSE TO GLOBAL CHANGE: Item 22 of the Agenda

Progress report on implementation of recommendations: Item 22.1 of the Agenda (Document A48/23)

Dr CHOLLAT-TRAQUET (Cabinet of the Director-General) said that document A48/23 provided an overview of the status of implementation of the 47 recommendations made by the Executive Board Working Group on the WHO Response to Global Change. It incorporated the changes approved by the Executive Board following its review of the subject in January 1995. Implementation had made steady progress and was at present slightly ahead of schedule, principally because the Director-General had concentrated efforts initially on implementing the more straightforward and less complex recommendations. Thus, some 12 recommendations dealing with issues of restructuring and policy had been implemented in the first phase, from May 1993 to May 1994. Subsequently, some 20 recommendations requiring consultations and consensus at all levels of the Organization, such as those relating to the managerial process, had been implemented in the period May 1994 to May 1995. At present, some 10 recommendations requiring more detailed preparation, principally relating to WHO country offices and staff matters, still remained to be implemented. Following its review of the matter, the Executive Board had urged that WHO's response to global change should not be limited to the Working Group's 47 recommendations but that the principle of continuing reform should become part of WHO's way of life. It was important to note that, as soon as any recommendation had been approved for implementation by the Board or the Health Assembly, it was incorporated in the programme management procedure.

Six development teams, which involved the participation of over 620 staff members throughout WHO, coordinated by the Management Development Committee and the Global Policy Council, had been established to undertake that task. The work of the development teams was summarized in section II of the report.

At the start of their work, it had been clear to the development teams that their terms of reference would have to be extended in order to ensure that the reforms that implementation of the 47 recommendations would bring to the various parts of the Organization would be effective. Various teams also shared areas of common interest. As a result, there had been a high level of coordination between all the teams from the outset. In order to strengthen the links between the Executive Board and the development teams in pursuit of the reforms, each team had been joined by a Board member.

Reviewing the work of the individual teams, she said that the development team on WHO policy and mission, which had operated principally at the subgroup level, had had one meeting, in August 1994, attended by Professor Caldeira da Silva. The development team on WHO programme development and management, whose task was perhaps the most complex, had held two meetings, which had been attended by Dr Chávez Peón. The team had considered not only the management of WHO programmes but also coordination between the different levels and the evaluation of programme budgets and staff performance. Its report would be considered by the Executive Board at its forthcoming session; based on that discussion and any comments made by the Health Assembly, a manual on the WHO managerial process would be issued together with detailed guidelines where necessary. The work of the development team on WHO information systems was closely associated with that of the team on WHO programme development and management. For that reason, and also because the work underlay most of the other reforms, it had been given a high priority, so that the team had made rapid progress. It had held two meetings, attended by Dr Al-Jaber, and would be submitting its report to the Board at its next session. The development team dealing with WHO's information and public

relations policy, a topic that had already been under serious consideration within the Organization for some time, had met once, with the participation of Dr Kamanga. Its report had been approved by the Board at its January 1995 session; most of the proposals that it contained had already been implemented. The team was thus no longer in operation. The development team on the role of WHO country offices, chaired by Dr Han, Regional Director for the Western Pacific, with the participation of Professor Li Shichuo, had had a complex task to carry out, but its report was also expected to be submitted to the Board at its next session. It would stress the importance of a WHO presence in each Member State, one that matched the scope and nature of the programmes in which the Organization was involved in the country concerned. The team's work was also closely linked to that of the team on WHO policy and mission and that of the team on WHO personnel policy (since considerable training and support for WHO Representatives was recommended in coming years). The development team on WHO personnel policy had held one meeting, which no Board member had been able to attend, and would meet again in May 1995. It was currently operating in subgroups. The team's primary task was to integrate a number of studies of personnel management procedures, such as the reform of the staff appraisal system, at present under way, and staff and career development. The team's final report would be submitted to the Board at its January 1996 session.

Section III of the report covered the recommendations outside the purview of the development teams. The Legal Counsel was concerned with recommendations 13 and 14, which dealt with the elections of the Director-General and the Regional Directors, and the designation of members of the Executive Board. The Management Development Committee was dealing with recommendations 16 and 24 relating to the methods of work of the governing bodies, and recommendations 36, 37, 38 relating to management of financial resources. The Global Policy Council was dealing with recommendation 23 relating to delegation of authority and also with coordination of the implementation of all the recommendations, which was covered in section IV of the report.

In summary, the report on information and public relations policy had been considered by the Board in January 1995, the reports on programme development and management, the management information system and the role of WHO country offices would be reviewed in May 1995, and the report on personnel policy in January 1996. In view of the need for consultation with and in Member States, the final report on WHO's policy and mission would not be submitted to the Board until January 1997.

Professor KUMATE (representative of the Executive Board) said that the progress report had been reviewed in detail by the Executive Board, together with the report of its Programme Development Committee.

The Board had also been presented with an interim report by the Director-General outlining the progress made on the WHO management information system. The Board had noted the key objectives, which were to enable management to focus on desired products and results as set out in the Ninth General Programme of Work, to support management decision-making by providing access to WHO policy, programme information and health information, and to develop a common management terminology. Such a system should increase the visibility of programme activities, permit better monitoring and evaluation of access to synthesized scientific and technical data, and disseminate WHO policy and strategic documents. The costs of developing the system were not known at the time, but the Board had noted that some funds had been included in the proposed programme budget for 1996-1997 for staffing and certain start-up costs. The Board had recommended that a briefing on the subject should be organized during the current session of the Health Assembly. It had also endorsed the communications and public relations policy submitted by the Director-General and recommended its immediate implementation.

To facilitate the decision-making process in the election of the Director-General, the Board had decided to establish an ad hoc group to consider options for nomination, including the possible use of a search process, and terms of office. It had taken the view that the role of the regions in the selection of Regional Directors should not be diminished, but that the ad hoc group might wish to consider the types and the method of presentation of the information submitted to the Board when Regional Directors were appointed. For reasons of economy, the ad hoc group would carry out its work when its members were attending other WHO meetings; the group would report to the Board at its ninety-seventh session in January 1996.

The Board had recommended that the opinion of Member States on the work of WHO should be surveyed through the continuous consultation mechanisms set up in all regions, and through the mechanisms established for coordination and consultation with the governing bodies, in particular, its Programme

Development Committee and the Administration, Budget and Finance Committee. The Board had also requested that other means should be found to sound out from time to time the opinions of Member States on specific aspects of the Organization's work and to be kept informed of those opinions.

The Board had decided that the method of work of regional committees should be reviewed in three to four years' time and Member States encouraged in the meantime to include Board members in their delegations to regional committees. The Board had also requested the Director-General to facilitate the participation of Board members in the management committees of all major extrabudgetary-funded programmes by for example, choosing the same time and place for those meetings. It had also requested the managers of all such programmes to invite Board members to attend the meetings of their management committees whenever possible, and had decided to examine the feasibility of assigning the follow-up of one or more programmes, whether funded by the regular budget or from extrabudgetary resources, to each Board member at no additional cost to the Organization.

Regarding the question of regional allocations, the Director-General had prepared an information paper for the May 1995 session of the Board, and the view had been that resource allocations could not be discussed separately from the renewal of the health-for-all strategy.

The Board had concluded its review by commending the Director-General for setting up coordinating mechanisms within the Organization and with the governing bodies to implement the recommendations on the WHO response to global change, and for the progress that had been made. It had endorsed the schedule for the submission of reports by development teams to future Board sessions, while also requesting that the work should be speeded up whenever possible. The Board had urged that steps should be taken to ensure that the changes reached all levels of the Organization and remained an integral part of WHO management, thus enabling the Organization to follow up and manage change once the 47 recommendations had been implemented. It had called for the creation of a focal point within the Organization to ensure adequate follow-up of the recommendations and their incorporation in the managerial process.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) congratulated the Director-General and his staff on undertaking the fundamental and essential review of the way in which WHO operated, set out in document A48/23. He welcomed the progress made in implementing the Working Group's recommendations, and looked forward to progress being made on those that remained to be implemented. The Organization had made great strides towards reinvigorating and improving its management structure. The reform of any organization was accompanied by upheaval, uncertainty and unease, and he applauded the determination of the Director-General to carry reform forward, and the goodwill with which his staff had approached the task. Much had already changed for the better, especially in the establishment of new structures and in the collegiate approach to management, e.g., in the Global Policy Council. It would take time for the benefits of reform to permeate all parts of the Organization, but even so it was to be hoped that no time would be lost in spreading those benefits more widely. Reform must spread and influence all levels and all regions of WHO; the process had, understandably, moved furthest at headquarters and in senior management structures, and the Director-General would have the support of the United Kingdom in moving it both downwards and outwards.

He stressed the key role of the development teams, in particular those on personnel policy and that on the work of the WHO country offices. Completion of their studies and implementation of measures arising from their work were eagerly awaited.

For the Organization's long-term benefit, it was essential that the reform process received adequate material support within WHO, and that a designated unit took responsibility for its further development. The United Kingdom was working with a number of other delegations on a draft resolution to encapsulate that message of support and encouragement for further reform, and hoped that it would be widely supported.

Dr TAPA (Tonga) commended the progress reflected in document A48/23 and praised the efforts of the Administration, Budget and Finance Committee, the Programme Development Committee and the six development teams. He endorsed the decisions and resolutions adopted on the subject. The Executive Board should continue to monitor progress on the implementation of the recommendations, including those which awaited further consideration and decision.

Dr LEPPO (Finland), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, submitted that WHO's relevance depended on its capacity to respond to change; implementation of the recommendations of the Board's Working Group was crucial to the strengthening of the Organization's role as the directing and coordinating agency in international health.

He commended the Director-General on the steps already taken to move forward the broad internal process of reform. However, the development of the most demanding recommendations regarding global change still lay ahead, for the three key areas were WHO's policy, and mission, its personnel policy and its programme development and management. Its policy and mission must be clearly focused and make full use of the uniqueness of the Organization's role. Hard choices would be called for in meeting the challenges of bridging gaps in matters of health, and that required a stronger emphasis on dialogue with Member States regarding the strategic areas for involvement. WHO's standard-setting role should be at the core of its policy and mission, and the Organization needed to consider carefully how, in the context of limited resources, it could strengthen its profile as a base for technical knowledge at the country level. With regard to policy development, he welcomed the renewal of the health-for-all strategy and regarded the first consultative document as a good start, although the focus on a new international conference should not overshadow the need to tackle the weaknesses in implementing present health-for-all components, not least those related to primary health care.

WHO's highly qualified, committed and diligent staff constituted the core of the Organization and shaped its credibility as a technical agency in health. WHO could attract new and excellent young people, but only if it had an updated and supportive personnel policy; that was an urgent matter, and he looked forward to the proposal, developed in consultation with the staff, that would be presented to the Board at its ninety-seventh session. Steps should be taken, *inter alia*, to increase the proportion of women in policy-making and other professional positions; and a fair geographical distribution of staff remained an important objective.

The reforms in programme development and management should enhance the Organization's ability to make clearer choices in terms of priorities, to improve coordination and integration, and to concentrate resources where they could best respond to the most critical needs. Greater attention should be given to rationalizing the programme structure in order to reduce verticality and foster programme collaboration. The fragmented nature of many WHO activities meant that limited resources were used less efficiently than they might be.

Changes in a multicultural and international organization such as WHO did not occur overnight; they formed a continuum, and their implementation called for determination, hard work, commitment, and the unprejudiced action and full support of all Member States and of the entire Secretariat. The Nordic countries wished to support and accelerate that process, and in that spirit associated themselves with the draft resolution on the matter announced by the United Kingdom.

Dr CHÁVEZ PÉON (Mexico) voiced his country's firm belief that a balance should be struck between WHO's guiding and standard-setting function and that related to technical cooperation, especially for the developing countries; neither of those roles could be assumed by any other organization working in the health field. There was also a need for technical cooperation to be carried out with country-level investment of high quality at the right time.

Commending the work of the development teams, he acknowledged that the process of modernizing WHO would take some time; but if it was encouraged by Member States he was certain that there would be an appropriate response, not only at headquarters but also at the regional and local levels.

Dr ONO (Japan) joined in commending the efforts to respond to global change. He observed that the new internal mechanisms were functioning well, and requested the implementation of the recommendations of the different bodies working on the issue promptly and at all levels, in concert with regional and national authorities. The reports of the Programme Development Committee and the Administration, Budget and Finance Committee had provided informative background material for members of the Executive Board and had facilitated discussions in that forum.

Mr CRONIN (Canada) observed that, during the three years since WHO had initiated the process of developing a response to significant worldwide economic, political and sociocultural changes, considerable

progress had been achieved in some areas of health care, while in others, the situation has worsened. He welcomed the initial results of the reform process and looked forward to the reports of the development teams, in particular that on WHO programme development and management. Planned expenditure should be linked to clear objectives and priorities and outcomes should be monitored and evaluated, thereby providing for a continuous assessment of programme effectiveness.

The Director-General should (1) continue to strengthen the role of WHO Representatives; (2) define better the comparative advantage of WHO within the United Nations system; (3) continue to unify the Organization, i.e. headquarters, regional and country offices and also to improve personnel policy, particularly in relation to performance evaluation, the participation of women and staff recruitment and development; and (4) ensure that appropriate changes were effected at all levels of the Organization. WHO must enhance its capacities to respond rapidly to emerging priority needs, determining where savings could be made or resources reallocated to meet those needs. Reform was not an end in itself, but a process which would demonstrate its true value by making for greater effectiveness in response and in programme delivery; hence it deserved full support.

Dr LIU Hailin (China) noted with satisfaction that WHO had begun to implement recommendations and revise programmes simultaneously; the changing needs that stemmed from the global situation should be fully reflected in the new programme budget. It was necessary to take full account of the views of Member States in WHO's work, including the monitoring of implementation of health-for-all strategies and the formulation of a new health policy on the basis of equity and solidarity. He was in favour of convening a high-level conference so as to obtain the greatest possible commitment on the part of all governmental departments - and not merely those dealing with health matters - to WHO's goals for the next century.

The discussions by the development team on WHO country offices represented a positive reaction to global change. Member States should be consulted in regard to staffing levels and the selection of WHO Representatives, so that such offices could serve better the real needs of Member States.

Mr QUAUNINE (Bangladesh), expressing appreciation of the progress reflected in document A48/23, said that since the decentralized structure of WHO had already proved its worth, it was important to strengthen the regional and country offices. The latter should establish closer relations with governments, as the reform process needed to consider individual country priorities. He therefore welcomed the work of the development team on the role of WHO country offices.

Bangladesh remained dedicated to the goal of health for all by the year 2000; that objective should be at the centre of the reform process.

Notwithstanding the obvious financial and other constraints on implementation of the various recommendations, the reform must avoid harming staff, who were the key to its success.

Dr PICO (Argentina) submitted that the progress described in document A48/23 marked the beginning of a transformation which he hoped would be pursued. Any responses to change in an open, interrelated system such as WHO would take time, and it was therefore important to have at least set the reform process in motion. WHO must press ahead with technical and administrative rationalization so as to create greater institutional efficiency, which was the only way to reduce inequalities in the health sector. That was why he supported the reform process and urged the continued monitoring of the results, with a view to more efficient strategic planning.

Dr ABU BAKAR Dato' SULEIMAN (Malaysia) also welcomed the progress made in implementing the recommendations on WHO's response to global change and endorsed the relevant decisions and resolutions adopted by the Executive Board. He emphasized the need to consult Member States as widely as possible in the process of elaborating WHO's policy and mission.

Ms INGRAM (Australia) remarked that almost three years had passed since the recommendations of the Executive Board Working Group had been made and that a great deal of work remained to be done. Several of the development teams would not report to the Executive Board until May 1995 or January 1996: she expressed concern at such delays and looked forward to the final reports.

The process of reform should be a dynamic one, creating a culture of reform throughout the Organization. As a part of that process, it was important to look carefully at any obstacles to reform, and more particularly to ensure that WHO's institutional and constitutional framework was adequate and relevant to the international health challenges of the late twentieth century and beyond.

Professor CALDEIRA DA SILVA (Portugal) endorsed WHO's commitment to the response to global change, although since 47 targets had been set to be achieved within three years, the process might be considered one of revolution rather than reform. That was a subject of concern to his country, which favoured continuous, dynamic and all-encompassing reform. He endorsed the decisions and resolutions adopted on the subject by the Executive Board.

Ms LOBBEZOO (Netherlands) welcomed the steps taken since the Forty-seventh World Health Assembly to implement the recommendations on the WHO response to global change, despite the difficulties faced by the Organization. The reform process should remain an integral part of WHO's management structure at all levels.

Her delegation was, however, disappointed that document A48/23 did not offer any genuine choices, and was concerned at the delays in the completion of the reports by the various development teams, which were crucial to the acceleration of the reform.

Professor LOUKOU (Côte d'Ivoire), noting with satisfaction that WHO's management was indeed responding positively to global change, said that it was important for the Organization to retain its role of leadership in formulating and initiating strategies to improve the state of health of populations worldwide. Whilst appreciating the progress made in implementing the 47 recommendations, he would urge the Director-General to intensify and accelerate the process so as to reduce the discrepancies and inequalities, at the same time stepping up the participation of African professionals. The achievement of a reformed and dynamic WHO by the year 2000 would be a source of pride for all Member States.

Mrs VOGEL (United States of America) also expressed satisfaction at the progress made and the desire to see more focus in WHO efforts, as well as a redefinition of the role and functions of WHO country offices, on the basis of governments' views on the matter. The monitoring of follow-up to the recommendations and careful scrutiny of the results were important and she concurred with previous speakers that much remained to be done - the reform process should forge ahead.

Mr MOEINI-MEYBODI (Islamic Republic of Iran) hoped that the remaining recommendations would be fully implemented in the near future. Democratic participation of Member States in decision-making was a basic tenet of international organizations. Referring to recommendation 13 on the nomination and terms of office of the Director-General and Regional Directors, he wondered how Member States could be involved in the process and was unsure whether the search mechanism was appropriate. Regarding recommendation 38 on regional and country allocations, he considered that any reallocation of the budget should be discussed with the regional committee of the region concerned, and the Members of the region informed accordingly.

Mrs TINCOPA (Peru) supported the reform, particularly the priority accorded to a response to the growing inequity in health matters stemming from increased poverty. Peru recognized the need to focus on the poorest people and to manage the support given by donors in order to lay the firm foundations of effective health systems; in that context, she drew attention to the initiative for intensified cooperation with the countries in greatest need and the reallocation of technical resources in the Organization to help the poorest countries become the protagonists in their own development. Greater coordination at all levels in the Organization, and the formulation of responses tailored to the individual demands of countries were perhaps the best evidence of the WHO reform and deserved full support.

Mr RONDÓ FILHO (Brazil) agreed that the solution to reform lay within the Organization, which should remain the lead organization in health matters. Steps should be taken to ensure that there was no duplication of effort but that WHO made best use of its cooperation with other organizations and institutions, for example; the Codex Alimentarious Commission and, in that connection, WTO; FAO and national

committees set up to follow up the International Conference on Nutrition; and WHO collaborating centres. Cooperation with the latter should be subject to regular evaluation. Decentralization was the key to efficiency, as recent experience in FAO had shown.

WHO must ensure that its work brought immediate results, focusing on the topics within its mandate and avoiding areas that were risky or difficult to monitor, such as public relations or awareness-raising. Effective action on health would itself raise awareness; any activities in other areas should be closely monitored.

Dr KHOJA (Saudi Arabia) remarked that the 38 admirable targets relating to various aspects of health adopted in 1985 in the European Region of WHO were not reflected in the other regions and he advocated the establishment of an advisory committee for each region to attempt to draw up a new strategy related to specific targets in order to ensure equity, equality of access to health services and solidarity, in keeping with the wishes of all Members. Guidelines on WHO's role, particularly in respect of the response to global change, could then be drawn up and the necessary budgetary allocations made.

Dr CHOLLAT-TRAQUET (Cabinet of the Director-General) said that many speakers had stressed that implementation of the recommendations adopted less than two years previously was slow. The difficulty lay in WHO's decentralized structure and the fact that time was needed, especially at international level, if changes were to be thorough.

The process had been speeded up in comparison with the original estimates of 1993 and about two-and-a-half years would be needed to implement the 47 recommendations. In fact, the important thing was that the momentum continued and the Organization adopted the changes into its corporate culture. She was aware that not all the methods were perfect but progress was being made and discussions would continue even after the adoption of the reports as was foreseen, for example, on WHO collaborating centres as proposed by Brazil. In any case, reform had become a lasting feature in WHO.

In regard to the budget reallocation mentioned by the delegate of the Islamic Republic of Iran, she replied that the Executive Board would study the question, an extremely complex matter which would take time and in which regional committees and countries would certainly participate.

Finally, she explained that proposals to speed up introduction of the information system had already been implemented in part.

Mr TOPPING (Office of the Legal Counsel), replying to a question from the Islamic Republic of Iran on how Member States could become more involved in selecting the Director-General, explained that the Executive Board had established an ad hoc working group to study the various options for nomination of the Director-General including search. The ad hoc group had met once; it would meet again during the Health Assembly and make proposals to the Executive Board in January 1996 which might contain a response to the question raised.

In the absence of any further comments, the CHAIRMAN took it that the Committee wished to thank the Board for its work, take note of the progress made, endorse the decisions and resolutions on the subject, and request the Board to continue to monitor progress.

It was so decided.

(For continuation, see page 212.)

Renewing the health-for-all strategy: Item 22.2 of the Agenda (Resolution EB95.R5; Document A48/24)

Dr CHOLLAT-TRAQUET (Cabinet of the Director-General), introducing the item, said that when the development team on WHO's policy and mission had examined recommendations 2, 3, 4, and 17 of the Executive Board Working Group on the WHO Response to Global Change, it had decided to analyse the world situation with a view to determining policy for the next 20-25 years, as well as WHO's role and mission. The development team had noted a number of positive indicators, such as the overall increase in

life expectancy during the previous 40-50 years and the decrease in infant mortality, but had observed the much slower progress in the least developed countries and the unacceptable gap between developing and developed countries. Similar alarming trends were the deterioration in sanitation in the least developed countries and the decrease in immunization with the diphtheria/pertussis/tetanus vaccine. Furthermore, the development team had considered that the positive changes in the political, economic, social and cultural situation in many countries could have negative short-term effects on health systems and the health status of populations, for example, the increasingly vast income gap between the richest and poorest sections of the world population and the growing poverty and marginalization of certain groups as a result of population growth.

The development team had concluded that it was essential to review strategy and to define a new health-for-all policy, integrating health and development and covering other problems of equity and solidarity. In order to be effective, the policy would have to be based on consultation between all concerned; it was therefore proposed to undertake a worldwide consultation based on the WHO regional offices but focused on the countries themselves and involving all those concerned in health development from governmental to local level, and culminating in the adoption of a charter to implement the new policy in 1997.

She drew attention to document A48/24 which contained a general introduction to the subject, including comments by the Executive Board, and document EB95/1995/REC/1 which contained resolution EB95.R5 and, in Annex 5, the Director-General's report to the Executive Board on renewing the health-for-all strategy, which would serve as a basis for the worldwide consultation. It was essential that the policy, once adopted, should be integrated into national plans and policies as well as into the different programmes of activities of organizations of the United Nations system and governmental organizations. For WHO, the policy would serve as a basis for the preparation of the Tenth General Programme of Work. Since the adoption of resolution EB95.R5, the Director-General had embarked upon some of the preparatory work for the consultation and WHO's Regional Office for the Americas had begun the consultation process itself.

Professor KUMATE (representative of the Executive Board) said that the development team on WHO policy and mission had proposed the formulation of a new global health policy for the next 25 years based on the health-for-all strategy. The Executive Board had reviewed the Director-General's report on the third monitoring exercise and expressed great concern at the negative trends in some major health indicators, which reflected a worsening health situation. The Board had taken the view that, on account of the obvious relationship between health and development, priority must be given to the most deprived, whether for reasons of poverty, marginalization or exclusion. The new global health policy would focus on poverty, equity and solidarity, with specific emphasis on the least developed countries and the worsening of certain conditions even in more highly developed countries.

The Board had acknowledged the considerable influence and achievements of the health-for-all strategy throughout the world, although the target might not be attainable by the year 2000. There had been increased recognition of the need for firm global and international commitment to an intersectoral approach extending beyond the health sector and linking WHO not only to governments but to the private sector and other organizations. The fundamental importance of shared responsibilities based on mutual self-interest among all countries to achieve better health for all had been emphasized. In the rapidly changing political, economic, social and cultural situation, health had to be regarded as an integral part of overall development. The Board had therefore stressed the importance of broad national and international consultation between the health and social development sectors, so as to strengthen the commitment to health under WHO leadership. WHO's role would be to assist political and financial leaders to appreciate more clearly the place of health in the economic and social structure of their countries. There was an urgent need to ensure the full participation of all concerned, especially within the United Nations system, other international organizations, nongovernmental organizations and countries themselves.

Mobilization at country level was essential for creating political will and avoiding duplication of effort. The Board had considered that the renewal of the health-for-all criteria should focus on strengthening WHO's influence in other organizations for the benefit of health development. The Board had therefore recommended the adoption of the resolution contained in resolution EB95.R5.

Dr ALLEYNE (Regional Director for the Americas) said that in the Region of the Americas the underlying principles of the health-for-all strategy were still valid and that the strategy itself, with some

modifications in relation to primary health care, was still appropriate. However, in many countries interest seemed to have flagged. Following the ninety-fifth session of the Executive Board consultations had begun in his Region with a view to renewing enthusiasm for the strategy.

As a first step, an advisory group had been set up in the Regional Office to discuss the consultation and renewal process. It was then intended to invite a small number of representatives of different countries to discuss how to set the process in motion, taking into account the specific characteristics of the different countries and areas. That would lead to wider consultations with Member States to ensure maximum involvement in the strategy at all levels of society.

The meeting rose at 16:30.

THIRD MEETING

Friday, 5 May 1995, at 14:30

Chairman: Professor A. WOJTCZAK (Poland)

WHO RESPONSE TO GLOBAL CHANGE: Item 22 of the Agenda (continued)

Renewing the health-for-all strategy: Item 22.2 of the Agenda (Resolution EB95.R5; Document A48/24) (continued)

The CHAIRMAN referred delegates to the summary records of debates at the Forty-seventh World Health Assembly in document WHA47/1994/REC/3, and at the ninety-fifth session of the Executive Board in document EB95/1995/REC/2.

Dr OMRAN (Bahrain) said that since it had become clear that it would be impossible to attain the original health-for-all objectives in the majority of developing countries, the Organization was trying to renew the strategy by setting health in a social context and implement it with the driving force of equality and solidarity, but it was by no means clear what equality in regard to health actually meant. There was great diversity between countries and regions, and equality did not necessarily mean equality of distribution. It was important to allocate more funds and resources to those areas which were in greatest need. However, if the equality being sought was not seen as cost-effective it was probably not wise to allocate such resources to the achievement of objectives that were intangible. It was easier to achieve equality on paper than in reality, and easier at the national than at the regional level. There was clearly a need for the strategy to be given more thought.

Because of different levels of development it was not feasible to apply general indicators to all regions and countries. With regard to infant mortality rates some countries were already well ahead of the targets set for the year 2000, while others would find it impossible to achieve them. Greater flexibility was needed, and indicators should take account of the actual ability of countries and regions to attain the various goals.

Mr KASTBERG (Sweden) described the widening gaps in health as veritable time bombs of social instability and conflict both within and between countries and regions - health inequalities could lead to war. Yet health could also be regarded as a bridge for peace, embracing other sectors and people not normally involved. Sweden was supportive of the need to mobilize those other sectors.

Renewal of the health-for-all strategy was central to the development of a common vision of WHO's policy and mission among Member States, and if the leadership of WHO received confused or contradictory signals and messages from Members, then the policy and mission would be unclear and unfocused as well. Much could be done to promote a consultative process that would enable countries to reach common ground marked out by a shared analysis of data. What was proposed was the broadest possible dialogue that would lead to a country consensus statement on health challenges and major policy orientations. The feedback from that process would in turn help to shape a common vision of WHO's role.

Sweden welcomed such a process, and to ensure its participation in the new strategy and its implementation, had established a national task force involving various agencies and ministries to follow and mobilize support for the global change process. However, that took time, though meanwhile bridges could be built. For that reason, Sweden wished to propose two amendments to the resolution recommended in resolution EB95.R5. The first was to replace the words "organize a high-level world conference, by the end of 1997, to adopt" in paragraph 4(8) with "secure ministerial-level endorsement in 1997 at the World Health Assembly of"; the second was to replace "arrangements for such a world conference" in paragraph 4(9) with "plans for this endorsement". Those proposed amendments had the support not only of Sweden but also of

Argentina, Australia, Austria, Belgium, Bulgaria, Canada, Denmark, Egypt, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, New Zealand, Norway, Slovakia, South Africa, Spain, Switzerland, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United States of America and Zimbabwe.

If WHO were now to embark upon a world conference, a great deal of energy and a large amount of funds and human resources would be expended on its practical preparation and negotiation. It would be much better to focus on the primary goal of renewing the health-for-all strategy. A special event could be organized in conjunction with the Health Assembly in 1997 at no extra cost and, if that succeeded, the time might then be ripe for considering a world conference which set goals for 2000 and beyond.

Mr CRONIN (Canada) submitted that the necessary revision of the health-for-all strategy should begin with an evaluation of the current strategy so that its weaknesses could be dealt with and its strengths built upon. Singling out for favourable comment the references in the Director-General's report (Annex 5 of document EB95/1995/REC/1) to safe water and adequate sanitation and to mental illness in aging populations as particularly important issues that would persist beyond the year 2000, he suggested that more consideration might be given to quality-of-life indicators, including that of "life expectancy in good health". Canada favoured the process outlined by the delegate of Sweden, believing that it would allow the timetable put forward by the Director-General to be advanced. The regional committees might be invited to discuss a draft resolution in 1995 so that the Board could adopt a final draft in January 1996 for consideration by the Forty-ninth World Health Assembly. Canada also supported the draft resolution recommended in resolution EB95.R5, and associated itself with the amendments proposed by Sweden.

Professor ORDÓÑEZ (Cuba) stressed that preparation of a new global health policy based on the health-for-all strategy should aim at the consolidation and development of primary health care, with more active participation of an intersectoral nature. Recalling the reference in paragraph 178 of the third report on monitoring health progress (document A48/4) to "three possible ways forward", he observed that most countries were struggling with the constraint of limited economic resources; optimum use must be made of all available human, material and financial resources in the development of primary health care, the focus being on what could, rather than should, be done.

In all countries, irrespective of their degree of economic development or political colouring, the State had a vitally important role to play in the preparation of health policies, notably in the area of pharmaceuticals, where the industry, worldwide, was extremely powerful. In the matter of controlling the production, distribution and use of medicaments, political will was not sufficient. Action was called for to ensure that commercial considerations did not assume more importance than therapeutic concerns.

Since Alma-Ata, the basic theoretical approach and focus of the health-for-all strategy had been primary health care, but most countries in fact spent most of their health budgets on secondary and tertiary care. Attempts were being made to control that tendency because it increased health costs and led to inequities as most people could not afford such services.

Cuba was a poor, small country suffering the effects of an immoral economic blockade, yet it was in a position to achieve health for all by the year 2000, notwithstanding restrictions and difficulties of all kinds. Cuba had met all the strategy's indicators, with the consolidation and the development of primary health care as its main priority. In 1983 there had been no family doctors in Cuba; there were now more than 25 000, serving 93% of the country's 11 million inhabitants. In 1983 the mortality rate for children under the age of one year had been 18 per 1000 live births; the figures for 1993 and 1994 were 9.4 and 9.9 respectively. In all modesty, he wished to submit that his country provided a good example of how the consolidation and development of primary health care permitted advances in the health-for-all strategy to be made, even in a context of political, social and economic crisis.

Mr JAKUBOWIAK (Poland) endorsed the proposal to develop a new 25-year global health policy, subject to periodic evaluation and modification if the need should arise. He stressed the importance as policy priorities of primary health care, health promotion and prevention as opposed to costly and specialized in-patient care, as well as the assessment of environmental influences on health. The countries of central and eastern Europe, whose economies "in transition" suffered from resource constraints, were well aware that

meeting those priorities would require the definition of detailed targets and objectives, to be followed up by regular monitoring.

The Polish Ministry of Health intended to establish a new intersectoral health policy, to be accompanied by state guarantees, so as to ensure universal access to basic health care services; his country was open to suggestions and was in turn ready to share its experience with other Member States.

He supported the draft resolution recommended by the Executive Board in resolution EB95.R5.

Dr ONO (Japan) said, in connection with the updating of the health-for-all strategy described in document A48/24, that it was important for the preparation of the proposed high-level conference to start as early as possible, in view of the rapid pace of changes in the world. Since the current health-for-all strategy had been very successful, WHO's initiative to convene such a conference was not only appropriate but essential. The Japanese Government fully supported that proposal and endorsed the recommended resolution.

Dr TAPA (Tonga) noted with satisfaction the emphasis laid on the continued validity of the health-for-all goal beyond the year 2000 and accordingly welcomed the proposal for the elaboration of a new global health policy for equity, solidarity and health, with a 25-year horizon. He accepted the framework for consultation on the proposed new policy and the specifications for the consultation mechanism, to ensure that that policy reflected the consensus of Member States, together with international and nongovernmental organizations. He appreciated the proposal for a high-level conference in 1997 in order to adopt a health charter, and endorsed the resolution recommended in resolution EB95.R5.

Dr KHOJA (Saudi Arabia) said that WHO had a preponderant role to play in ensuring improved health status throughout the world. However, in view of the difficulty of attaining the health-for-all goal, and particularly the disparity between the strategy and its implementation, a number of health workers had experienced considerable frustration.

Saudi Arabia supported the recommended resolution, together with the amendments proposed by the Swedish delegation. It further believed that a new slogan was required to replace "Health for all by the year 2000", taking greater account of existing realities and developments in the health field.

Greater financial resources and more intensive training of health personnel were essential to cater to the needs of vulnerable and high-risk groups and workers. Those constituted attainable goals for WHO in accordance with the health-for-all concept.

Ms LOBBEZOO (Netherlands) remarked that the Declaration of Alma-Ata, on which the health-for-all strategy was based, had been a source of inspiration for the past 20 years; therefore it was a challenge to reformulate such a strategy. Renewal was essential, but should not be considered as an internal WHO process. In order to avoid excessive vagueness, the roles and tasks of all the participants in the strategy at global, regional and national level had to be clearly defined.

However, she felt that the necessary strengthening of the management component was not evident in the proposals and might create problems when the policy was implemented. The third monitoring report on the implementation of the health-for-all programme would serve as a useful guide in determining a new strategy as well as helping to constitute a link between the update and the contents of Agenda 21 to be discussed under item 32.1 of the Health Assembly's agenda. Agenda 21 stressed the need for a multisectoral approach to development, which was not given a high profile in the current health-for-all strategy, so that cooperation with other international organizations was not as close as it might be.

She would welcome clarification as to how the launching of the new health-for-all strategy was to be financed, since she was unable to find any provision for it in the budget proposals. She supported the recommended resolution as amended by the delegate of Sweden.

Mr CHAE Thae Sop (Democratic People's Republic of Korea) said that since the adoption of the health-for-all strategy at Alma-Ata in 1978, much had been achieved; but unfortunately there was a great deal of ground to be covered before the targets were reached. Extreme differences still existed, not only between countries, but even within certain developed countries.

He approved the recommended resolution and was in favour of a world conference in 1997. In renewing the health-for-all strategy, stress should be laid on embodying the principles of equality, solidarity and social justice, as well as on intersectoral and international cooperation.

Dr ADAMS (Australia) said that although his country favoured a new global health policy, involving close consultation with Member States, and although it did not underestimate the value of such consultation, it would be uneasy if that process were to last too long, be too complex or costly, or if it were to distract people from the work of priority-setting and resource allocation. He therefore strongly supported Sweden's proposed amendment to the draft resolution recommended in resolution EB95.R5.

However, it was apparent from the Director-General's report that in some areas the goals were receding. In view of the fact that some of the far-reaching implications of WHO's response to global change might go beyond its present legal framework, Australia had initiated a draft resolution, cosponsored by 24 other countries, proposing that the Health Assembly should call upon the Executive Board to assess whether the Constitution still remained appropriate and relevant. If the Board were to conclude that a review of the Constitution was necessary, it should consider how that should best be accomplished. The Australian draft resolution also proposed that the Health Assembly should request the Director-General to report to it in 1996 on the progress made.

Mr QUAUNINE (Bangladesh) pointed out that, despite considerable progress in health-related technology and research, the health situation in a large number of developing countries had failed to improve. Hence the renewal of the health-for-all strategy was crucial.

His delegation was pleased to ascertain that the appropriate recommendations had been taken up by the WHO development team, and hoped that the new global health policy would be geared to pragmatic objectives. Such targets should be achieved through appropriate resource mobilization by WHO headquarters, regional and country offices.

He was circulating some minor amendments to the resolution recommended in resolution EB95.R5, with the aim of reflecting the special situation in the least developed countries such as Bangladesh.

Dr STAMPS (Zimbabwe) noted that there was a tendency for vertical programmes to creep into an overall primary health care policy because of the excessive dependence on extrabudgetary resources and the ease of donor control of allocations and follow-up of effectiveness indicators in such activities; there was thus a risk of easy options taking priority over urgent needs, as shown by deteriorating health indicators in the most vulnerable communities and countries, a syndrome highlighted in the Director-General's report, which ascribed it to poverty.

The health-for-all concept emphasized the holistic nature of health needs, and he therefore proposed the insertion of the word "holistic" before "global health policy" in paragraph 4(1) of the resolution recommended by the Executive Board for adoption by the Health Assembly. He also endorsed the amendments proposed by Sweden, subject to the insertion in paragraph 4(8) of "by July 1997" to set a time-limit.

Dr LIU Hailin (China) commended document A48/24 since it showed how changes in the world could be confronted, taking into account the diversity of the situations existing in countries. The health-for-all policy had played a major role in mobilizing action for a decade; the slogan had played a decisive part, and the new policy should be formulated on similar lines.

The new policy should emphasize continuity of health development and fully reflect the principles of equity and solidarity on the basis of an assessment of existing health policy at country level. Furthermore, a global dialogue should be instituted on new partnerships in health policy. WHO should provide consultants to countries needing them to assist in providing information and training in regions and at global level.

Mr RONDÓ FILHO (Brazil) agreed that obstacles to health for all stemmed from failure to implement the agreed policies. Document A48/24 made it clear that partnerships must be sought in implementing policies; as he had said earlier, WHO already had appropriate structures for that purpose and had conducted consultations in the past, e.g., in connection with the International Conference on Nutrition. Advantage should be taken of such structures, and WHO should consider strengthening them. The document stressed

the importance of involving other organizations, but it was necessary to go further and approach them directly.

Revision of the health-for-all strategy should be followed by continuous monitoring, to ensure that the Organization could respond to change.

At various meetings, questions had been raised by Member States about the methods of implementing policies. The decision to convene a world conference should not be taken by WHO without consulting its national partners, if only because of the enormous burden that it would impose on the public services in general and the various ministries involved in countries that were already in greatest need. He therefore endorsed the amendments proposed by Sweden to the recommended resolution.

Dr JEANFRANCOIS (France) said that the document on renewing the health-for-all strategy contained much that was of vital importance, in particular the need to involve all partners at all decision-making and implementation levels. The key to success lay in ensuring that, once the new charter was adopted, all concerned felt that they had a share in it. Her delegation was therefore fully committed to the consultation process proposed in the document and wished to participate in it. It also endorsed the resolution recommended in resolution EB95.R5, with the amendments proposed by Sweden, which seemed to satisfy the concerns regarding the time and cost factors expressed by a number of delegations. Indeed, the operation should be carried out with the least possible additional strain on WHO's limited resources.

Dr MZIGE (United Republic of Tanzania) said that his country was now embarking on cost sharing in health, not cost recovery. It had realized that the target of free health for all resulted in health for none and that the private sector also had a role to play. The salaries of health personnel were meagre and doctors in the government sector were being allowed to hold clinics after office hours so as to reduce economic hardship. Moreover, traditional healers, who numbered some 40 000 as compared with less than 5000 medical doctors, had formed a society, and the Ministry of Health was finalizing a policy on traditional medicine.

A major problem at present was the arrival of over 600 000 refugees from Rwanda and Burundi, and his country was therefore requesting the help of international organizations to repatriate them as a long-term measure. Political stability was of great importance in the development of any sustainable health programme.

His country's health policy was geared towards improving the health of women and children, and free health care was still being provided to the vulnerable under-five group and pregnant women, who constituted 40% of the population. Despite a meagre budget, resource mobilization and reallocation was an important factor in sustainable health.

The CHAIRMAN suggested that as a number of amendments to the resolution recommended in resolution EB95.R5 had been proposed, the Committee might wish to consider setting up a drafting group to prepare a revised text.

Professor CALDEIRA DA SILVA (Portugal), commending the work done on WHO's response to global change, and especially the new policy and mission, said that, although the strategy of health for all by the year 2000 was vitally important and had borne fruit, it was no longer attractive. Something completely different must now be offered to communities, authorities and politicians. There was at present a great deal of talk about rights, but what was important was to translate rights into realities. As far as health was concerned, there was also a need to consider duties and responsibilities, not only of the State, but also of individuals, families, groups and communities.

He therefore supported the ideas on which the new policy and global strategy were based. The idea of the State as universal provider had been relatively successful for over 40 years but new policies were now necessary; he had great expectations of the proposed charter based on equity, responsibility, commitment and security, and which assigned great importance to health for development. Solidarity was a key factor, and he therefore supported the idea of inviting as partners not only politicians and other government representatives, but also and above all "civil society". However, the consultation mechanism envisaged would be very complex and demanding for all those involved. The new policy and global strategy should take into account not only the primary health care approach but also globally integrated health care.

Dr EL-KHAYATT (Jordan) thanked WHO for its endeavours to improve health throughout the world. Discussion of the new health-for-all strategy was vital and must be given due importance in the Organization's strategic plans. An attempt must also be made to improve health management and quality of care. That approach had been adopted in her country at both national and district level, and its consolidation would assist health services and promote the involvement of other sectors in health care. Funding was a fundamental concern in health care sectors everywhere, and financial services in Jordan would be mobilized to provide fresh resources. In fact, health must be viewed as a crucial component of all development programmes, and her country's activities would bring it closer to the goal of health for all.

Dr SULEIMAN (Oman) agreed that the health-for-all strategy needed to be reviewed and revitalized at national, regional and international levels. Clear goals and targets had to be identified, taking into account the social, economic and cultural characteristics of each region, but the process must begin at national level where the benefits of implementation would be felt most.

Many recent international conferences had been on topics closely related to health, and it was therefore of paramount importance for the results of those conferences to be taken into consideration and WHO's strategy brought into line with them.

He endorsed the draft resolution before the Committee, as amended by Sweden.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) endorsed the draft resolution recommended in resolution EB95.R5, as amended by Sweden, and stressed both the importance of Member States' being closely involved in the development of the new health strategy and its common ownership. He understood that a glossary was being produced which would assist in defining precisely such terms as "equity" and "solidarity", since they were open to different interpretations. He asked whether any estimate of the costs of the proposed world conference had been made.

Dr SHRESTHA (Nepal), after welcoming document A48/24, which contained many new ideas including the proposal for a worldwide consultation, strongly supported the renewal of the health-for-all strategy, as well as the resolution recommended in resolution EB95.R5.

Mrs VOGEL (United States of America) recognizing the profound global changes affecting health that had occurred since the Declaration of Alma-Ata, supported the effort to renew the health-for-all strategy, together with the proposal to prepare a new document that would delineate WHO's philosophy more clearly, emphasizing intersectoral and international approaches to complement country-level primary health care. She also welcomed the proposed broad consultative process to develop the new global policy, a process which would assist countries in solving their health problems. Although it was important to involve leaders at a high level in order to ensure political commitment, it was not necessary to convene a world summit on health, especially in view of the tight budgetary constraints that all countries were having to face. She therefore supported the resolution recommended in resolution EB95.R5, as amended by Sweden. As considerable support had been expressed for the Swedish amendment, it might be preferable to proceed directly to consideration of the draft resolution rather than set up a drafting group as suggested by the Chairman.

Professor AGBOTON (Benin) welcomed document A48/24, which represented a challenge to Member States to reexamine their constitutional commitment to work, under WHO leadership, to raise the health status of the people to the highest possible level. Five years from the year 2000, however, poverty was increasing and health status throughout the world was deteriorating. It was essential, therefore, to make an effort to avoid a catastrophe of almost apocalyptic dimensions. What proportion of national resources were countries prepared to invest in world health under WHO's leadership? What proportion of the expenditure on armaments or on matters of prestige were they willing to direct to improving health throughout the world? Answers to those questions must be found if health gaps were to be bridged and he therefore supported the renewal of the health-for-all strategy, as well as the resolution recommended in resolution EB95.R5, as amended by Sweden.

Dr OHN KYAW (Myanmar) said that, since the Alma-Ata Declaration, his country had adopted the health-for-all strategy with the primary health care approach, and had developed a national health plan to

attain the goals of WHO's strategy for health for all by the year 2000. Experience over the last 15 years had shown, however, that the strategy required revision in the light of the socioeconomic changes that had taken place in the country; implementation of the health-for-all strategy must be in line with country needs and policies. He therefore supported the resolution recommended in resolution EB95.R5.

Dr SHONGWE (Swaziland) supported the health-for-all strategy, but considered that new, more realistic targets were required that took account of the socioeconomic situation of each region. The new strategy must be based on the principles of equity, social justice, sustainable development and solidarity. He strongly supported the amendment proposed by Sweden to the resolution contained in resolution EB95.R5, believing that securing endorsement at ministerial level at the 1997 World Health Assembly would be cost-effective.

Dr ABELA-HYZLER (Malta) agreed that the health-for-all strategy should be revised, and welcomed the emphasis on the validity of the health-for-all goals established in 1977. He also agreed that the new global health policy should be based on pragmatism rather than theory. In formulating the revised health policy, care should be taken to apply the lessons of past experience and not to alienate any section of the health professions. Although the focus should continue to be on primary health care, more attention should be paid to integrating secondary and primary health care, since failure to do so had created difficulties in the past.

While appreciating the views expressed by the delegates of Brazil, Netherlands and Sweden on the proposed world conference, he said that it was important to realize that one of the problems in the past had been that the health-for-all strategy had been regarded as simply a sectoral strategy to be implemented by ministries of health; the revised strategy must be intersectoral. Thus an intersectoral conference should follow the ministerial conference, if the health-for-all strategy was to be successfully implemented.

While supporting the resolution recommended in resolution EB95.R5, he suggested that paragraph 2(1), which was somewhat prescriptive or even alarming in tone, should be reworded by replacing the reference to alerting the general public by a phrase such as "raising the awareness of the general public of the need to place health high on the political agenda."

Dr DOFARA (Central African Republic) expressed support for the recommended resolution, as amended by Sweden. Community participation in health costs had been widely accepted by the population as a means of improving the quality of health care. However, the current economic crisis was leading to increasing exclusion and marginalization as purchasing power decreased, making the slogan "Health for all by the year 2000" an unattainable dream. He therefore supported the renewal of the strategy but requested WHO, in doing so, to take into account the socioeconomic problems of the different countries and regions.

Mr DEBRUS (Germany) supported the amendments proposed by Sweden to the resolution contained in resolution EB95.R5. Concerning the level of the proposed conference, he urged a realistic approach; despite the importance of the health sector economics, finance or other sectors must also be taken into account.

The renewal of the health-for-all strategy and its implementation at ministerial level was a major undertaking calling for thorough and comprehensive discussions with all Member States. To ensure the full participation of Member States, WHO must prepare documents for endorsement at ministerial level; circulate final documents to Member States for comments at least six months before endorsement, to allow time for internal discussion; and fully involve Member States in the entire preparatory process. Unless WHO incorporated Member States' proposals into the strategy in the course of its preparation, Members would no longer identify with the Organization. The comprehensive consultations, preparation, endorsement and follow-up of the strategy would provide WHO with an opportunity to enhance its position and international leadership.

Dr PRETORIUS (South Africa) said that South Africa was pleased to be part of the process of renewing the health-for-all strategy, as it had been unable to be present at the Alma-Ata Conference. After April 1994, his country had embarked upon a review of its own health care system, using the primary health care approach and the health-for-all strategy and principles. All the communities and population groups in the country had been involved in the consultation and policy development process, based on an intersectoral

approach. He supported the recommended resolution, as amended by Sweden and Zimbabwe, and agreed that the new global health policy should include clear guidelines for implementation.

Mr AL-THANI (Qatar) endorsed the new health-for-all strategy outlined in document A48/24, together with the proposal to hold a world conference, for which high-level preparation would be necessary.

Dr LEPPO (Finland) said that Finland had always believed in the principles and goal of health for all. The renewal of the health-for-all strategy was an important step in the revitalization of health policy and action throughout the world.

Some of the concepts central to the new strategy deserved emphasis, in particular the consultative process; broad consultation would ensure the level of commitment necessary for implementation. Consultation would achieve the consensus which was essential in the challenging task of developing a global policy; such consensus might be reached first and foremost on the proposed amendments to the draft resolution contained in resolution EB95.R5 by a drafting group. Consensus on that resolution would give a good start to what was the most important policy process ever undertaken by the Organization.

Dr PICO (Argentina) said that it was appropriate to renew the health-for-all strategy so that it could be adapted to the ever-changing political, economic, social and health situation. Such renewal should be achieved through an integrated and strategic system-based approach that would respect the cultural values of the populations concerned and the position in the different regions of the Organization. In that connection, regional offices had a major role to play in critically examining the problems and in evaluating both achievements and failures, with the greatest possible participation of Member States. He supported the basic idea of improving health activities with a view to achieving equity, solidarity, effectiveness, efficiency, and essentially what was socially feasible; in the past, many problems had been caused because that had not been taken into account and because the views of the people for whom the health care was intended had been ignored. He therefore endorsed the recommended resolution, as amended by Sweden; the health-for-all strategy should be renewed, and a drafting group should meet to reconcile the different positions on the matter.

Mrs HERZOG (Israel), responding to a remark made by the delegate of Germany, wondered whether there was indeed anything more important than health. She repeated what had been said in previous Health Assemblies, namely that health was not everything, but without health everything was nothing. She commended the Director-General on his report on renewing the health-for-all strategy and supported the resolution contained in resolution EB95.R5, with the amendment proposed by the delegate of Malta.

Mr KASTBERG (Sweden), responding to remarks made by the delegate of Malta, said that as he had indicated earlier he fully agreed that an intersectoral approach was needed. However, bringing together different sectors took time. He had also said that, if the process succeeded, with endorsement at the Health Assembly in 1997, a world conference might then be convened to set the goals for the year 2000 and beyond. He hoped that the views of all delegations on the recommended resolution might be accommodated without the need to establish a drafting group.

Professor FIKRI BENBRAHIM (Morocco) commended the work done by the Director-General and the Executive Board in renewing the health-for-all strategy, and fully supported the proposed method of consultation on the new policy and consequently the resolution contained in resolution EB95.R5. He suggested, however, that paragraph 2(2) should include the final date by which countries should communicate the results of their consultations to WHO.

Dr CHOLLAT-TRAQUET (Cabinet of the Director-General) said that all the speakers had stressed the importance of consulting Member States and particularly of the consultation process within Member States between health ministries and their partners in economic and social development. Prior to the Alma-Ata Conference, consultations on future action over 20 or 25 years had already taken place. As she had mentioned earlier, a document would be prepared suggesting various methods of consultation for the renewal process. Intersectoral consultation, as several delegates had pointed out, would take some time to be

completed. The delegate of Canada had suggested that the consultation period should be shortened, but to allow countries only a matter of months to determine policy for the following 20 years might be rather too short a time. She therefore appealed for the consultation period to remain at between eight and ten months at country level.

Bahrain and Cuba had spoken of the problem of equality in health. Neither WHO nor its Member States could ensure equality in outcomes as health also depended on economic, social and cultural conditions which WHO could not influence. However, the Organization and Member States could endeavour to provide equality of access to health and access to equal distribution of health goods. That was why a strategy for closing the gap between rich and poor was to be proposed to alleviate the plight of those most affected by poverty and marginalization. Such remedial policies would continue to be based on primary health care. Yet there had been two major developments in the previous 20 years. New forms of treatment had emerged, even among the poorest populations, and that would mean that the concept of primary health care and the framework for the strategy would have to be widened. Secondly, one of the stumbling blocks in implementing the strategy of health for all by the year 2000 had been the failure to take into account the financial aspects; in the future, at national and international level, economic strategy would have to be linked more closely to health problems.

One of the results of drafting the new policy would be the redefinition of WHO's mission, as the Director-General had decided that the mission should be redefined in the context of the new health-for-all policy. A re-evaluation of WHO's mission in the Constitution would be something for the Executive Board to consider at a later date.

There was a need for periodic evaluation of strategies and as simple a system as possible would be set up, with indicators linked to the programme budget indicators so that the Organization's activities could be evaluated in relation to national and international strategies.

Two delegates had indicated that the title of the strategy was neither elegant nor practical; however, the title was only provisional and a new one would be found.

In reply to the delegate of the Netherlands, she indicated that the budget for both the consultation period and the development of the policy was not large. It would come mostly from extrabudgetary funds. The details could be passed to interested delegations.

There were very few funds in the regular budget to finance a world conference and it had been envisaged that it could be financed almost wholly from extrabudgetary sources. The conference was important because it would give visibility to the new policy. A formal setting in a conference such as the Alma-Ata Conference, to which many delegations had referred, would provide a showcase for the strategy. In order to save funds, it might be possible to hold such a conference in the place of a governing body session, perhaps in 1998. Further thought would have to go into the type of event to be held, but it would have to be a suitably solemn occasion to mark the launching of the new strategy.

The DIRECTOR-GENERAL said that all new strategies had to be well communicated through Heads of State and through provincial leaders, in order to sensitize public opinion. At the World Summit for Social Development Mme Simone Weil, the French Minister of Social, Health and Urban Affairs, representing the European Union, had said that health policy had become one of the priorities in public policy in the European Union. The renewed health strategy of WHO would require an extremely high level of endorsement. If Member States wanted the new strategy to succeed, they would have to promote it through a conference. The Constitution of the Organization required that a Health Assembly take place each year, but that Assembly could be replaced in 1998 by a high-level ministerial meeting of two or three days, followed by a Conference of Heads of State, thus achieving the joint goals of promoting the policy while avoiding an additional financial burden. Such a conference would give new visibility to the governing body and would be a fitting celebration of WHO's fiftieth anniversary.

The CHAIRMAN suggested that a drafting group composed of the delegations of Bangladesh, Benin, Canada, China, Malta and Sweden and any other interested delegations should meet to discuss the proposed amendments to the draft resolution contained in resolution EB95.R5.

It was so agreed.

(For continuation, see page 214.)

The meeting rose at 17:00.

FOURTH MEETING

Monday, 8 May 1995, at 9:00

Chairman: Professor A. WOJTCZAK (Poland)

1. EXTERNAL AUDIT MATTERS: Item 23 of the Agenda

External audit report on the Regional Office for Africa: Item 23.1 of the Agenda (Documents A48/25 and A48/39)

Mr HIGGINS (representative of the External Auditor), presenting the report of the External Auditor on the Regional Office for Africa (document A48/25), explained that since the External Auditor and his team had been unable to complete the necessary missions to the Regional Office for the audit of the 1992-1993 accounts, for reasons entirely beyond their and WHO's control, and because the Regional Office for Africa accounted for a large proportion of WHO's resources, the External Auditor's opinion on WHO's accounts, which had not been an adverse one, had had to be limited in scope. Furthermore, the External Auditor had given an explicit undertaking to carry out an audit of the Regional Office as soon as circumstances permitted, and to report the results to the Health Assembly at the earliest opportunity. The timing of that audit, November 1994, had been chosen to avoid the dates of the internal audit and of the review by WHO's own consultant, and to be as near as possible to the date of the Forty-eighth World Health Assembly.

It had been a normal financial audit designed to complete the unfinished work from the previous biennium and at the same time to move forward with the audit work for the 1994-1995 biennium. It had not been intended to single out the African Region, which had received no more attention than in other years, nor had it covered areas that were not part of the regular audit process. It had been carried out by a team with considerable experience in the audit of United Nations bodies, including the lead auditor responsible for the WHO external audit and the resident audit manager in Geneva, who had been directly responsible for Geneva work, including WHO, since 1990.

At the conclusion of their audit, the team had held an exhaustive exit meeting with senior staff of the Regional Office for Africa to present and discuss findings and obtain comments prior to the preparation of the draft report. Such exit meetings were a routine part of audit missions. The Regional Director had been invited but had been unable to attend. On return to Geneva, the team had also held an exit meeting with headquarters finance staff in order to report on the findings and obtain their comments, but had been informed that the findings told them nothing new. The draft report had then been prepared and sent to WHO.

In the past, the draft report stage had proved highly beneficial in terms of: continuing dialogue with the Organization; discussion of the audit findings; and confirmation of the accuracy and presentation of findings before a revised draft was put more formally to the Director-General for comments, prior to submission to the Health Assembly. Consultation with the Director-General before finalizing the report was, moreover, provided for in the relevant provisions of the Financial Regulations. However, contrary to all past practice, no substantive comment had been received, despite repeated oral and written enquiries: it had merely been stated that no useful purpose was seen in discussing the draft report, and the External Auditor had been invited to send the report to the Director-General, who offered to provide written comments if the findings of the External Auditor were treated as a management letter rather than a draft report for the Health Assembly. Since management letters were not published or transmitted to the Health Assembly, and as the External Auditor had undertaken explicitly to report the results of the audit to it, the External Auditor had considered that it would have been a discourtesy to the Health Assembly to have failed to do so in full. Meanwhile, the draft report had been revised, ensuring that all findings were fully supported by audit evidence; that full account was taken of the representations made at the Regional Office to the extent

consistent with the audit evidence; and that the text represented a fair, balanced and accurate report of the audit findings and conclusions. It was that report that was now before the Committee.

A high degree of cooperation and trust between an organization and its External Auditor was essential, if the external audit function was to operate to the benefit of that organization and its Member States. The Secretariat's lack of cooperation on the report before the Health Assembly represented a serious breakdown of that relationship. In those circumstances, the External Auditor had concluded that he would be unable properly to carry out his professional responsibilities in future bienniums and, with very great regret, had withdrawn his candidature for reappointment beyond the current biennium. He would fulfil his existing appointment for the 1994-1995 biennium with the same commitment and to the same high professional standards as in the past.

Turning to the substance of the report, he said that Part One set out the background to the audit work, with particular reference to the serious disturbances which had disrupted normal life in Brazzaville in late 1993 and early 1994. The difficulties suffered by those working at the Regional Office were fully appreciated and had clearly contributed to the shortcomings found in the audit. The audit had taken account of two reports produced by WHO's internal auditors and a consultant who had been appointed to assist Regional Office staff in reviewing and improving the Office's accounting environment; the latter's report, dated August 1994, accorded with many of the External Auditor's findings. It was normal for an external auditor to draw on the work of others in order to ensure cost-effectiveness, avoid duplication and take account of the Organization's own efforts to improve its work. Part Two of the report set out the conclusions and recommendations, and Part Three the detailed findings.

Paragraphs 3.1 to 3.7 dealt with imprest accounts. Such accounts, prepared by all country offices and others to whom money was provided by the Regional Office, were required by the WHO Manual to be reported monthly to the Regional Office so that they could be posted to WHO's main accounts. A significant backlog had been found in the processing of imprest accounts at the end of the 1992-1993 biennium, with the result that over US$ 6 million of disbursements had not been properly reflected in WHO's financial statements. It was appreciated that the backlogs had arisen because of the severe operational problems caused at the Regional Office by the civil unrest, and it was encouraging to note that most of the delays had been reduced to acceptable levels in 1994. The examination had also shown significant deficiencies in the imprest accounts themselves, with sometimes poor quality documentation and large numbers of unverified and uncleared transactions. Shortcomings in imprest keeping in country offices had indeed been revealed by the Regional Office's own reviews. The External Auditor had consequently recommended that steps should be taken to improve the quality of imprest accounts, for example by visiting country offices more frequently to assess training needs, although it was appreciated that there might be time and money constraints.

Paragraphs 3.8 to 3.13 dealt in detail with cash at bank and in hand. The audit had found that no bank reconciliations - i.e. matching of transactions in a bank account with corresponding entries in WHO's books - had been carried out on the Regional Office's main payments account for 1994, up to the time of the audit in November 1994. Altogether, sums amounting to US$ 8 million had been involved. The reconciliation prepared for December 1993 had been unsatisfactory on account of the large number of unverified and unmatched items, and it had been impossible to corroborate the balances making up the reconciliation. Work undertaken by the Regional Office during the audit visit to match those entries had not been completed by the end of the audit. It had therefore been recommended that the Regional Office should keep all bank reconciliation work up to date, as required by the WHO Manual. Time could be the enemy of good financial control. It was gratifying to note the improvements reported. The External Auditor had also recommended that surprise cash counts should be carried out from time to time, noting that the Regional Office held large amounts of cash and travellers' cheques.

Under the heading "Accounts Receivable", covered in paragraphs 3.14 to 3.18 of the report, the largest category of money due to the Regional Office concerned advances made to individual staff members for education grants, travel costs, salary and other purposes. It was important for the relevant documentation, such as authenticated travel claims, to be provided as soon as possible. Those personal accounts included large numbers of long outstanding items, some going back to the 1990-1991 biennium. It had therefore been encouraging to note that the total amount owed to WHO under that heading had been reduced by US$ 0.5 million following a review carried out by a WHO consultant - an encouraging trend in view of the importance of the time factor in recovering debts. It had therefore been recommended that personal and other account balances due to WHO should be regularly reviewed and systematically followed up.

Unliquidated obligations (paragraphs 3.19 to 3.20) arose when WHO had entered into a financial commitment but where the money had yet to be paid: the audit team's test of large-value unliquidated obligations had revealed some errors in the recording of those obligations. It had been recommended that all such obligations should be reviewed monthly, as required by the WHO Manual.

With regard to procurement and contracting (paragraphs 3.21 to 3.24), the basic principle was that all purchases from third parties should be made in competition. It had been gratifying to note that a number of firms had been asked to bid for the upgrading of the Regional Office's telecommunications system, although only one tender had resulted. The auditors had been informed that there had not been enough time to seek further bids. The contract for the radio link part of the project had been placed three months before the Contracts Review Committee had considered the matter. Although unforeseen events might preclude that stage in the procedure, as had reportedly been the case in that instance, the External Auditor had recommended approval by the Contracts Review Committee in future, noting that that was required by the WHO Manual for all purchases over US$ 70 000.

With regard to staffing matters, covered by paragraphs 3.25 to 3.34, the audit had revealed that two apparently unsuitable appointments had been made, some children's education grants had not been properly supported by evidence, and rents charged to staff had been out of date and in two cases had not been deducted at all. It had therefore been recommended that the prescribed procedures should be complied with, that claims should be properly evidenced and that housing guidelines and rents should be reviewed.

Regarding physical assets (paragraphs 3.35 to 3.40), details should be recorded in inventories. A variety of records had been found at the Regional Office, but key inventories had not been sufficiently detailed to enable each item to be identified. The Regional Office also kept inventory records for items held by country offices, which were required to confirm the accuracy of those records periodically. At the time of the audit visit in November 1994, 30% of the inventory cards sent out in April and May 1994 to check the position at 31 December 1993 had not been returned. Although the return rate was now reported to have reached 81%, it had been recommended that firmer action should be taken to expedite the response.

There had been some critical comments in the report, and he had been very glad to note the improvements brought about by the Regional Office in a number of areas, some of which had been referred to in the report by the Director-General (document A48/39). At the same time, the External Auditor did not accept that the Director-General's report effectively refuted the External Audit findings, and the External Auditor stood by the contents of his own report. The scope limitation which the External Auditor had applied to his opinion on WHO's financial statements for 1992-1993 had been justified given the backlog which had arisen on imprest accounting and on bank reconciliations, coupled with the shortcomings in financial control in areas such as accounts receivable. If the External Auditor had been able to do the work a year earlier, he would undoubtedly have asked for a number of changes to be made to the draft accounts; and only if they had been incorporated could he have been in a position to provide an unqualified opinion. That, however, was conjecture, and the situation could not be recreated. Among the points made in the report by the Director-General on the External Auditor's report which he could not accept were the comments that the External Auditor lacked knowledge of WHO's policies and procedures, notably the provisions of the WHO Manual; that he had failed to take account of the views and representations expressed in the Regional Office; and that he had focused only on transactions of known dubiety. For those reasons, he stood by what was stated in the report.

Dr SAMBA (Regional Director for Africa) said that he had been extremely annoyed on initial perusal of the External Auditor's report on the Regional Office for Africa for 1992-1993, a few weeks after taking over the Regional Office. It should be standard practice internally to conduct an audit before transferring any office to a new incumbent. After discussing the matter with the external auditors and staff at headquarters, however, he was satisfied that the report could not have been sent earlier and that there had been no intention of discrediting anyone, or of engaging in "Africa-bashing". He was no longer angry.

Regarding the substance of the audit, he was happy to announce that it was clear from the report and from discussions he had had with the external audit staff and at headquarters that there had been no fraud. Regarding the backlog on claims, imprest accounts, bank reconciliations, etc., steps had been taken to reduce it, a process which he had accelerated after taking office on 3 February 1995, with the result that the backlog had now been absorbed. It was true that large amounts of cash were kept at the Regional Office, the reason being that there was no functioning bank in Brazzaville. All staff salaries, including his own, were paid in

cash, a procedure that was of course most inconvenient, as well as time-consuming for finance staff, but was common in some countries in Africa.

He paid special tribute to the staff in the Regional Office, who during the civil unrest had had to cope with conditions whose difficulty had not been sufficiently reported to the outside world, including physical abduction and the resulting shock (from which some had not yet fully recovered). Some had had to come to work by boat through rapids because roads had been blocked. It was little wonder that some of them had not been functioning as they would normally have done. They deserved a public tribute because, despite everything, the Regional Office had never stopped functioning.

In order to reduce the backlog, computers would be installed in a few weeks' time, and he had taken steps to improve the quality of staff so as better to cope with the workload and delays. In other parts of the world, failure to receive documents within 2 or 3 weeks of posting was a cause for concern; in Africa, receipt within 2 or 3 months was a good achievement. Thus backlog was relative to the situation. Following repeated requests to headquarters, the Regional Office would be installing E-mail facilities for the transfer of documents. He had personally requested and expected the approval of the Congolese Government for the necessary connections to national facilities. An internal audit mechanism had also been established in accordance with the External Auditor's recommendation so that both country offices and the Regional Office would be audited regularly; such a mechanism had been used successfully in the Onchocerciasis Control Programme in West Africa. Payments for overtime had been stopped definitively, and replaced by compensatory time off where necessary. Rents for houses on the campus had been increased in line with the recommendations of the External Auditor. Furthermore, a mechanism had been introduced to ensure that procurements, contracts and recruitment were strictly in accordance with the rules, and advances would be reduced, again in strict accordance with the rules. Countries had been asked to collaborate with the Regional Office for Africa so that scholarships were handled in accordance with agreed resolutions.

In spite of the initial embarrassment, he could promise the Health Assembly that everything possible would be done by the Regional Office for Africa to ensure that future audits did not give rise to such acrimony.

Mr AITKEN (Assistant Director-General) said that the External Auditor's report was not considered indicative of the normal situation in the Regional Office for Africa, because of the civil unrest in the area, and it was felt that it should have been subject to the usual internal communication mechanism with the External Auditor, namely, the management letter. However, that view had not been shared; although he understood why, it remained the view of the Secretariat.

There had been differences on points in the report, but it had been felt that any discussion might lead to the risk of negotiating over the report, which would have been inadvisable.

Turning to more positive matters, he stressed that all facilities would continue to be made available to the External Auditor to conduct his audit work, and invited him to alert the Director-General or himself to any difficulties encountered in future. He did not expect any similar problems in the conduct of the normal biennial audit of the accounts, and said that the audit of the Regional Office for Africa had been a special case. WHO was fully committed, as Dr Samba had already indicated, to the highest standards in its financial and accounting affairs.

Mr UHDE (Division of Budget and Finance) informed the Committee that his Division had, in line with the need for transparency and the suggestions of past Health Assemblies, provided written comments on the External Auditor's report in the form of document A48/39, as well as in document BFI/95.1, available in English and French. Those comments covered all of Mr Higgins' points; however, he wished to make some additional remarks which might assist the review of the agenda item.

Paragraph 9 of the Appendix to the Financial Regulations obliged the External Auditor to afford the Director-General an adequate opportunity of explanation on any matter which was the subject of criticism in the report. However, the Organization was not obliged to hold discussions with the External Auditor or correct his report, although that had been the practice in the past and his Division had supported and followed that practice since WHO's inception. In the case of the audit of the Regional Office for Africa, discussions had not been possible, for reasons he would explain. WHO had violated no rule or regulation by not having detailed discussions with the External Auditor, although contacts had been made with the External Auditor

as described in paragraph 3(i) of document A48/39. It was, in fact, the External Auditor himself who had declined to listen appropriately to the staff of the Regional Office for Africa.

He reminded the Committee that senior officials in the Division of Budget and Finance had extensive accounting and auditing experience with a combined total of 45 years of professional and living experience in Brazzaville, Congo. Thus they understood the African Region. The Division would never complain of any overauditing, but would vigorously challenge any poor auditing procedures and incorrect audit findings, as in the present case.

In the Regional Office for Africa, the books of account had been properly maintained and balanced, submissions of financial data to headquarters had been timely, and no fraud had been found as a result of the External Audit, nor had there been any negligent loss of assets. However, paragraphs 1.7 and 2.15 of the External Auditor's report painted a rather pathetic picture of the African Region with which his Division could not agree. His Division had had difficulties with many of the 66 paragraphs of the External Auditor's report, of which some contained significant errors in figures; the report would have been more accurate if the field work had been carried out properly in Brazzaville, and the Regional Office staff consulted and listened to by the External Auditor.

Of the 64 recommendations made since 1988 by the External Auditor, 56 had been either accepted, implemented or considered, and only eight had never been implemented. That showed that the recommendations were appreciated and implemented when relevant for WHO.

Referring to document A48/39, he drew attention to the Director-General's basic comments in paragraphs 1, 2 and 3. When the chain of trust and cooperation between both parties to an audit was broken, then it could no longer serve its purpose. In the case of the Regional Office for Africa, the chain had been broken by the External Auditor in Brazzaville in November, 1994, as evidenced by the fact that on 4 November a member of the external audit team had asked the regional finance officer directly whether the accounts and obligations had been manipulated to show higher performance than had actually been the case. The Regional Office had protested against that remark, and while another member of the audit team had apologized for it, the damage had been done and the attitude of the External Auditor to the audit had been fixed from then on.

The Regional Director at that time, Dr Monekosso, had written a letter to the External Auditor in December 1994 (reproduced in the Annex to document BFI/95.1) stating that the External Auditor had not paid due respect to the WHO Manual, and that the Regional Office staff had ended up defending it. Language difficulties had been experienced, and there had been a feeling that Regional Office was being probed rather than audited, in order to support a predetermined conclusion. Dr Monekosso had not been given an opportunity to comment on a written draft report, despite a promise to that effect by the External Auditor; the Director-General had therefore been deprived of the chance to benefit from a critical review by Dr Monekosso.

A senior finance officer in the Regional Office had written that in future there would be no need for discussions during the audit and exit meetings since explanations were not taken into account, no matter how valid they were.

Two Directors in the Regional Office for Africa had felt that the External Auditor had come with preconceived ideas and objectives, that the auditors were not familiar with the working procedures of WHO, that there were real communication problems, and that the attitude of some auditors had hurt the feelings of some of the Regional Office administrative staff. Consequently the Regional Office had not been able on that occasion to look to the External Auditor for help in making improvements, as had been the case in the past.

The WHO consultant whose work had been quoted by the External Auditor in paragraphs 1.4 and 3.15 of document A48/25 was a retired WHO staff member who had said that he had been directly involved in answering the External Auditor's questions and had attended meetings with the External Auditor's team. The consultant had expressed surprise at the way in which his in-house notes had been used by the External Auditor totally out of their original context, and had said that the auditors had not heeded the explanations given by the Regional Office staff, including himself.

The staff of the African Regional Office had been eager and willing to provide answers to the auditors, but they had not been seriously listened to or consulted. Consequently the Secretariat, located thousands of miles away, had not been in a practical position to discuss the external audit draft report after the basic breakdown in Brazzaville.

The Director-General's comments set out in paragraph 3 of document A48/39 were self-explanatory, but he drew attention to the fact mentioned in paragraph 3(iii) that the usual practice of issuing a management letter (a letter addressed to the Regional Director) had not been followed.

In summary, discussions at headquarters had not been deemed useful, owing to the External Auditor's failure to listen to or consult appropriately with the Regional Office staff, refusal to change the substance of his report even if there had been a meeting (see paragraph 3(ii) of document A48/39) and finally his decision not to issue the usual management letter, as was done for other regional offices.

Document BFI/95.1 gave a thorough response to document A48/25, including a summary of 14 major observations and comments on each paragraph of the External Auditor's report, which hopefully would help to clarify the Secretariat's position. His Division appreciated the work of both the External Auditor and the internal auditors and looked forward to continued good working relations with them.

Dr PRETORIUS (South Africa) pointed out that, since WHO was the trustee of money for improving the health of all people, every cent not used appropriately might deny a child the opportunity to be vaccinated or treated. Such "emotional" money therefore necessitated unemotional financial administration. In addition, the media reaction to any possible mismanagement of public funds in an organization such as WHO did not advance its goals; on the contrary it negatively affected the potential for external donor funding. The withdrawal by the present External Auditor of his candidature for the next financial biennium underlined the seriousness of the problem. However, from the External Auditor's report there did not appear to be any serious shortcomings in the existing WHO rules and regulations; the key problems had been insufficient capacity and unacceptable attitudes in implementing the rules and regulations. There was now a new Regional Director for Africa at the helm, who would need all the support possible.

He called on the entire Organization, Member States, governing bodies and Secretariat to recommit themselves to sound financial practices, and to the strengthening of technical support to the regions and country offices to ensure proper financial management.

Mr MUTISO (Kenya) said that the reasons given during the Forty-seventh World Health Assembly by the External Auditor to explain his inability to visit the Regional Office and carry out the audit had been far from satisfactory. The report just presented might have serious implications, since it painted a bleak picture of the Regional Office for Africa and did not recognize the good work done by its staff. The External Auditor had no doubt been intent on criticizing the work of the Regional Office staff; with the appointment of a new External Auditor, it was to be hoped that that would change. He himself commended the work of the internal auditor and the Regional Office staff.

Kenya was aware of the communications problems in Brazzaville which rendered access to the Regional Office difficult and would be happy to host the Regional Office in Nairobi.

Professor AGBOTON (Benin) expressed concern that the Regional Office for Africa had for some years come under financial scrutiny - the only Regional Office in that unenviable position. Intellectual honesty dictated that the Committee should listen attentively to the explanations of the Regional Director, as it was clear that the situation in Africa and especially in Brazzaville had been extremely difficult during the past few years. Nevertheless, that situation appeared capable of improvement, particularly in view of the progress already made and the commitment given by the Regional Director. However, the question remained as to why the External Auditor did not understand fully the Financial Regulations of WHO in the context of external audits. Did those Regulations differ from one region to another? The socioeconomic situation of the world in general and Africa in particular required that all those involved in decision-making in WHO, at both regional and headquarters levels, made every possible effort to ensure the healthy and transparent management of the Organization.

Dr SHRESTHA (Nepal) said that the External Auditor's report was neither factual nor fair, nor did it meet recognized audit standards. It was neither concise nor clear, and was confusing as compared with earlier reports. Furthermore, it ignored the representations made by the staff in Brazzaville; it might have been expected that the External Auditor would at least have taken their advice into account and referred to it in the report. The audit had been more like a probe, and information had been sought in order to support a predetermined conclusion. The External Auditor had relied extensively on the notes of the WHO consultant

who had visited the Regional Office in 1994 for operational work, not for audit purposes, and had also quoted from the report on the internal audit, but at the same time had not reviewed audit working papers.

In 1994 the audit of the Regional Office had not been severely disrupted, and the External Auditor should have gone to Brazzaville in 1993 or immediately after mid-May 1994. The internal auditor had visited the Regional Office three times in a period of 12 months while the External Auditor had visited it only once. The dynamic internal audit staff at headquarters were to be congratulated.

The External Auditor had failed to appreciate the seriousness of the unrest in the Brazzaville area. In fact, despite very difficult circumstances and staff shortages, internal controls had never broken down during those difficult times, and the health programme had been kept going throughout, often on the basis of emergency decisions. Yet the External Auditor had criticized the Regional Office while he himself had been unnecessarily afraid to go to Brazzaville for well over a year.

Many of the findings of the External Auditor were incorrect, and he had shown a lack of understanding of established WHO budget and finance procedures. There were inaccuracies in the report, and too much emphasis had been placed on minor administrative issues; there had also been undue use of the work of others. He therefore totally disagreed with the report.

Mr SALA Vaimili II (Samoa) pointed out that, in the Western Pacific Region, in accordance with the strict instructions given by the Regional Director, every cent spent was accounted for. At the end of the twentieth century the most modern methods of control were available. However, he did not wish to condemn any party at the present stage. It was better to look forward, not back and, in the spirit of equity and solidarity, a destructive fight between two parties should be avoided in the interests of all.

Mr ORR (Canada) found the report of the External Auditor an unexciting document given the extremely difficult circumstances in which the Regional Office for Africa had been compelled to operate. The report should have been responded to routinely; an appropriate response would have been to state that WHO recognized the problem and was endeavouring to solve it. However, communications with the External Auditor seemed to have broken down, particularly at headquarters. Moreover, there seemed to be some difference of opinion within the Secretariat itself. While Mr Aitken had said that he expected no further problems with the external audit, Mr Uhde had given the impression that there were serious problems throughout the system. It was clearly in the spirit of the Organization's Financial Regulations for the Director-General to respond to any concern expressed by the External Auditor in order to avoid a situation in which two separate reports were submitted to the Health Assembly. He was encouraged, on the other hand, by the approach that had been adopted by the new Regional Director for Africa. He sought assurance that the difficulties experienced would not affect completion of the 1994-1995 audit and suggested that some form of resolution or statement might be issued at the close of the discussion in which the External Auditor and the Secretariat were encouraged to maintain an open and free-flowing dialogue for the benefit of Member States.

Mr BOYER (United States of America) said that Member States depended on the External Auditor for information on the Organization's accounts and an understanding of the issues involved. The Secretariat therefore had a duty to listen and respond to his comments. The breakdown in communication reflected in the submission of separate documents to the Health Assembly and the continued bickering in public at the current meeting did not reflect well on the Organization. However, he commended the attitude of the new Regional Director for Africa, who was clearly determined to rise above existing differences, to maintain cooperative relations with the External Auditor and to improve the financial situation of the Regional Office for Africa.

Dr CHATORA (Zimbabwe) said that the report of the External Auditor and the Secretariat's comments in document BFI/95.1 and at the current meeting pointed to inadequate consultations between the two parties. For example, the Secretariat's response to the External Auditor's reference to over-reliance on personal trust in the management of education grants was to claim that its comments had been ignored.

The civil unrest that had impeded the functioning of the Regional Office for Africa and the difficulties that Member States had encountered in communicating with the Office were issues of serious concern. The

civil unrest had abated but if the communication problems persisted the location of the Regional Office might have to be reconsidered.

Dr METTERS (United Kingdom of Great Britain and Northern Ireland) said that the recommendations contained in the report of the External Auditor deserved to be considered and acted upon in the interest of Member States. He failed to understand why the Secretariat had chosen to ignore its obligation to cooperate with the External Auditor, adopting the somewhat negative approach reflected in document A48/39. He was also concerned about the criticisms of the External Auditor made by Mr Uhde, which seemed to be at variance with the more constructive remarks of Mr Aitken, who had affirmed that cooperation with the External Auditor would be maintained in the future.

He had been greatly reassured by the progress reported by the new Regional Director. Nobody who had listened to his description of the hardships suffered by the Regional Office during the civil strife could have failed to be impressed by the dedication of its staff, who had kept the Office functioning at considerable personal risk.

Dr WETZ (Germany), referring to the Director-General's summary of comments on the External Auditor's recommendations contained in document A48/39, said that he had been surprised to find a series of references to the Organization's Manual rather than an account of proposed action to remedy any shortcomings. He hoped that the detailed response referred to in paragraph 8 of the document, which should have been issued as an official document, would contain the missing information.

He deplored the lack of cooperation between the Secretariat and the External Auditor, as shown by the two contradictory reports submitted to the Health Assembly and the conflicting statements made by the representative of the External Auditor and Mr Uhde, and by the fact that the Secretariat had not even attempted to engage in a discussion with the External Auditor on his report. That situation was not acceptable to Member States, who relied on the administration to make the best possible use of their financial contributions. If the existing system of checks and balances broke down, the financial credibility of the Organization would be jeopardized. He therefore urged the Director-General to return to the former practice of close cooperation with the External Auditor.

Mr MUYLLE (Belgium) thanked the External Auditor and his assistants for their valuable services over the years to the Organization and its Member States. He deeply regretted the External Auditor's decision to withdraw his bid for reappointment. Member States, who paid large financial contributions each year, had every right to be kept informed of the Organization's financial situation. The Secretariat was therefore duty bound to cooperate fully with the External Auditor and was indirectly depriving Member States of their right to information by making his life so difficult that he had to withdraw his services. Belgium deplored such an unacceptable turn of events and hoped that the new External Auditor would be offered full support and cooperation.

Mr YAMBAO (Philippines), referring to paragraphs 1.5, 1.6 and 1.7 of the report of the External Auditor on the Regional Office for Africa concerning the objectives of the audit, the audit approach and the overall results, asked for clarification concerning the exact opinion expressed by the External Auditor. How did the result of the audit affect the qualified opinion previously expressed on the consolidated statements for 1992-1993?

He agreed with previous speakers on the need for closer dialogue with the External Auditor, who must nevertheless remain independent. The lack of such a cooperative relationship could defeat the purpose of the external audit, which was to contribute to the efficiency with which the Organization pursued and accomplished its mission.

Mr GONZÁLEZ DE LINARES (Spain) said that it was particularly unfortunate that the region whose external audit had given rise to such problems, dissension and misunderstandings was the one whose needs were greatest and whose health problems were most pressing. It was time to turn over a new leaf. A new External Auditor would shortly be appointed, the statement of the new Regional Director for Africa had given a favourable impression, and Mr Aitken had given a firm undertaking that the Secretariat would work to ensure maximum efficiency and transparency in the management of financial resources. He trusted that the

new era would be one of dialogue and cooperation, so that the prestige and general health of the Organization would be maintained.

Mr HIGGINS (representative of the External Auditor), commenting on the debate, said that the restricted opinion delivered in 1994 had not been an adverse one but had been occasioned by the inability of the External Auditor to travel to the Regional Office at the time. He was very heartened by the statement of the new Regional Director. The fact that there was now said to be no backlog at the Regional Office augured well for the future, and he congratulated the staff of the Office on its achievements under such difficult circumstances.

The External Auditor's perspective on the Organization was unique inasmuch as he was an outsider with an insider's view of its financial operations. The best way to use his services was to adopt a constructive approach to his recommendations. Mr Aitken had said that all facilities would be provided for the 1994-1995 audit, and he could rest assured that the External Auditor and his team would do their utmost to promote a constructive dialogue until the 1994-1995 audit was completed.

He regretted the negative attitude adopted by Mr Uhde. At the end of the audit in the Regional Office for Africa, an intensive four-hour consultation had been held with the staff, the results of which had been reflected in the report. The field work had been carried out to the best professional standards. The basic approach had been that of random sampling, using monetary unit samples under which every transaction had an equal chance of being selected for audit. All the supporting evidence was available for consultation.

It had been suggested that the Regional Office for Africa had been made to feel somewhat uncomfortable, having been given the impression that they were being probed rather than audited. He would hope that his staff were probing in order to get to the root of the matter that they were investigating, but he would not wish them to be gratuitously offensive or aggressive, and he was quite confident that they had not been. By the time that the report had been prepared, Dr Monekosso had completed his term of office as Regional Director but he had been fully informed on what the contents of the report would be. By the time that the draft report had been ready in February 1995, Dr Samba had succeeded him.

He resented the accusation that his staff had gone to Africa with preconceived ideas of what they would find there; in fact they had gone there with open minds. He appreciated the comment made by the delegate of South Africa, who had suggested that the Health Assembly should recommit itself to the principle of sound financial management; that was an approach that could certainly be endorsed by everyone.

He regarded as extraordinary the suggestion that the External Auditor had seemed unaware of the Organization's Financial Regulations on the external audit. Those Regulations, and specifically paragraph 9 of the Appendix to the Financial Regulations, required the External Auditor to give the Director-General the opportunity to see what was to be said in the auditor's report. As others had observed, the implication was that, not only should the External Auditor himself deliver a draft to the Director-General but that at various times leading up to that point there should also be consultations at the staff or working level. It was at that juncture that the consultation process had broken down.

The delegate of Canada had expressed the hope that the audit for 1994-1995 would be completed without problems. He himself could give an undertaking that the External Auditor would be as open as usual in his dealings before completing his report. There was no desire to spring surprises by presenting a report that had not been seen before or raising a problem that could have been more easily dealt with at an earlier stage.

The delegate of the Philippines had asked what impact the audit had had on the biennial accounts for 1992-1993. If the audit had been undertaken in 1993 the External Auditor would have been requesting amendment of the accounts in a number of ways, and if that had been done and the outcome of the audit had been otherwise satisfactory there could have been an unqualified opinion at that time.

Turning to the question of the appointment of a successor, he said that the External Auditor was in a very privileged position, the Member States' eyes and ears through which they were given an indication of what was going on in the management of the Organization by someone who was independent of it. He trusted that whichever organization succeeded the United Kingdom National Audit Office it would enjoy unimpeded cooperation in the future. For the rest of his term of office, the current External Auditor and his staff would do all they could to maintain that productive dialogue.

Dr SAMBA (Regional Director for Africa) thanked those speakers who had commended the attitude that he had adopted during what had been a very unpleasant episode. The audit for 1992-1993 had reported no case of fraud, and he emphasized that, in 14 years of handling millions of dollars in the Onchocerciasis Control Programme in West Africa, he had never once received a negative audit report. Indeed, on several occasions the auditors had not regarded it as necessary to attend meetings where the audit report on that Programme had been discussed and the budget approved. He realized that the Regional Office for Africa was a more complicated operation than the Onchocerciasis Programme, but he would do everything he could to prevent the recurrence of such an episode. He regarded the External Auditor not as an enemy but as someone whose job it was to help the Regional Office for Africa to do its job better. It was his intention to continue to implement the recommendations of the External Auditor immediately.

If any region needed WHO and donor support it was Africa, which contained the majority of the least developed countries and the biggest of the world's health problems. He assured Member States that their money was safe and that the Regional Office would endeavour to solve any problems that remained as soon as possible.

Mr AITKEN (Assistant Director-General) said that there had clearly been strong differences of view between the staff of the Division of Budget and Finance and some staff of the then Regional Office for Africa and the External Auditor, but the need now was to move forward by ensuring the closest cooperation with the External Auditor. He did not envisage any problems for the 1994-1995 biennium or for the new External Auditor whoever he or she might be.

The CHAIRMAN said that if there were no objections he would take it that the Committee wished to note the report of the External Auditor on the Regional Office for Africa, and the comments made by the Director-General, and to encourage close collaboration and dialogue between the External Auditor and the Secretariat.

It was so decided.

Report on the implementation of the recommendations of the External Auditor: Item 23.2 of the Agenda (Resolution WHA47.15; Document A48/26)

Professor KUMATE (representative of the Executive Board) said that the Director-General's report on the progress made in implementing the recommendations of the External Auditor, contained in his report to the Forty-seventh World Health Assembly, had been reviewed by the Executive Board at its ninety-fifth session in January 1995. The Board had considered and noted the Director-General's report, as mentioned in paragraph 2 of document A48/26.

The CHAIRMAN said that, in the absence of any comment, he would take it that the Committee wished to note the action to implement the recommendations of the External Auditor concerning the financial report for 1992-1993.

It was so decided.

2. APPOINTMENT OF THE EXTERNAL AUDITOR: Item 24 of the Agenda (Documents A48/27, Corr.1, Corr.2, and Add.1)

The CHAIRMAN drew attention to the annexes to document A48/27 containing proposals from the candidates for the position of External Auditor. It was the first occasion on which WHO had invited nominations in accordance with the practice recently established in a number of other organizations of the United Nations system.

Mr ÖRTENDAHL (Sweden) said that external auditing of high quality, unquestioned independence and total candour was now of very great importance to the Organization. Both Member States and the Secretariat must give external auditing their wholehearted support. While the professionalism and independence of the Swedish National Audit Office would be of great value, there were other candidates for the position of External Auditor with such qualities, and Swedish auditors had performed the task in the past. To assist in the rapid achievement of a consensus, therefore, the Swedish National Audit Office was withdrawing its candidacy for the position of External Auditor.

The CHAIRMAN said that following the withdrawal of the candidacy of the Swedish National Audit Office, there remained four candidates, namely, the Australian National Audit Office, the Philippine Commission on Audit, the Auditor-General of the Republic of South Africa, and the Auditor to the Mutual Aid Association of State Civil Servants of Spain. He invited the remaining candidates to make brief presentations in alphabetical order of their countries.

Ms WENSLEY (Australia) said that the accounting and auditing skills of the Australian National Audit Office were among the best in the world, and through its involvement with the International Organization of Supreme Audit Institutions (INTOSAI) it was highly respected in the international audit community. It was a recognized leader in the development of modern audit methodologies and practices, and the use of technology. It had developed and refined its approach to financial statements and value-for-money auditing, and its client service philosophy involved talking to all levels of management within an organization. It was committed to understanding its client, and the sincerity of that commitment was demonstrated by its visits to WHO headquarters and regional offices during and since the preparation and submission of its proposal. It had had discussions with the Director-General, senior finance staff, programme managers and all regional directors in order to understand all parts of the Organization thoroughly.

The Australian National Audit Office would add value to WHO. It ensured that all its commitments were met, potential problems anticipated and surprises avoided. It provided senior management with insights into the condition of their organization and suggestions for improvement; it also obtained a regular assessment of its own performance from senior management. Like WHO, it operated in many and varied locations and was required to deliver the best possible results in an environment of change and scarce resources. It was a multicultural employer, and was accustomed to exercising the necessary flexibility to assist rather than hinder management and staff. It had a history of open, honest and objective analysis which was valued by its clients. It offered WHO a fresh, modern approach consistent with the best international practice at the most competitive price, with the assurance that it would work together with management to improve the Organization. It had been the first to submit a bid, and its cost was the lowest. Its risk-based auditing approach was a modern one which provided sufficient, balanced coverage most efficiently, enabling it to form an audit opinion without giving rise to additional or unnecessary work that would result in increased costs for the body being audited.

Mr GANGAN (Philippines) said that the Philippine Commission on Audit would conduct a value-for-money audit in accordance with the provisions of WHO's Financial Regulations concerning External Auditors. The Commission would devote 85% of the estimated time to the audit of the Organization's financial statements and 15% to audits in which WHO's operations would be reviewed from the point of view of cost-effectiveness, efficiency and economy. For the services being offered, the Commission's estimated cost was the lowest and was based on the estimated maximum time needed to complete the audit; if less time was taken, the cost to WHO would be reduced.

The Commission would employ highly trained, competent and experienced auditors, who had had substantial experience in the audit of international organizations; the Commission had served for nine years as a member of the United Nations Board of Audit. Its staff had also had considerable experience in the use of computerized systems.

The proposed audit programme provided for visits to WHO regional offices wherever necessary. A Director of Audit would be assigned to headquarters to be available for consultations and dialogue. The Commission would strictly observe the reporting protocols specified in the WHO Financial Regulations.

The Commission was an independent body and could therefore act professionally with independence, objectivity, fairness and impartiality. Its staff were fully aware of the shared problems, needs and aspirations

of the peoples of developing countries, and hoped to be able to contribute to the success of the Organization if awarded the mandate.

Mr KLUEVER (South Africa) said that an independent, external audit was essential to ensure accountability and facilitate proper management of WHO's resources. Extensive discussions at the present and prior Health Assemblies had highlighted the budgetary constraints under which WHO would have to operate and the need for budgetary reforms and greater openness and transparency.

The Office of the Auditor-General of South Africa could play a major role in strengthening the reform process. Although located in a developing country it had world-class capabilities; the Office had been a part of the process of dramatic change in South Africa, setting an example for the world.

The Office had gained its knowledge of WHO from a study of the literature, and from visits to Geneva, Lyon and Brazzaville, enabling it to form a sound basis for its proposals. If awarded a contract, he was confident that its contribution would be of great importance to many countries around the world.

The Office would maintain a permanent presence in Geneva and would keep the effectiveness and efficiency of the audit process continually under review. Its record of independence was an example to many, and it was able to provide a highly professional service at a competitive cost. Professionalism, independence, impartiality, technical competence and the ability to report in plain language without fear or favour were the essential characteristics that the External Auditor of WHO needed to possess, as explicitly laid down in the Financial Regulations.

There was a need to strengthen the involvement of Member States in the financial oversight of the Organization to facilitate timely communication and corrective action at an appropriate level. South Africa would consult all relevant players to examine how best such involvement could be achieved in practice.

Dr ADÁN CARMONA said that he had trained as an economist and was currently a State finance inspector in Spain. He now sought to use his auditing skills to increase the prestige of WHO and to ensure that its funds were used effectively.

Auditing was not a purely theoretical procedure; it was in its practical aspects that it found its truest expression, and it was in those aspects that he had specialized, having worked in the Spanish administration since 1963. He had had experience of all aspects of auditing, as financial comptroller with respect to legal aspects, and as internal and external auditor working in all relevant areas, including economic aspects, efficiency and effectiveness, in both operational and computerized auditing. He had held many posts in international organizations including those of Chairman of the Court of Audit of the European Space Agency, internal auditor of EUROCONTROL, and auditor of the Spanish Presidency for the Schengen Agreement.

As well as the technical programme that his team had drawn up, he would encourage all Member States to send all matters of concern to them to the internal auditor so that they could be included in the auditing programme. A report would then be sent to the Member State in question. If the matter was of major importance it could be included in the auditor's final report. The weak points revealed in previous audits would thus be the starting point. Logically, the most important part would be the overall examination of the budget, for which purpose the most modern auditing techniques and computer programs would be used so as to reflect in much greater depth the state of the Organization's finances. The independence of the audit team should be clearly established, which would lead to good relationships with, and the respect of all delegations. Thus his appointment would increase WHO's prestige and take account of the concerns of Member States, while the most important parts of the budget would be examined by means of the most advanced computer techniques.

Mr MANDANI (Qatar) suggested that it might be advisable for an ad hoc committee to examine the various proposals made by the candidates for the position of External Auditor to assess competence and cost.

Mrs MANYENENG (Botswana) supported the appointment of the Auditor-General of the Republic of South Africa as External Auditor, enabling WHO to benefit from the experience and professionalism available in the African continent.

Mr SATA (Zambia) said that, although all four candidates were without question distinguished and competent, it was important to bear in mind the need for an equitable geographical distribution of posts.

Mr MUTISO (Kenya) said that it was not clear whether the candidates were individuals or countries. Thus Australia's presentation had been made by that country's ambassador rather than the individual concerned.

Mr VIGNES (Legal Counsel) replied that Article 12.1 of the WHO Financial Regulations specified that, although the External Auditor was a personal appointment, the person concerned had to be the Auditor-General of a Member Government.

Ms WENSLEY (Australia) said that she had presented the bid on behalf of the Australian National Audit Office because the National Auditor had only recently been appointed and was unable to be present at the Health Assembly. In addition, her delegation had been advised that the presentation had to be made by a member of the delegation to the Health Assembly.

Mr SALA Vaimili II (Samoa) proposed that the discussion should be closed and a vote taken.

Mr AITKEN (Assistant Director-General), in reply to the delegate of Qatar, said that it was laid down in the Financial Regulations that it was the Health Assembly which appointed the External Auditor.

The CHAIRMAN drew attention to the fact that in similar circumstances in 1993 at UNESCO the decision had been by election. Rules 80 and 81 of the Rules of Procedure of the Health Assembly described the procedure to be followed in an election, which would necessarily be by secret ballot.

Mr VIGNES (Legal Counsel) said that in order to simplify matters, voting would be for the country which had proposed a candidate.

Professor H. Agboton (Benin) and Professor Li Shichuo (China) were appointed tellers.

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

Members entitled to vote	159
Members absent	30
Votes cast	129
South Africa	59
Australia	35
Philippines	20
Spain	15
Number required for simple majority	65

As no candidate had obtained the required majority, it was decided that a second ballot would be held at 14:30.

The meeting rose at 13:25.

FIFTH MEETING

Monday, 8 May 1995, at 14:30

Chairman: Professor A. WOJTCZAK (Poland)
later: Mr M.S. DAYAL (India)

1. APPOINTMENT OF EXTERNAL AUDITOR: Item 24 of the Agenda (Documents A48/27 and Corr.1, Corr.2, and Add.1) (continued)

Mr VIGNES (Legal Counsel) reminded the Committee that, in accordance with Rule 81 of the Rules of Procedure, the second ballot for the choice of External Auditor would be restricted to the two candidates who had obtained the largest number of votes on the first ballot, Australia and South Africa. He therefore invited delegates to indicate their choice of one of those two countries; ballots bearing the names of both, or of any other country, would be considered null and void.

Professor H. Agboton (Benin) and Professor Li Shichuo (China) were appointed tellers.

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

Members entitled to vote	159
Members absent	31
Votes cast	125
Abstentions	1
Papers null and void	2
South Africa	75
Australia	50
Simple majority	63

Having obtained the required majority, the South African candidate for the position of External Auditor was elected.

The draft resolution contained in paragraph 6 of document A48/27, completed in accordance with the result of the secret ballot, was approved.[1]

2. FIRST REPORT OF COMMITTEE B (Document A48/48)

Dr EL KALA (Egypt), Rapporteur, read out the draft first report of Committee B.

The report was adopted.[2]

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[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.18.

[2] See page 276.

3. REPORT OF COMMITTEE B TO COMMITTEE A (Document A48/49)

Dr EL KALA (Egypt), Rapporteur, read out the draft report of Committee B to Committee A.

The report was adopted.[1]

4. WHO RESPONSE TO GLOBAL CHANGE: Item 22 of the Agenda (continued)

Progress reports on implementation of recommendations: Item 22.1 of the Agenda (continued from the second meeting)

The CHAIRMAN invited the Committee to consider the following draft resolution entitled "WHO response to global change", proposed by the delegations of Argentina, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Ghana, Greece, Ireland, Italy, Japan, Malta, New Zealand, Norway, South Africa, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania and United States of America:

The Forty-eighth World Health Assembly,

Recalling the requests and recommendations of the Forty-seventh World Health Assembly to the Executive Board and the Director-General in its resolution WHA47.6 on WHO response to global change;

Having considered the progress report by the Director-General contained in document A48/23;

Having also considered the Executive Board's decision on the subject;

Welcoming the steps taken since the Forty-seventh World Health Assembly to implement further the recommendations on global change;

Recognizing the difficulties faced by the Organization in adapting to the needs of global change;

Convinced that reform should permeate the Organization at all levels and in all regions without delay, and that it should remain an integral part of WHO's management culture once action has been taken on all 47 recommendations;

Considering that WHO's staff are its most important asset, and that an effective personnel policy is essential to the effective implementation of reform,

1. WELCOMES the action of the Director-General and his staff in their continuing implementation of the comprehensive plan for managerial and administrative reform endorsed by the Health Assembly;

2. REQUESTS the Director-General:

(1) to accelerate and sustain the work of the development teams created to carry forward the process of WHO reform, in particular those dealing with WHO's personnel policy and WHO country offices;

(2) to strengthen the structural capacity at WHO headquarters to ensure that reform permeates all levels of the Organization and that the reform process receives due priority and becomes an integral part of WHO's management culture;

(3) to report regularly to the Executive Board on progress and any obstacles encountered in the process of WHO reform;

(4) to report to the Forty-ninth World Health Assembly on further progress made in implementation of reform throughout WHO;

[1] See page 278.

3. REQUESTS the Regional Directors to pursue vigorously the implementation of reform as well as to report regularly to the Executive Board on progress and any obstacles encountered in the implementation of reform in their regions;

4. REQUESTS the Executive Board to continue to monitor progress in reform and advise the Director-General on measures to overcome any obstacles encountered.

Mr SIMMONS (United Kingdom of Great Britain and Northern Ireland), introducing the draft resolution, said that it was intended to indicate that WHO's reform should go far beyond what was recommended in a single document, and that it was the shared responsibility of the Secretariat and Member States at all levels and in all regions. Furthermore, the broad sponsorship of the draft resolution underlined the fact that WHO reform was of concern to all.

Mr VAN REENEN (Netherlands) said that the Netherlands would be pleased to be included among the sponsors of the resolution if the words "WHO's policy and mission," were inserted after the "dealing with" in operative paragraph 2(1).

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

Renewing the health-for-all strategy: Item 22.2 of the Agenda (continued from the third meeting)

The CHAIRMAN invited the Committee to consider the following draft resolution entitled "WHO response to global change: Review of the Constitution of the World Health Organization", proposed by the delegations of Argentina, Australia, Austria, Belgium, Canada, Denmark, Fiji, France, Ireland, Japan, Lao People's Democratic Republic, Lesotho, Malaysia, Malta, Micronesia (Federated States of), Nauru, Netherlands, New Zealand, Norway, Palau, Republic of Korea, Samoa, Solomon Islands, Swaziland, Sweden, Tonga and United Kingdom of Great Britain and Northern Ireland:

The Forty-eighth World Health Assembly,

Noting that the World Health Organization is approaching a landmark in its history, the fiftieth anniversary in 1998;

Noting the significant changes in the international system and in the composition and membership of the Organization in recent years;

Noting the WHO response to global change and its far-reaching implications for the Organization, some of which may exceed its present legal framework;

Noting that the Constitution has not been thoroughly reviewed since its entry into force in 1948;

Recognizing the need for review of the Constitution to ensure that the Organization remains equal to the international health challenges of the late twentieth century and beyond,

1. CALLS UPON the Executive Board to examine at its ninety-sixth session whether all parts of the Constitution of the World Health Organization remain appropriate and relevant; and if the Executive Board concludes there is a need for a review of the Constitution, to consider how best the review of the Constitution should be taken forward;

2. REQUESTS the Director-General to report to the Forty-ninth World Health Assembly in 1996 on progress on this matter.

The draft resolution was approved.[2]

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[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.15.

[2] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.14.

The CHAIRMAN invited the Committee to consider a draft resolution entitled "WHO response to global change: Renewing the health-for-all strategy", which comprised the recommendation addressed to the Health Assembly by the Executive Board in resolution EB95.R5, as amended by a drafting group. The amended text read:

The Forty-eighth World Health Assembly,

Stressing the continued validity of "health for all" as a timeless aspirational goal, while recognizing that it may not be universally attainable by the year 2000;

Recognizing that political, economic, social, cultural and environmental situations are changing throughout the world;

Concerned by the negative trends in some of the major health determinants shown by the third monitoring of progress in implementation of strategies for health for all by the year 2000;[1]

Recognizing the need to give priority attention to those most seriously deprived in terms of health or health care, whether owing to poverty, marginalization or exclusion; and recognizing also in this regard, the need for intensified support of the international community;

Stressing the importance of a broad national and international consultation among those dedicated to health and social development in order to create a renewed commitment to health under WHO leadership;

Having considered the report of the Director-General[2] outlining the steps taken to implement the recommendations of the Executive Board Working Group on the WHO Response to Global Change[3] on the updating of the health-for-all strategy, objectives and targets in response to global change;

Having noted with appreciation the contribution of the task force on health in development created by resolution WHA45.24;

Agreeing that a new global health policy should be elaborated,

1. ENDORSES the steps already taken by the Director-General to implement the recommendations on updating the health-for-all targets in response to global change;

2. URGES Member States:

(1) to take appropriate steps for consultations to raise the awareness of the general public, political leaders, ministries and other partners concerned with social and economic development policy to the need to place health high on the political agenda, in order to address the serious health challenges of the coming decades and to ensure that the foundation is laid for implementation of the global health policy in countries;

(2) to forward to WHO the consensus views on health challenges and major policy orientations resulting from the national consultation to serve as a basis for the elaboration of the global health policy;

(3) to adapt the global health policy, after its adoption, into national or subnational context for implementation, selecting approaches specific to their social and economic situation and culture;

3. CALLS ON other organizations of the United Nations system as well as intergovernmental and nongovernmental organizations active in the field of health to participate in the elaboration of the global health policy, to define their role in carrying it out and to join forces with WHO for its implementation;

4. REQUESTS the Director-General:

(1) to take the necessary steps for renewing the health-for-all strategy together with its indicators, by developing a new holistic global health policy based on the concepts of equity and

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[1] Monitoring of progress in implementation of strategies for health for all by the year 2000, third report (documents EB95/5 and EB95/INF.DOC./13).

[2] Document EB95/1995/REC/1, Annex 5.

[3] Document EB92/1993/REC/1, Annex 1.

solidarity, emphasizing the individual's, the family's and the community's responsibility for health and placing health within the overall development framework;
(2) to ensure the convergence of all relevant work carried out on the subject at all levels of the Organization;
(3) to consult widely with all Member States and other partners of WHO in health development to this effect;
(4) to support Member States in the elaboration of their contribution to the global health policy, *inter alia,* by preparing user-friendly material to that effect, accessible to all sectors;
(5) to solicit the contribution of other institutions dedicated to health and social development, such as those of the United Nations system and other international and nongovernmental organizations, to the formulation and implementation of the global health policy;
(6) to elaborate the new global health policy, based on the outcome of the consultation process, to serve as objective and guidance for the updating of global, regional and national health-for-all strategies and for the development of mechanisms to enable all concerned to fulfil their role, taking into account that essential aspects of primary health care have not yet been achieved by a number of countries, especially the least developed countries;
(7) to redefine WHO's mission and the meaning of technical cooperation for WHO in pursuance of that global health policy;
(8) to take the necessary measures for WHO to secure, at a special event connected to the World Health Assembly of 1998, in conjunction with the fiftieth anniversary of WHO, high level political endorsement of a health charter based on the new global health policy, in order to obtain political ownership of the policy and commitment to its implementation;
(9) to report on the plans for securing this endorsement to the Forty-ninth World Health Assembly.

Mr ÖRTENDAHL (Sweden), presenting what he considered to be a very satisfactory outcome of the deliberations of the drafting group, and commending the leadership exercised in that regard by the Chairman of the Committee, voiced the understanding that the "special event" referred to in operative paragraph 4(8) would take place in connection with the Health Assembly and the fiftieth anniversary of WHO in 1998.

With that understanding, the draft resolution was approved.[1]

Technical discussions: Item 22.3 of the Agenda (Resolution EB94.R2)

Professor KUMATE (representative of the Executive Board), introducing the draft resolution recommended by the Board in resolution EB94.R2, remarked that the replacement of Technical Discussions in the manner proposed should result in savings of some US$ 200 000 in the biennium. At the present Health Assembly, a limited number of technical meetings had been held during the midday break: if the Board's proposal was adopted, that practice would become official.

The draft resolution recommended by the Executive Board in resolution EB94.R2 was approved.[2]

Mr M. S. Dayal (India), Vice-Chairman, took the Chair.

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.16.

[2] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.17.

5. SCALE OF ASSESSMENTS: Item 26 of the Agenda

Assessment of new Members and Associate Members: Item 26.1 of the Agenda (Document A48/46)

Mr AITKEN (Assistant Director-General), introducing document A48/46, which contained a draft resolution on the assessment of Palau, said Palau had become a Member of WHO on 9 March 1995. Since the United Nations General Assembly had not yet established a rate of assessment for Palau, the Director-General was proposing that, in line with WHO practice, a provisional minimum assessment rate of 0.01% should be applied, and that the definitive assessment rate should be fixed when the Health Assembly considered the matter once the United Nations rate had been established. The Director-General was also proposing, again in accordance with normal practice, that Palau, since it had joined in March, should pay only nine-twelfths of its regular assessment for 1995.

Mr UEDA (Palau) said Palau stood ready to accept the provisional assessment rate indicated in document A48/46, pending establishment of a rate by the United Nations General Assembly, and undertook to be responsible for the 1995 instalment based on nine-twelfths of that provisional assessment. He expressed appreciation of the Director-General's decision in the matter, and urged that the draft resolution be approved.

The draft resolution contained in document A48/46 was approved.[1]

Scale of assessments for the financial period 1996-1997: Item 26.2 of the Agenda (Document A48/28 and Corr.1)

Mr AITKEN (Assistant Director-General) said WHO also traditionally followed the United Nations on the matter of general scales of assessment, and the proposal contained in document A48/28 was therefore based on United Nations scales. Although in the past the United Nations had adopted a single set of rates for all three years of each financial period, on the present occasion it had adopted one scale for 1996 and a different scale for 1997: the same had been done in the proposal now put forward by WHO. The 1996 United Nations scale had been expressed to four decimal places, and that was the formula followed for the WHO scale. It would be noted that the United Nations had in some cases made considerable changes between the current 1995 scale and the scale now before the Committee.

Slight amendments would have to be made to the figures shown to take account of the decision just taken, which would add Palau's assessment of 0.01% to the total. The amendments would particularly concern 1996, and would require a recalculation to four decimal places: however, because Palau's assessment was so small, the effect on most Member States would be marginal.

The Committee was invited to consider the draft resolution set out in paragraph 5 of document A48/28.

Dr SUZUKI (Japan) pointed out that, as a result of the changes in the scales of assessment just outlined, it was proposed that the WHO assessment for Japan should be 15.1746% for the year 1996, and 15.38% for the year 1997. Since its assessments for 1994 and 1995 had both been 12.24%, adoption of the proposal contained in document A48/28 would mean a drastic increase which Japan would find it impossible to pay in full.

Japan accordingly proposed that the WHO scales of assessment for the years 1996 and 1997 should be determined on the basis of the United Nations scales for the years 1995 and 1996 respectively. It was planning to submit a draft resolution to the Committee to that effect, and would welcome comments.

Mr AITKEN (Assistant Director-General) replied that the United Nations had adopted special scales for 1996-1997, as it had for 1995. Because WHO was bound by a Health Assembly resolution to adopt the latest available scale, it had adopted for the forthcoming biennium the United Nations scales for 1996-1997, but had adopted for the current biennium the scale for 1994, in effect missing out the year 1995.

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[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.19.

He believed that when delegates studied the proposal of Japan they would see that, while it would result in the reduction of Japan's contribution for 1996, it would have the opposite effect on the contributions of many other countries which would otherwise benefit by reductions in their rates of assessment. For the Committee now to enter into discussion on a resolution would essentially amount to the reopening of a debate which had already taken place in New York, and might be unduly time-consuming.

If it would satisfy the delegate of Japan, he would suggest that the Administration, Budget and Finance Committee of the Executive Board should look into the question in two years' time, with a view to giving advice to the Board and the Health Assembly on possible future action should the same situation recur. Meanwhile, it might be in the best interests of the Committee to follow current practice, and to retain the 1996 and 1997 United Nations scales for WHO's contributions for those years.

Subject to the adjustments referred to, the draft resolution contained in document A48/28 was approved.[1]

6. REVIEW OF THE WORKING CAPITAL FUND: Item 27 of the Agenda (Resolutions WHA47.20 and EB95.R16)

Dr NGO VAN HOP (representative of the Executive Board) said that the Director-General, in his report to the Executive Board in January 1995, had recommended that Part I of the Working Capital Fund, financed by advances made by Member States and totalling US$ 5 139 390, should be abolished and that the amount standing to the credit of each Member State should be refunded on 1 January 1996 by offsetting it against any regular budget contributions due by that date. It had also been recommended that, to compensate partly for the refund of advances to Members, the Health Assembly should authorize the Director-General to transfer US$ 5 million from casual income to the Working Capital Fund, on the same date.

The Board had fully endorsed the Director-General's recommendations. It was understandable that, in the absence of cash income during the first years following the creation of the Organization, the Health Assembly had had no other solution but to request Member States to pay advances to the Working Capital Fund. However, for the past 30 years, all increases in the Fund had been financed by transfers from the casual income account. In view of the Organization's current credit position, it was no longer necessary to ask Member States to pay additional advances. Retention of Part I of the Fund would impose a burden of unnecessary administrative costs on Member States and on the Organization, and its abolition would result in greater efficiency, as well as in a simplification of administrative tasks.

Resolution EB95.R16 contained a draft resolution on the subject, recommended by the Board for adoption by the Health Assembly.

The draft resolution recommended by the Executive Board in resolution EB95.R16 was approved.[2]

7. REAL ESTATE FUND: Item 28 of the Agenda (Resolution EB95.R18; Documents A48/29 and A48/44)

The CHAIRMAN observed that the situation regarding the Real Estate Fund had changed substantially since the Executive Board had considered it at its ninety-fifth session. The Administration, Budget and Finance Committee of the Executive Board had discussed the matter at a meeting on Monday, 1 May 1995, and had recommended that the resolution contained in document A48/29 should be approved. Details of the Committee's discussion could be found in its third report, contained in document A48/44.

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[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.20.

[2] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.21.

Mr AITKEN (Assistant Director-General) explained that it had been considered appropriate that the additional funding found to be available under casual income should be used for financing a particular project. The revised version of the Board's original recommendation to the Health Assembly was contained in paragraph 12 of document A48/29.

Dr LARIVIÈRE (Canada) said he was mindful of the report of Committee B to Committee A, adopted earlier in the meeting, concerning the use of casual income to help finance the 1996-1997 regular budget; he was also aware that most Member States appreciated efforts to reduce contributions to the budget. However, the amount of casual income thought to be available when the Executive Board had discussed the matter in January 1995 was far below the actual figure. The Director-General had consequently taken the initiative at that time of proposing spreading the cost of the new local area computer network (LAN) over two years, with the dual aim of reducing the use of casual income in any one year and of seeking ways and means to reduce contributions. Canada agreed with the current proposal that the new LAN should be entirely financed from the Real Estate Fund, but suggested that the cost should be spread over two years, as proposed in January: US$ 3 400 000 to be appropriated from casual income available in 1995; US$ 3 365 000 to be appropriated in 1996 from casual income earned in 1995. That would cover the full cost of the project but would free more casual income for use in reducing assessed contributions in 1995.

Regarding the Regional Office for the Eastern Mediterranean, he recalled that, of the amount appropriated some years previously, at least US$ 1 million had been spent with very little to show for it and there were plans for a further US$ 300 000 to serve as WHO's share of the new tendering process. He was nevertheless pleased to see that the project might come to fruition with the full support of the Egyptian Government.

Mr BOYER (United States of America) noted that the cost of replacing the LAN was US$ 6 765 000, making it one of the largest projects ever covered by the Real Estate Fund. Was WHO getting the best possible price? What steps were being taken to minimize costs? The Canadian proposal was intriguing; he looked forward to the Director-General's response.

Mr VAN REENEN (Netherlands) supported the draft resolution proposed in document A48/29. Referring to paragraph 5 of that document, he requested both the Organization and the local authorities to give careful consideration to the details of the proposal for the Regional Office for the Eastern Mediterranean to share premises with the Egyptian Ministry of Culture, in order to avoid unforeseen deficits and possible calls on the Real Estate Fund.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) said that negotiations, concerning Regional Office premises had lasted for more than eight years. Some days previously, he had received a letter from the office of the Prime Minister of Egypt, promising a building plot in either Alexandria or Cairo. That would eliminate the problems of jointly constructing and sharing a building with the Ministry of Culture, and might mean that part of the money already paid out would be restored. It might also mean that the Executive Board and the Health Assembly would be approached in future for money to build on the plot.

Mr AITKEN (Assistant Director-General), replying to the delegate of the United States of America, said that the LAN project would be put out to worldwide tender, and that it would be divided into two parts, cabling and hardware. The actual cost might therefore be lower, but that remained to be seen.

Replying to the Canadian delegate, he explained that the first call on casual income was to cover shortfalls arising from fluctuations in the exchange rate; in the current biennium, the sum of US$ 21 million was already needed. Accepting Canada's proposal might be too risky, since it was not known whether there would be sufficient casual income available in 1996 to both fund the project and compensate for unforeseen exchange rate movements. Much as he understood the desire to reduce Member States' contributions, he recalled that the Committee had just approved a draft resolution which would return US$ 5 million to Member States through a recasting of the Working Capital Fund. He therefore asked Canada to reconsider its position.

Dr LARIVIÈRE (Canada) said that he was not satisfied but that he understood the reasons given. He noted that his proposal had given rise to some curiosity, but had elicited no support.

The draft resolution contained in document A48/29 was approved.[1]

8. PERSONNEL MATTERS: Item 29 of the Agenda

Recruitment of international staff in WHO: biennial report: Item 29.1 of the Agenda (Resolutions WHA46.23, WHA46.24, EB93.R17 and EB95.R19)

Dr NGO VAN HOP (representative of the Executive Board) said that the Board had considered two reports by the Director-General, one concerning geographical representation in the recruitment of international staff and the other concerning the recruitment and participation of women in the work of WHO. The report on geographical representation, which had compared staffing figures for September 1994 with those for September 1992, had shown that the target of 40% for recruitment from unrepresented and under-represented countries and those below the mid-point of the desirable range had been exceeded, and stood at 48%. The Board had nevertheless decided to maintain the target at its current level, and had asked the Director-General and the Regional Directors to continue their efforts to improve geographical representation during the rest of the current biennium. The Board had recommended a draft resolution for consideration by the Health Assembly in its resolution EB95.R19.

The Director-General's report on the recruitment and participation of women had been submitted pursuant to resolution EB93.R17, which called for measures to increase the number of women employed in professional posts, particularly at the D2 and higher levels. In fact, between 1992 and 1994, the representation of women at those levels had increased only slightly, from 12.2% to 13.2%. The percentage of women occupying professional and higher-graded posts had reached only 26% and the target of 30% was unlikely to be achieved by the deadline of September 1995.

The report to which he had just referred was of an interim nature: the full biennial report on the recruitment and participation of women in WHO's activities would be set before the Board and the Health Assembly in 1996.

Mr SATA (Zambia), supported by Dr IYAMBO (Namibia), asked for the item to be kept open until Thursday, 11 May to allow for the preparation of a draft resolution.

Dr LARIVIÈRE (Canada) expressed support for the draft resolution recommended by the Board in resolution EB95.R19, noting with satisfaction that the 40% target for recruitment from unrepresented and under-represented countries had been passed.

Turning to the employment and participation of women in the work of WHO, he submitted that, although some progress had been made, the percentage of women employed by the Organization was still too low. One reason which had been suggested was the problem of retaining existing women staff; in 1993, a total of 46 women had joined the Organization, but the same number had left. The rules governing the employment of spouses were another reason. It was essential not only to recruit competent women staff, but also to ensure that they continued to work for WHO, by making their jobs challenging and satisfying and offering them good career prospects. He welcomed the Director-General's appointment of a special adviser to review the whole process of recruitment.

Document A48/INF.DOC./9, entitled "Collaboration within the United Nations system: women, health and development and World Conference on Women", outlined measures for improving the recruitment of women throughout the United Nations system, including pooling lists of candidates for posts in various United Nations organizations and asking field staff to identify potential candidates for jobs in other sectors.

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.22.

The measures had been proposed by ACC, and it was gratifying to see such a firm commitment on the part of a high-level body.

Mr QUAUNINE (Bangladesh) said that, although it was obviously important to ensure that WHO was run by efficient staff, the principle of equitable and balanced geographical representation must be sincerely applied. Affirmative action for regional representation, especially from the developing countries, was a declared priority of the United Nations system, although there had been little progress so far. There were by now enough properly qualified applicants from developing countries to make affirmative action both meaningful and feasible, and it was high time for a new initiative to ensure true regional diversity.

While he endorsed the goal of appointing women staff to fill 30% of all professional and higher-graded posts, initiatives for the increased recruitment of women must not be allowed to affect the campaign for equitable geographical representation. In future, it might be possible to fulfil both objectives at once by recruiting women from developing countries. He hoped that the Director-General would take those points into account when preparing his report on the recruitment of women for the next Health Assembly. As part of the reform process, due weight should be given to the matter of ensuring that WHO staff members received the training that would enable them to confront the health-related challenges of the future.

Mr VAN REENEN (Netherlands) noted with regret that the 30% target for women in professional and higher-graded posts would probably not be achieved by the September 1995 deadline, although the situation had improved slightly over the past two years in respect of D2 and ungraded-level posts. Every possible measure should be taken, particularly in the regions, to increase affirmative action in favour of women staff.

Mr BOYER (United States of America) welcomed the progress made in the campaign for equitable geographical representation of Member States among WHO staff, but agreed that more action was needed in favour of the unrepresented and under-represented countries. He also urged WHO to redouble its efforts to increase the number of women in professional posts, particularly at more senior levels.

Mr ÓLAFSSON (Iceland) regretted the failure to reach the 30% target for women in professional and higher-graded posts, particularly since more women than men graduated from higher education in many countries.

Dr LIU Hailin (China) commended the progress made in achieving equitable geographical representation of Member States in WHO's staff. The method used for calculating the desirable range of staff posts for each Member State seemed both reasonable and practical. However, it was important to continue efforts to promote the recruitment of staff from unrepresented and seriously under-represented Member States, as a means of encouraging the active participation of those States in WHO activities and so improving cooperation in the solution of global health problems, even though it was not always easy to find well qualified candidates from such countries. The same considerations applied to the recruitment of women staff. He supported the draft resolution recommended by the Executive Board.

Mr ROBERTSON (Australia) likewise welcomed the progress made in achieving geographical representation and endorsed the draft resolution. Concerning the recruitment of women staff, he recalled the provisions of resolutions WHA38.12 and WHA46.24, and urged the Director-General to continue to give priority consideration to applications from appropriately qualified women candidates, particularly for posts at the D2 and ungraded levels. Member States could help by advising appropriately qualified women of vacancies within WHO.

Mr AITKEN (Assistant Director-General), responding to the discussion, said that the Director-General would continue his efforts, in collaboration with Member States, to improve geographical representation, particularly of unrepresented and under-represented countries, and to encourage the recruitment of women staff at all levels.

The CHAIRMAN suggested that the Committee might wish to take up the Zambian proposal at the next meeting.

It was so agreed.

The meeting rose at 17:25.

SIXTH MEETING

Tuesday, 9 May 1995, at 9:00

Chairman: Mr M.S. DAYAL (India)
later: Professor A. WOJTCZAK (Poland)

1. PERSONNEL MATTERS: Item 29 of the Agenda (continued)

Recruitment of international staff in WHO: biennial report: Item 29.1 of the Agenda (Resolutions WHA46.23, WHA46.24, EB93.R17 and EB95.R19) (continued)

Mr DEBRUS (Germany) said that equity was one of the key words of the present Health Assembly and a fundamental principle to be applied both outside and inside the Organization. Despite commendable efforts, progress in improving geographical representation had been very slow and there were still 48 unrepresented and 12 under-represented Member States. Furthermore, for some countries there had been a high degree of under-representation over a number of years. Germany had a degree of representation that was below 50% of the mid-point of the desirable range which, combined with the fact that, unlike other comparable Member States, it was rarely entitled to designate a person to serve on the Executive Board, indicated a definite problem.

There was no question of asking for privileges, only for equal and adequate opportunities for all countries, in whatever region, to participate in the work of WHO. One way to achieve equity more quickly would be to increase the target of all vacancies arising in professional and higher-graded posts subject to geographical distribution for the appointment of nationals of unrepresented and under-represented countries, and those below the mid-point of the desirable range. He therefore proposed that paragraph 1 of the resolution recommended in resolution EB95.R19 should be amended to indicate that the target should be increased from 40% to 60%. His proposal was supported by many delegations.

Dr DESSER (Austria) observed that equitable geographical distribution was an important principle in any international organization, since it helped to increase a sense of ownership by all Member countries. Staff of a high quality were also essential, and the professional qualifications of candidates must also be given careful consideration. The aim should be to recruit highly competent persons from a wide range of countries. The matter was crucial for the future of WHO and he therefore supported the amendment proposed by the delegate of Germany.

Mr LOSADA (Spain), expressing concern at the slow rate of improvement in geographical representation, agreed that efforts should be stepped up and therefore supported the amendment proposed by the delegate of Germany. In addition, future reports should indicate the posts occupied by staff from under-represented countries. Indeed, to improve transparency a complete picture should be given of which staff members occupied which posts and at what level.

Dr SAVEL'EV (Russian Federation) endorsed the remarks made by the delegates of Germany and Austria. He therefore supported the proposal to increase the target from 40% to 60%.

Dr CHÁVEZ PEÓN (Mexico) endorsed the views expressed by the delegates of Germany and Austria and agreed with the delegate of Spain on the need for information regarding the levels as well as the numbers of posts occupied by staff members from under-represented countries. Mexico and indeed the Region of the Americas were among the least well represented on the staff of WHO. In addition, vacancy notices should be received in good time. They frequently arrived so late that only a week remained before the expiry date.

Mr BOYER (United States of America) reminded the Committee of the concern he had expressed the previous day about attaining adequate geographical representation of staff at WHO as well as his support for increased progress in that area. However, it was clear both from the WHO Constitution and from the point of view of Member States that the prime consideration in the selection of candidates should be quality, i.e., the best possible staff should be recruited for the best possible programmes. By raising the target from 40% to 60% there might be a risk of loss of quality. He therefore sought assurance that if the target was changed, the level of quality in the Organization would be maintained.

Mr AITKEN (Assistant Director-General) reminded delegates that the current and recent practice was to have a target of 40% for recruitment from the lesser represented countries. Annex 8 of document EB95/1995/REC/1 contained a list of those countries. Of the speakers so far, he noted that Germany, the Russian Federation, Austria, Spain and indeed the United States of America were all under-represented. With regard to the list of unrepresented countries, with few exceptions they were all either recent new Members or very small countries, which nevertheless had also to be given attention.

As mentioned by the United States delegate, the primary consideration in recruiting staff was clearly ability, together with qualifications and experience, as specified in the Staff Regulations. At the same time, account had to be taken of the criteria established for geographical distribution. It was clear that if the Health Assembly decided to increase the target as proposed, the choice in terms of countries would be reduced, and 60% of recruitment would have to be sought from the countries on the lists mentioned. Delays in recruitment might then occur owing to the inability to find suitable candidates in the countries on the lists immediately. While there was no doubt that qualified people existed in all countries and could be found in due course, the greater the restriction the greater the difficulties. It was nevertheless up to the Health Assembly to decide whether to increase the figure from 40% to 60%, which was after all only a target. At present, the current target had been exceeded, the level having reached 48%, and every effort would be made to achieve 60% if the Health Assembly approved the proposal.

Mr DEBRUS (Germany) emphasized that it was not the intention of his proposal that there should be any reduction in quality. Choice would be increased, not decreased, by increasing the target to 60%, since that would increase the size of the reservoir of qualified candidates.

Dr TAPA (Tonga) recalled that in previous Health Assemblies proposals that the target should be increased had always been made by certain members of the unrepresented or under-represented groups of countries. He was opposed to such a large increase as that proposed, i.e., from 40% to 60%, at the present stage. He asked when the current target of 40% had been set.

The CHAIRMAN reminded the Committee of the request made on the previous day by the delegations of Zambia and Namibia, to keep the debate on the item open for two days. He requested the Legal Counsel to clarify the procedure on that matter.

Mr VIGNES (Legal Counsel) said that, if the delegations in question held to their positions, the Chairman could indeed decide to hold the debate open as requested.

The CHAIRMAN asked the Zambian delegation if it wished to pursue its request for the debate to be held open for two days.

Mr SATA (Zambia) pointed out that it was a tradition of the Committee and indeed of other committees to grant requests from delegates for an item to remain open. In the present case, two Member States had made such a request in order to prepare a draft resolution. He wished to protest that, at the time the request should have been made the previous day (during discussion of item 22, WHO response to global change), he had been distracted from presenting it. He considered that to represent undemocratic tactics, and had expected the Secretariat to advise correctly and not to hinder the democratic process.

He confirmed his request for the item to remain open for two days.

The CHAIRMAN invited the Committee to consider the proposal.

Mr NAITO (Japan) said that the smooth running of the meeting was involved; it was already far behind schedule. Democracy meant that the rules had to be respected; he did not consider it necessary, therefore, to prolong the debate.

Dr IYAMBO (Namibia) expressed the view that the proposal made by the delegate of Zambia was democratic; requests from Member States to keep a specific item open had always been granted. He therefore again seconded the request of Zambia, as that country wished to present a draft resolution.

The CHAIRMAN, noting that there was no formal objection to the proposal, said that he took it that the Committee agreed to keep the item open for two days.

It was so decided.

(For continuation, see summary record of the eight meeting, section 7.)

Confirmation of amendments to the Staff Rules: Item 29.2 of the Agenda (Resolution EB95.R21)

Dr NGO VAN HOP (representative of the Executive Board) said that, following the decision of the United Nations General Assembly to revise the salary scale for the professional and higher categories of staff by including a post adjustment in the net base salary, on the basis of the "no loss - no gain formula", resulting in an increase of 4.1%, the Executive Board had adopted resolution EB95.R20 under which a new scale for professional category and directors' posts came into effect on 1 March 1995.

The Health Assembly now needed to decide on the changes to be made to the salaries for ungraded posts and the Director-General. In its resolution EB95.R21, the Executive Board had recommended the adoption of a resolution on that subject whereby new gross and net salaries would come into effect on 1 March 1995 for the posts of Assistant Directors-General, Regional Directors, the Deputy Director-General and the Director-General.

The draft resolution recommended by the Executive Board in resolution EB95.R21 was approved.[1]

2. UNITED NATIONS JOINT STAFF PENSION FUND: Item 30 of the Agenda

Annual report of the United Nations Joint Staff Pension Board: Item 30.1 of the Agenda (Document A48/30)

Mr AITKEN (Assistant Director-General) said that document A48/30 summarized the report of the United Nations Joint Staff Pension Board for 1994 and the decisions of the United Nations General Assembly thereon. He suggested that the only action to be taken by the Health Assembly was to note the information that it contained, including the current status of the United Nations Joint Staff Pension Fund.

The CHAIRMAN said that, in the absence of any comments, he would take it that the Committee wished to convey the following draft decision to the plenary:

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.23.

Decision: The Forty-eighth World Health Assembly noted the information contained in the annual report of the United Nations Joint Staff Pension Board,[1] including the status of the United Nations Joint Staff Pension Fund.[2]

Appointment of representatives to the WHO Staff Pension Committee: Item 30.2 of the Agenda (Document A48/31)

The CHAIRMAN said that, as explained in document A48/31, the Health Assembly was called upon to appoint two representatives to the WHO Staff Pension Committee to replace a member and an alternate member whose terms of office expired at the close of the Forty-eighth World Health Assembly. He invited nominations by name of delegates from regions no longer represented on the Committee - the Region of the Americas and the South-East Asia Region - for the offices of member and alternate member.

Mr MOE (Barbados) proposed Dr J. Larivière (Canada) as a member of the WHO Staff Pension Committee and a worthy representative of the Region of the Americas.

Dr CHÁVEZ PEÓN (Mexico), Mr NUNLIST (Switzerland) and Mr DEBRUS (Germany) seconded the proposal.

Mrs PRADHAN (India) proposed Dr V. Tangcharoensathien (Thailand) as an alternate member of the WHO Staff Pension Committee representing the South-East Asia Region.

Mr NGEDUP (Bhutan) seconded the proposal.

The CHAIRMAN said that, in the absence of objections, he would take it that the Committee wished to convey the following draft decision to the plenary:

Decision: The Forty-eighth World Health Assembly appointed Dr J. Larivière, delegate of Canada, as a member of the WHO Staff Pension Committee, and Dr V. Tangcharoensathien, delegate of Thailand, as an alternate member of the Committee, the appointments being for a period of three years.[3]

Professor Wojtczak took the Chair.

3. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 32 of the Agenda

General matters: Item 32.1 of the Agenda (Documents A48/33, A48/INF.DOC./2 and A48/INF.DOC./3)

Dr NGO VAN HOP (representative of the Executive Board), reviewing the discussions on the item in the Executive Board, said that the Director-General's report (document A48/33) had highlighted the question of the extent to which the governing bodies of the organizations of the United Nations system, other than WHO, were being invited to consider health policy matters that could conflict with the international policy-making role of the Health Assembly. In 1994, for example, WHO staff had held lengthy consultations with Member States in bodies such as the United Nations Economic and Social Council and the United Nations

[1] Document A48/30.

[2] Decision WHA48(10).

[3] Decision WHA48(11).

General Assembly with a view to preventing such inconsistencies, which seemed to be related to coordination among national ministries and the degree of importance attached to ministries of health.

WHO had been involved in many United Nations conferences and other activities. In particular, it had assisted the Secretary-General of the United Nations in preparing an Agenda for Development. It had also collaborated with the World Bank and intergovernmental organizations outside the United Nations system. After attending a World Bank meeting, a member of the Executive Board had noted a considerable improvement in coordination between the two organizations in her country.

The Board had considered a document submitted by the Director-General in September 1994 to ACC in connection with its debate on the development crisis in Africa. It had welcomed the importance being given to Africa in current and planned activities with other organizations, e.g., in the light of the International Conference on African Development held in Tokyo in 1993. It had noted, however, that solid partnerships with other organizations of the United Nations system were necessary to ensure that the role of health in development was constantly reaffirmed at country level.

A representative of UNDCP had reported to the Board on joint activities with WHO to combat the many problems stemming from the misuse of drugs.

The Board had taken note of the Director-General's report on collaboration within the United Nations system and with other intergovernmental organizations.

Dr KAWAGUCHI (Division of Interagency Affairs), introducing document A48/33, said that the restructuring of the Secretariat of the United Nations, its programmes and funds, and the effort to ensure policy coherence and to enhance coordination with the United Nations were of importance to WHO. The Organization was closely following developments in the new smaller executive boards of UNICEF, UNDP and UNFPA, which had become more actively engaged in providing guidance at intergovernmental level. It was also contributing to a report on efforts to achieve a strengthened United Nations Resident Coordinator system at country level for discussion by the United Nations Economic and Social Council in June/July 1995.

WHO had prepared two reports on health matters for the substantive session of the Economic and Social Council opening in June 1995, which would focus on HIV/AIDS, malaria and diarrhoeal diseases, narcotics and drug abuse control and "tobacco or health". A one-day high-level meeting of the Council would discuss implementation of the programme of action of the International Conference on Population and Development. WHO would ensure that the Organization's role in reproductive health was brought to the attention of the Council and the United Nations General Assembly.

ACC had discussed such issues as improvement of the status of women in the Secretariats of the United Nations system and the continuing crisis of development in Africa. WHO was a member of the steering committee established by the Secretary-General to enhance support by the United Nations system for Africa and was participating in the five working groups.

The Organization was involved in a number of initiatives launched by ECA, OAU, the African regional economic communities and the African Development Bank group in support of the United Nations New Agenda for the Development of Africa in the 1990s. It had collaborated with OAU in formulating a draft health protocol for the Treaty Establishing the African Economic Community, which had been well received at a recent meeting of African ministers of health, and it had held a consultation with the Secretary-General of the newly established Common Market for Eastern and Southern Africa (COMESA).

WHO's Working Group on Continental Africa, established in March 1994 to enhance WHO's collaborative effort, had reviewed a discussion document entitled "WHO policy orientation for African recovery and development", which established policy objectives, priorities for health and implementation mechanisms for the continent as a whole.

Collaboration with the other regional development banks in Asia, Europe and the Americas, with the Islamic Development Bank and with the European Union and other intergovernmental organizations had been strengthened with a view to encouraging greater investment in health and human development.

The first overall WHO/World Bank review meeting had been held in Geneva in 1994 to introduce a systematized pragmatic framework for joint action to improve health development at country level. An information meeting held during the Health Assembly the previous week had heard reports by government representatives from Bolivia, India, Lebanon and Zambia on collaboration with WHO and the World Bank in their countries.

Finally, the Committee was invited to consider the matters dealt with in paragraphs 4 and 5 of document A48/33.

Dr ONO (Japan) welcomed WHO's efforts to work more closely with the World Bank and regional development banks, and commended the holding of the first overall WHO/World Bank review meeting, and an information meeting on WHO/World Bank collaboration during the current Health Assembly. He hoped that similar initiatives would be taken in conjunction with other United Nations bodies and with intergovernmental and nongovernmental organizations. A brochure on WHO/World Bank partnership contained valuable recommendations for action in health development.

Mrs PRADHAN (India) welcomed WHO's initiative in increasing its collaboration with other international agencies, which was particularly important because WHO provided the technical support to health programmes for which financial resources were often made available by other bilateral and multilateral funding agencies. She also welcomed the first overall WHO/World Bank review meeting, and hoped that WHO's role in such collaboration would increase, especially because of the increasing role of other United Nations bodies and funding agencies in the health sector.

Mr SATOULOU-MALEYO (Central African Republic) commended document A48/33, which showed that health, until recently regarded as an unproductive sector by financiers, was beginning to attract the interest and financing of a number of agencies. Health was now seen as the basis for development. As a body which gave technical support to governments, WHO, through its collaboration with other bodies which provided funds for development, was able to help governments to secure finance for the health sector. In the Central African Republic, there was close collaboration between WHO and UNDP which had been extended to include the World Bank. Although that collaboration was clearly defined at secretariat level, there appeared to be problems at lower levels. There had been references during the meeting to the concept of leadership, and he wondered exactly what that amounted to, and whether there were well established mechanisms for coordinating interagency collaboration. Such collaboration involved both medical and non-medical professionals, such as sociologists and economists, and he had not seen any clear definition of the skills required by the latter.

Dr SAMBA (Regional Director for Africa) agreed that coordination was very important, especially when resources were diminishing. At the level of the Director-General and the Regional Directors the collaboration was always good and well structured but at the country level, where the collaboration needed to be translated to solve problems, it varied from excellent to "conflicting". Efforts were being made at the regional level to institutionalize collaboration in countries rather than leaving it for agency representatives to work together or not as they wished.

Dr KAWAGUCHI (Division of Interagency Affairs) welcomed the fact that there had been general appreciation of, and support for WHO's initiatives in strengthening coordination with other agencies. He was aware of the problems at the country level, and stressed that ministries of health should be central to the coordinating role, with the support of WHO.

Dr BERLIN (European Commission), speaking at the invitation of the CHAIRMAN, welcomed the reference in paragraphs 46 and 47 of document A48/33 to the European Union's activities in the health field, but pointed out that they were more extensive than indicated. For example, chemical safety had been an area of concern to the Community almost from its inception, and there was now comprehensive European legislation protecting the public as consumers, the labour force and the environment. Close cooperation had been maintained with the International Programme on Chemical Safety, which was a joint activity of WHO, ILO and UNEP. In addition, the European Council of Ministers was discussing proposals for action in the fields of cancer, AIDS, communicable diseases, drug dependency and health promotion, and had recently adopted a comprehensive framework research programme which included a specific programme on biomedicine and health and a research programme for supporting cooperation with the developing countries, which embraced the vaccine component and a working relationship with WHO. The European Commissioner responsible for research had established a task force on vaccine and viral diseases which, over the coming

months, would identify the opportunities for a major research initiative; further details of that initiative would be provided to the Forty-ninth World Health Assembly.

Committee B took note of document A48/33.

Indigenous peoples

Ms WILSON (New Zealand) introduced a draft resolution on the International Decade of the World's Indigenous People proposed by the delegations of Argentina, Australia, Botswana, Canada, Chile, Costa Rica, Denmark, Finland, Mexico, New Zealand, Norway, Samoa, South Africa, Sweden and Tonga, which read as follows:

> The Forty-eighth World Health Assembly,
>
> Recalling United Nations General Assembly resolution 48/163 of 21 December 1993, which proclaimed the International Decade of the World's Indigenous People commencing on 10 December 1994, and requested specialized agencies to consider with governments and indigenous people how they can contribute to the success of the Decade;
>
> Recalling also that United Nations General Assembly resolution 49/214 of 23 December 1994 invited the specialized agencies to give increased priority and resources to improving the conditions of indigenous people, with particular emphasis on the needs of those people in developing countries, including by the preparation of specific programmes of action for the implementation of the goals of the Decade, within their areas of competence;
>
> Noting that the goal of the Decade is the strengthening of international cooperation for the solution of problems faced by indigenous people in such areas as health;
>
> Mindful of WHO's objective of health for all by the year 2000;
>
> Recalling further resolution WHA47.27 concerning WHO's participation in planning for, and implementing the objectives of, the International Decade of the World's Indigenous People,
>
> 1. REQUESTS the Director-General to report to the Forty-ninth World Health Assembly on WHO's implementation of resolution WHA47.27, including measures at the regional level;
>
> 2. INVITES those Member States which have designated a focal point for indigenous health issues as suggested in resolution WHA47.27 to provide the Director-General with the contact details of the focal point.

New Zealand attached great importance to the health of the world's indigenous people. It fully supported resolution WHA47.27 concerning WHO's participation in planning for, and implementation of the objectives of the International Decade of the World's Indigenous People, and was in favour of strengthening international cooperation in dealing with the common health problems of indigenous people. United Nations General Assembly resolution 49/214 had called for the preparation of specific programmes of action for the implementation of the goals of the Decade by the specialized agencies within their respective areas of competence, and New Zealand and a number of other countries were cooperating in that endeavour. Resolution WHA47.27 had invited Member States to consider designating a focal point on indigenous health issues; in New Zealand that focal point was the Ministry of Health, in which there was a Maori health unit. She invited the Committee to approve the draft resolution, which was supported by 15 delegations.

The draft resolution was approved.[1]

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA48.24.

Global study on cocaine use

Mr BOYER (United States of America) drew attention to a WHO press package that had been released in March 1995 to announce a global study on cocaine use undertaken jointly by WHO and the United Nations Interregional Crime and Justice Research Institute. The United States Government had been surprised to note that the package seemed to make a case for the positive uses of cocaine, claiming that use of the coca leaf did not lead to noticeable damage to mental or physical health, that the positive health effects of coca leaf chewing might be transferable from traditional settings to other countries and cultures, and that coca production provided financial benefits to peasants.

Although his country reaffirmed its support for WHO's work on the scheduling of narcotic and psychotropic substances under international conventions, it took the view that the study on cocaine, evidence of WHO's support for harm-reduction programmes and previous WHO association with organizations that supported the legalization of drugs, indicated that its programme on substance abuse was heading in the wrong direction. The press package undermined the efforts of the international community to stamp out the illegal cultivation and production of coca, *inter alia* through international conventions.

The United States Government considered that, if WHO activities relating to drugs failed to reinforce proven drug control approaches, funds for the relevant programmes should be curtailed. In view of the gravity of the matter, he asked the Director-General for an assurance that WHO would dissociate itself from the conclusions of the study and that, in substance abuse activities, an approach would not be adopted that could be used to justify the continued production of coca.

In reply, Dr PIEL (Cabinet of the Director-General) said that the cocaine study was an important and objective analysis by experts using data collected in a large number of countries. It represented the views of the experts, whereas WHO's continuing policy was to uphold the scheduling under the international conventions on narcotic drugs and psychoactive substances. Consequently, WHO was making its position clear, and because of the wording of the study, which could lead to misunderstanding, was not intending to publish the report as such. It would be looking into the matter carefully.

Mr BOYER (United States of America) took issue with Dr Piel's characterization of the cocaine study as an important and objective analysis. The study was not in conformity with WHO's basic and rigorous standards on the conduct of research projects, and he hoped that some way could be found for it to undergo a peer review by people recognized as genuine experts in research, and in conformity with WHO's rigid research procedures.

Dr PIEL (Cabinet of the Director-General) said that that was one of the options the Organization would be considering.

Environmental health

Mr VAN REENEN (Netherlands) said that, although the Organization had made a good start in the field of environment and health, document A48/INF.DOC./3 did not take sufficient account of other aspects of sustainable development, e.g., poverty alleviation, population and the development of primary health care, all of which were dealt with in Agenda 21.

Dr KREISEL (Office of Global and Integrated Environmental Health) replied that WHO had been designated as the task manager of chapter 6 of Agenda 21, which embraced primary health care but not population and poverty alleviation, which were to be found in other chapters and whose task managers were other entities of the United Nations system. WHO had taken up those matters at the last meeting of the Commission on Sustainable Development, and would be including them in its report in preparation for the follow-up conference to the United Nations Conference on Environment and Development, to be held in 1997. Discussions had begun, involving the Division of Intensified Cooperation with Countries and other WHO programmes, on links between poverty, environmental health and population issues, and the objective was for a coherent WHO policy on the outcomes of the International Conference on Population and

Development, the World Summit for Social Development and the United Nations Conference on Environment and Development.

Establishment of the joint and cosponsored United Nations programme on HIV/AIDS: Item 32.2 of the Agenda (Resolutions WHA46.37, EB93.R5 and EB95.R13; Document A48/34 and Add.1)

The CHAIRMAN drew the attention of the Committee to the following draft resolution on the establishment of the joint and cosponsored United Nations programme on HIV/AIDS proposed by the delegations of Australia, Austria, Belgium, Brazil, Bulgaria, Burkina Faso, Cambodia, Canada, China, Congo, Côte d'Ivoire, Cyprus, Denmark, Finland, France, Germany, Greece, Guinea-Bissau, Ireland, Italy, Lao People's Democratic Republic, Luxembourg, Madagascar, Mali, Nepal, Netherlands, Portugal, Singapore, Spain, Sweden, United Kingdom of Great Britain and Northern Ireland and United States of America:

The Forty-eighth World Health Assembly,

Stressing the increasingly grave implications of the HIV/AIDS epidemic for health and the provision of adequate and appropriate health services, as well as for many other economic and social sectors;

Recalling that resolution EB93.R5 recommends the development and establishment of a joint and cosponsored United Nations programme on HIV/AIDS administered by WHO, in keeping with the consensus option as presented in the report of the Director-General on this issue;

Further recalling that resolution EB95.R13 requests the Director-General to pursue efforts towards establishing the programme;

Having examined the report of the Director-General on progress to this end;

Welcoming the endorsement of the programme's establishment by the governing bodies of the other cosponsoring organizations;

Taking note of resolution 1994/24 adopted by the Economic and Social Council at its July 1994 session;

Considering the support given to the programme in the Declaration of the Paris AIDS Summit;

Taking note of the report of the Committee of Cosponsoring Organizations to the Economic and Social Council;

Welcoming the appointment of an Executive Director for the programme, with effect from 1 January 1995;

Aware of the urgent need to proceed with the establishment of the programme in order to ensure that it is fully operational by 1 January 1996;

Considering that the programme must play a central normative and coordinating role in the development, at national and global levels, of common strategies whose activities concerning HIV/AIDS will be supported by the cosponsoring agencies;

Recognizing that substantial capacity has been built up within WHO to respond to the HIV/AIDS epidemic, primarily through its Global Programme on AIDS;

Reaffirming the importance of the role of the national authorities as principal coordinators of national response to the HIV/AIDS epidemic;

Welcoming the progress made towards establishing the joint United Nations programme on HIV/AIDS,

REQUESTS the Director-General:

(1) to facilitate implementation of the programme in accordance with resolutions EB93.R5 and EB95.R13, taking into account the report of the Committee of Cosponsoring Organizations to the Economic and Social Council;

(2) to provide administrative support to the Executive Director of the programme and his staff during the transition period and to arrange for WHO to meet the administrative needs of the programme once it is operational, in the light of the Organization's role as administering agency;

(3) to provide the programme with financial support from the regular budget of WHO and with staff support;

(4) to give the WHO Representatives the necessary instructions to ensure close collaboration at country level with the other cosponsoring organizations;
(5) to ensure continuation of the work of the Global Programme on AIDS during the period of transition until the joint programme is fully operational;
(6) to ensure that strategies are developed, in close collaboration with the joint United Nations programme on HIV/AIDS, for integrating the HIV/AIDS component into the work of WHO;
(7) to report on progress made towards establishment of the programme to the Forty-ninth World Health Assembly in May 1996.

Dr NGO VAN HOP (representative of the Executive Board) said that the Board had discussed the report of the Director-General on progress towards the establishment of the joint and cosponsored United Nations programme on AIDS. The Board had welcomed the appointment of the Executive Director and noted the endorsement of the programme by the governing bodies of the other cosponsors. It had emphasized the increasingly grave consequences of the AIDS pandemic and expressed concern about the potential for gaps in support to Member States during the period of transition. The Board had therefore called upon the Director-General to ensure the continued functioning of the Global Programme on AIDS during the transitional period, and to invite the Executive Director of the new programme, the Joint United Nations Programme on AIDS (UNAIDS), to take advantage of WHO's considerable capacity to respond to the AIDS pandemic.

Dr PIOT (Joint United Nations Programme on AIDS) said that the launching of the new programme made 1995 a crucial year for WHO and United Nations responses to the AIDS epidemic.

The epidemic was continuing to expand in most countries throughout the world and, increasingly, countries were only now beginning to face its health and societal consequences. WHO's Global Programme on AIDS (GPA) had estimated that there were currently some 15 million people worldwide infected with HIV. Cumulatively, 20 million people had been infected since the epidemic had begun, a figure which was increasing by about 6000 a day. The distribution of the virus was very uneven; sub-Saharan Africa, with over 8 million cases, had more than half of all HIV infections in the world. South and South-East Asia accounted for over 2.5 million infections, and in Latin America and the Caribbean over 1.5 million were infected. Although rates were stabilizing in some areas, they continued to rise steeply in others.

The unequal spread of the HIV virus was reflected in the distribution of AIDS cases. Of the 5 million cumulative cases of AIDS, over 70% had been in sub-Saharan Africa, and it was expected that Asia's share of 6% would increase significantly over the next year. Globally the AIDS epidemic was only just starting; conservative estimates from GPA showed that in the year 2000 over 2 million adults would be needing AIDS care. AIDS was a problem not only in numerous developing countries but also in the industrialized world. It was the leading cause of death among young men in the United States of America, and recent studies from central and eastern Africa showed that in some communities over half of all adult deaths were due to AIDS - among young adults the figure was close to 90%.

There was now clear evidence that intervention was successful. In France condoms were used by almost 90% of young people for their first sexual intercourse. In northern Thailand, prevention had reduced the incidence of HIV in military recruits to almost zero. There was an impressive and growing response from governments, nongovernmental organizations, communities and families working together to provide care and support for people with HIV and AIDS. The AIDS Support Organization (TASO) in Uganda, founded by people affected by AIDS, was one example; it also helped the community to accept people with AIDS and was becoming more involved in prevention efforts. The decline in treatable sexually transmitted diseases in countries as diverse as Thailand, Costa Rica and Zimbabwe was also a major indication of a change in sexual behaviour.

There were six major challenges for the future: to ensure continuing political commitment and overcome the denial which was still prevalent in many communities and individuals; to scale up prevention efforts, particularly for those who were especially vulnerable; to improve the organization of care and support; to overcome stigmatization; to overcome the root causes of the epidemic; and to ensure support for relevant research to provide better tools for prevention and care.

UNAIDS had come into being as a response to the request by countries for better coordinated and more effective support for AIDS and sexually transmitted disease programmes. Its three major roles were: to be

the advocate for the global response to AIDS; to be the primary source in the United Nations system of policy and technical and strategic guidance on responding to the AIDS epidemic; and to assist countries to build national capability to respond to AIDS. It would be working in four areas: the prevention of infection; care and support for affected individuals and communities; the creation of a supportive environment for prevention, care and support; and the reduction of the societal and economic impact on communities.

UNAIDS would have approximately 50 professional staff in Geneva. Most staff would be based in countries. There would be approximately 50 programme officers to help with the planning, coordination and evaluation, and a further 30 or so technical staff serving multiple countries. WHO would provide administrative support. The United Nations Economic and Social Council had established the structure of the governing body mentioned in the Director-General's report, the Programme Coordinating Board (PCB); it was to comprise 22 member states, including five seats for Asian/Pacific countries, five for Africa, three for Latin America and the Caribbean, two for Eastern Europe and the Commonwealth of Independent States, and seven for the Western Europe and Others group. Individual country membership would be decided in the following three weeks. The six cosponsors and representatives of nongovernmental organizations would likewise participate in the Programme Coordinating Board. There was also a Committee of Cosponsoring Organizations (CCO), made up of the executive heads of the six cosponsors, which would ensure smooth collaboration among the agencies and see to it that HIV/AIDS was on their agendas and that it was integrated into their other programmes.

At the country level, the major objective of UNAIDS was to strengthen the national capacity to plan, coordinate, implement and monitor responses to the HIV/AIDS epidemic. That would be done by ensuring effective and coordinated support by the United Nations to national AIDS programmes including better coordination of country-level activities; building on achievements to date at country, regional and global levels; enhancing, catalysing and facilitating the assistance provided by each of the cosponsoring United Nations agencies to the programme and serving as a prime source of technical expertise which was user-friendly and appropriate to country needs.

UNAIDS would thus develop improved coordination of country-level AIDS activities; assist with needs assessments, monitoring and evaluation of national AIDS programmes; assist with resource mobilization through the cosponsors and other agencies; provide financial support for selected activities; furnish technical assistance and training, and promote international best practice on HIV prevention and care; and monitor and report on United Nations support to national activities.

Many countries already coordinated their AIDS activities, which indeed was their prerogative and responsibility. Improved coordination of United Nations activities was not intended to supplant that but to be of service to them in that respect. Theme groups on HIV/AIDS, comprised of representatives of the cosponsors and other relevant agencies, would relate to each government as appropriate. The primary tasks of the theme groups were to enhance joint and coordinated United Nations activities, including policy development, project planning and implementation, monitoring and evaluation, and fund-raising. UNAIDS programme officers would support the theme groups, although their primary role was to provide assistance to countries.

He assured the Committee that efforts were being made to ensure continuity of HIV/AIDS activities, in collaboration with GPA, during the transition to the new Programme.

Mr DURAND-DROUHIN (France) said that the AIDS epidemic was just beginning and the situation was everywhere becoming more serious. In all populations, it was the poorest who were most vulnerable, to say nothing of women and children. It was necessary to make the fight against AIDS a national priority and a collective, cooperative response to the disease. The summit meeting organized by France which had taken place on 1 December 1994, and the declaration signed by 42 countries, showed how important such a commitment was. Cooperation with associations of those infected by the virus was also important. Seven major initiatives had been agreed by consensus in Paris, covering the same areas as those covered by the new joint programme; their implementation and follow-up should be effected within the framework of that Programme.

The draft resolution had received wide support and highlighted the urgent need for a strong and integrated response. It called on WHO to provide the necessary administrative and financial support in establishing the joint programme and to instruct WHO Representatives to coordinate their activities with those of the representatives of the other cosponsoring organizations.

He proposed that the draft resolution should be amended by the insertion of a new operative paragraph to read as follows:

URGES Member States elected to the Programme Coordinating Board of the joint programme on AIDS to take account of the importance of experience and expertise in public health.

Dr AL-JABER (Qatar) said that the Health Assembly had requested the Director-General to negotiate with the Committee of Cosponsoring Organizations. However, the results of those negotiations had not yet been approved by the Health Assembly. If they were not so approved, the joint programme would not have legal status. He therefore requested the Director-General to submit the results of the negotiations for consideration. He was surprised that an attempt had been made to set up a new coordinating board (Programme Coordinating Board) whose authority was greater than that of the Director-General and the other executive heads and pointed out that such a board was illegal since the United Nations Economic and Social Council had no authority over specialized agencies. The Health Assembly should reject any such interference, which would set a dangerous precedent.

The roles of the different agencies should be more clearly defined, and especially that of WHO. With regard to document A48/34 Add.1, he requested clarification regarding the basis for the regional representation on the Programme Coordinating Board.

He proposed that the draft resolution should be amended by the insertion after the words "Welcoming the progress made towards establishing the joint United Nations programme on HIV/AIDS" of the following two operative paragraphs:

ENDORSES the establishment of a joint and cosponsored United Nations programme on HIV/AIDS, to be administered by WHO, in accordance with the consensus option;

and

RECOGNIZES the Committee of Cosponsoring Organizations (CCO) as the board responsible for the management of the joint programme.

Mr CLICHE (Canada) pointed out that the joint programme was due to become operational in seven months' time. He consequently voiced concern that there was already one month's delay, particularly with regard to the setting up of the Programme Coordinating Board, which was crucial to the Programme's development and operation. He therefore urged the Director-General to take all appropriate measures to eliminate any obstacles to its implementation attributable to WHO or the other cosponsoring organizations.

It was essential that, by January 1996, WHO had a strategy to integrate HIV/AIDS concerns in all the normal activities of the Organization in accordance with the policies and recommendations of the joint programme, the process known as "mainstreaming". The cosponsoring organizations should also facilitate the transition from GPA to the joint programme by providing the necessary human and financial resources to the latter.

He supported the draft resolution before the Committee.

Dr MZIGE (United Republic of Tanzania) was concerned that, during the transition from GPA to UNAIDS, the job security of those working for GPA might be adversely affected. He was also unsure whether the various cosponsors would be on an equal footing, or whether one would be dominant, thereby increasing bureaucracy rather than efficiency. He asked how activities would be conducted during the transitional period and whether a budget had already been set for UNAIDS; there was a danger that such a budget might affect allocations to nongovernmental organizations working in the same area.

The United Republic of Tanzania would welcome the mobilization of resources to help to cater for the needs of more than 600 000 refugees already in the country, who were consuming its resources and not receiving adequate support from the donor community. In addition to condoms to help prevent the spread of HIV/AIDS, supplies such as gloves, detergents, and HIV test kits were also needed.

While maximum resources were now being channelled into fighting the AIDS pandemic, it was important to remember that there were other diseases linked to AIDS causing morbidity and mortality in the same communities, such as malaria coupled with anaemia and malnutrition, tuberculosis, leprosy and sexually transmitted diseases.

He sincerely hoped that UNAIDS would produce positive results, and supported the draft resolution.

Mrs FLEMING (United States of America) said that, during the eight years since GPA had been established, a great deal of progress had been made, yet the AIDS pandemic was certainly not receding; on the contrary, it was advancing on new populations and communities. In her country, nearly one million people were infected with HIV, i.e., one in every 250.

The establishment of UNAIDS heralded a new era in the struggle; it had been created in recognition of the uniquely intersectoral nature of the epidemic and the need for better coordination at both country and global levels. It had not been easy to set up a new programme, on which divergent views had been expressed. However, agreement had ultimately been reached, and the joint programme - together with Dr Piot and his staff - deserved universal and enthusiastic support. UNAIDS should consequently be regarded as the main forum for developing AIDS policy and strategy. Each cosponsor was responsible individually for ensuring that there was no duplication of UNAIDS' efforts, but that those efforts were integrated into every appropriate programme in each agency by the process known as "mainstreaming". At country level, agencies and governments must ensure the proper and effective functioning of the resident coordination and theme group system, each agency contributing in accordance with its own comparative advantage. In that way, the Programme would fulfil its vital role as a catalyst, bringing about a greater collective result than could ever be achieved by individual efforts alone.

She asked for further information on WHO's "mainstreaming" plans in connection with its organizational structure, staffing plans and any AIDS-related functions possibly remaining within other WHO programmes, such as vaccine research or blood safety.

She was pleased to note that, in the preliminary proposals for UNAIDS for the 1996-1997 biennium, 51% of the net budget was targeted to direct support for individual countries, and hoped that that percentage would be increased in future budgets. She also welcomed the establishment of the Programme Coordinating Board, enabling UNAIDS to proceed expeditiously, with a view to the establishment of a fully functional programme by January 1996.

The United States Government fully supported UNAIDS. She endorsed the amendment proposed by the French delegation but strongly disagreed with the views expressed by the delegate of Qatar.

Dr MTAFU (Malawi) hoped that, during the transition from GPA to UNAIDS, his Region would receive some assistance. He was disappointed to see that, in spite of the large and rising number of AIDS cases in Africa, that continent had been allocated only five seats on the Programme Coordinating Board.

Malawi had faced a large influx of refugees since 1988, for whom insufficient provision had been made by United Nations organizations. Large tracts of land had subsequently been destroyed, but promised funding for reafforestation had not been forthcoming. Malawi was also being unfairly penalized as a tobacco-producer, and required greater support.

His Government regarded AIDS as a high priority item on its agenda. It was time for the AIDS information campaign to be given greater publicity, particularly in bars and night clubs, and for steps to be taken to counter unjustified discriminatory measures against people from areas of high AIDS prevalence who wish to stay or study in other regions.

He supported the draft resolution before the Committee.

Dr MWANZIA (Kenya) endorsed the establishment of the joint programme and was confident that Dr Piot and his staff would provide the sound leadership necessary. He therefore supported the draft resolution.

He agreed that it was important to ensure a smooth transition from GPA to UNAIDS, and that WHO Representatives should work closely with ministries of health to coordinate HIV/AIDS activities and provide guidance to the proposed theme groups, which he supported. The role of regional offices should also not be forgotten: technical officers were required to collate information and transmit it to other regions.

Dr AMMAR (Lebanon) emphasized the need for the outcome of the negotiations between the Director-General and the representatives of the other five cosponsors to be submitted to the Health Assembly so as to ensure that the status of the joint United Nations programme was legal.

He was surprised that an attempt had been made to establish the Programme Coordinating Board in such a way as to give it greater authority than the Director-General. Such an approach was illegal, as it

meant that the Programme Coordinating Board would be set up by a body that did not have the competence to do so.

Dr RODRIGUES (Brazil) welcomed the progress made in the establishment of the joint programme. However, in view of the role of other sexually transmitted diseases in the expansion of the AIDS epidemic, she suggested that subparagraph (6) of the operative paragraph of the draft resolution should be amended by the replacement of "HIV/AIDS" with "HIV/AIDS/sexually transmitted diseases".

In line with the French proposal, her delegation also proposed that a new subparagraph (8) should be added at the end of the draft resolution, to read:

(8) to request that Member States elected to the Programme Coordinating Board (PCB) of the Joint United Nations Programme on AIDS consider the importance of maintaining public health experience and expertise on HIV/AIDS/STD when selecting their representatives to the Programme Coordinating Board.

She supported the draft resolution, subject to the proposed amendments.

Professor AGBOTON (Benin) said that HIV/AIDS was an example of a health issue that called for international solidarity in order to reduce inequalities effectively. He appealed for increased financial, human and material resources to help contain the pandemic in Africa, and agreed on the need to strengthen WHO's leadership role in health programmes, which in no way precluded a multisectoral approach and cosponsorship by other bodies of the United Nations system and organizations committed to sustainable development. Such leadership should be reflected in activities at the country level, including those for the benefit of young people and women. An example was Benin's experimental project for and by unemployed young people to which, he hoped, WHO would pay special attention.

Benin supported the draft resolution as amended by Qatar, emphasizing the need to involve the African continent and its Regional Office in the planning and programming of UNAIDS.

Dr BAATH (Syrian Arab Republic) said that the spread of HIV/AIDS called for global action on the part of governments, United Nations organizations and other bodies. Without such a collective effort it would be impossible to attain the objective of combating the disease and preparing for the future. While welcoming the interagency meetings and the agreement reached - and endorsed by the Executive Board - on the establishment of UNAIDS, he said that the legal status of that agreement remained in doubt, since it hinged on approval by the Health Assembly. The legal status of the Programme Coordinating Board was another matter for concern; he wished to know who had established it, who led it and what the associated financial implications would be. He had misgivings about the apparent abandonment by WHO, at least to some extent, of its leading role in relation to a major health issue, although that in no way meant that collective efforts should be discouraged. He therefore supported the amendment to the draft resolution proposed by Qatar to the effect that the programme should be administered by WHO.

Dr SUZUKI (Japan) said that he was pleased that UNAIDS was now developing a strategic plan and budget at the global and the country level. While it was necessary for WHO to provide support for UNAIDS during the transitional period, it was a joint and cosponsored United Nations programme and, as such, responsibility for the provision of financial and technical support should be fully shared by all cosponsors, not just WHO. Like other speakers, he was concerned about the fate of WHO's HIV/AIDS-related activities, such as blood safety, the interaction between tuberculosis and HIV/AIDS, and reproductive health, once the new Programme became operational in January 1996. He therefore requested WHO to ensure the mainstreaming of such activities as soon as possible.

He proposed that the draft resolution as amended by France should contain an additional operative paragraph after the final preambular paragraph, reading:

URGES all Member States to pursue in the respective governing bodies of cosponsoring agencies the provision to the programme of financial and staff support from the regular core budget.

If that amendment was approved by the Committee, Japan wished to cosponsor the draft resolution.

Dr PARRAS (Spain), commending the efforts to establish UNAIDS, expressed concern about the apparent difficulties that had arisen in ensuring that the joint programme was fully operational in

January 1996. The gravity and special characteristics of the AIDS pandemic made it more than a strictly health problem, so that coordination between all organizations of the United Nations system was required in order to avoid duplication of effort and unwarranted expense. Global action would undoubtedly be conducive to greater effectiveness in the fight against AIDS and to a more rational use of resources. It was a responsibility to be shared by all the bodies involved, especially WHO. He therefore supported the new Programme under the leadership of Dr Piot.

At a time when the various donor countries were reaching a point at which they could increase their extrabudgetary contributions no further, a good dose of common sense was needed on the part of all concerned in order to avoid problems caused more by competition for authority and for control over resources and administration than by the desire to take action to combat an epidemic causing so many deaths among the most vulnerable, especially in the developing countries.

His delegation, which was cosponsoring the draft resolution, supported the amendment proposed by France.

Dr FIO-NGAINDIRO (Central African Republic) said that, at a time when the spread of HIV/AIDS had given rise to national programmes to combat the pandemic, the international community's concern that WHO could no longer shoulder the responsibility on its own and the decision to establish a cosponsored programme was a welcome development. He therefore supported the draft resolution. The countries most affected should be involved in the joint programme at all levels.

In his country, financial restrictions brought about by the devaluation of the CFA franc had led to increased emphasis on traditional medicine, which had a role to play in the treatment of AIDS. Further research should be undertaken in that area with a view to strengthening its contribution. Many doctors in the Central African Republic were working in that direction and needed support.

Ms EL ETR (Egypt) commended WHO's past efforts to combat the spread of HIV/AIDS and welcomed the appointment of Dr Piot as Executive Director of UNAIDS. While WHO's role in UNAIDS was crucial, cooperation between the cosponsoring agencies was essential to the success of the new Programme. She stressed that programme activities at country level should not be reduced.

Dr ABUSALAB (Sudan) said that the appointment of Dr Piot as Executive Director of UNAIDS gave the new Programme sufficient executive authority, and he failed to understand why there was a need to establish a Programme Coordinating Board. In addition, the United Nations Economic and Social Council had no supervisory authority over the specialized agencies and the Programme Coordinating Board would increase programme costs. If programmes were duplicated, the role of WHO in implementing its specialized health programmes would be diminished. He supported the amendment to the draft resolution proposed by Qatar.

Mrs PRADHAN (India) welcomed the establishment of UNAIDS since AIDS control required a multisectoral approach, although WHO should continue to play its important and catalytic role in the health sector. Ongoing HIV/AIDS activities of all the cosponsoring agencies, including WHO, should be maintained and enhanced; health issues must not be sidelined. Like other speakers, she stressed the importance of HIV/AIDS-related activities, such as blood banking and sexually transmitted disease programmes, which in India came under the national AIDS programme, as well as tuberculosis and reproductive health. She therefore advocated an enhanced role for WHO in the new Programme.

India supported the draft resolution with the amendments proposed by France and Japan.

Dr PICO (Argentina) commended the emphasis in UNAIDS on strengthening ongoing country programmes, improving technical cooperation mechanisms and supporting national AIDS control activities. Improved coordination between ministries of health and the cosponsoring organizations would be beneficial to all.

Although the problem of AIDS was not strictly confined to the health sector, he stressed the importance in UNAIDS of the leadership and competence of WHO at the global level, of PAHO at the level of the Region of the Americas and of ministries of health at the national level, ensuring maximum participation and coordination. He welcomed the decision of the United Nations Economic and Social Council on the

membership of the Programme Coordinating Board, and hoped that the latter would be constituted on 1 June 1995 as planned.

A common message on AIDS prevention was needed for all peoples, making for greater consistency in health education campaigns. He therefore proposed that the draft resolution should be amended by the insertion of a new operative subparagraph (7) reading:

(7) to promote the development of a common message and basic contents in health education concerning AIDS, taking account of the cultural diversity of Member States.

That amendment was supported by the delegations of Australia, Bolivia, Canada, Chile, Colombia, Costa Rica, Cuba, Ecuador, Mexico, Peru, Uruguay and Venezuela.

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

4. TRIBUTE ON THE OCCASION OF THE FIFTIETH ANNIVERSARY OF THE END OF THE SECOND WORLD WAR IN EUROPE

Dr SAVEL'EV (Russian Federation) said that many countries were currently commemorating the end of the Second World War, which had taken many millions of lives. On behalf of the delegation of the Russian Federation he extended greetings to all on the occasion of the fiftieth anniversary and proposed that a minute's silence should be observed in memory of all those who had lost their lives defending their peoples, freedom and democracy during that war and subsequent armed conflicts.

The Committee stood in silence for one minute.

The meeting rose at 13:00.

SEVENTH MEETING

Tuesday, 9 May 1995, at 14:30

Chairman: Professor A. WOJTCZAK (Poland)

COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 32 of the Agenda (continued)

Establishment of the joint and cosponsored United Nations programme on HIV/AIDS: Item 32.2 of the Agenda (Resolutions WHA46.37, EB93.R5 and EB95.R13; Documents A48/34 and Add.1) (continued from the sixth meeting)

Mrs WU Jihong (China) said that the implementation of the joint United Nations programme on AIDS would bring together the resources and expertise of various international organizations while promoting existing national efforts, particularly those of developing countries. The coordination, support and operational mechanisms of the programme were important at both the national and international level. Furthermore, the functions of the different sectors involved should be strengthened and clarified. At the national level, it would be important to involve national authorities and to make optimum use of existing health resources and institutions.

Ms NESBITT (Australia) said that her country had much to contribute to HIV/AIDS prevention, management and care issues and was committed to the creation of a multisectoral joint and cosponsored programme on HIV/AIDS. She welcomed the decision by the United Nations Economic and Social Council that the Programme Coordinating Board should be established as the governing body of UNAIDS, and disagreed with the arguments advanced by the delegate of Qatar at the previous meeting.

Supporting the draft resolution before the Committee, she emphasized that the Director-General was also required to implement resolutions EB93.R5 and EB95.R13, as noted in subparagraph (1) of the operative paragraph of the draft resolution, in a manner consistent with resolution 1994/24 adopted by the Economic and Social Council. With regard to subparagraph (2), it was Australia's understanding that the words "administering agency" referred to WHO's responsibility for the administration in support of the joint programme as one of the six cosponsors who would be equal partners in it. Concerning subparagraph (3), Australia further understood that staff support for the joint programme would be provided in accordance with requirements: a principle which reflected its view that decisions in that connection should be the responsibility of the Executive Director of the programme. Furthermore, the decision to establish UNAIDS reflected the will of the Member States of the United Nations; Australia therefore expected that WHO would cooperate fully with the programme, notably through the timely provision of technical and financial resources.

Finally, as a cosponsor of the draft resolution, Australia welcomed the amendments proposed by the delegations of Argentina, Brazil and France.

Dr SOMBIE (Burkina Faso) said that it was regrettable that discussions on the joint programme were taking place in advance of the scheduled information meeting on HIV/AIDS. Furthermore, in spite of the Executive Director's clear albeit succinct statement, grey areas still persisted regarding WHO's precise role, and the transition from GPA to the joint programme. He shared the views of the delegate of Qatar, and hoped that WHO would become the undisputed leader in running UNAIDS and that its Member States would thus become more involved in taking the important decisions relating thereto.

Ms LOBBEZOO (Netherlands) reiterated her delegation's strong support for the joint programme and voiced the hope that the Programme Coordinating Board, whose members should be appointed by the United

Nations Economic and Social Council, would soon convene and begin its work. However, GPA could be assured of continued financial assistance from the Netherlands until it ceased to exist. While recognizing the fact that the Executive Director should have the freedom to select UNAIDS staff, she hoped that WHO would lessen to the extent possible the impact of the change on GPA personnel.

WHO should determine the actions to be undertaken within its mandate following the introduction of the joint programme and should develop a strategy in close consultation with UNAIDS for the mainstreaming of its HIV/AIDS-related activities in connection, for example, with tuberculosis, sexually transmitted diseases, reproductive health and blood safety. In addition, the development of vaccines should be the full responsibility and an integral part of the joint programme. WHO should also consider establishing a liaison bureau to facilitate contact with UNAIDS.

Finally, as an earnest of its commitment, the Netherlands urged WHO to direct a substantial part of its regular budget towards the joint programme.

Mr MOEINI-MEYBODI (Islamic Republic of Iran) remarked that the international community, particularly WHO, had a great responsibility in the matter of improving worldwide health conditions. However, the legal position and financial mechanism of the programme under discussion remained unclear. His delegation had already voiced its concern regarding increased bureaucracy resulting from the establishment of the new programme, and he agreed with the delegate of Qatar that WHO was the appropriate international body to manage it. If the Health Assembly so agreed, it might be asked to support the programme financially from the regular budget.

He called for clarification of the reference to "financial support" in subparagraph (3) of the draft resolution. In his opinion, that should come from GPA and in that connection, he referred to the third preambular paragraph of resolution 1994/24 of the United Nations Economic and Social Council, which stated that WHO was to be responsible for the administration in support of the programme.

He proposed that a new preambular paragraph be added to the draft resolution before the Committee, to read:

> Stressing that an important function of the programme will be to strengthen national capacities to plan, coordinate, implement and monitor the overall response to HIV/AIDS.

Mr JAKUBOWIAK (Poland) expressed support for the draft resolution as amended by France and said that Poland wished to be included as a sponsor.

His country, which had favoured the creation of GPA, believed that WHO would have an important role to play in the implementation of the new joint programme.

Mr QUAUNINE (Bangladesh) noted with satisfaction that the establishment of the joint programme would help to maximize the utilization of scarce resources. The AIDS pandemic was increasing in south and south-east Asia. Much was expected from UNAIDS in terms of support for national AIDS programmes and Bangladesh looked forward to close cooperation. Associating himself with the delegate of the United States of America, he said that maximum resources should be directed to the country level.

He joined other speakers in voicing the hope that the transition to the joint programme would be handled delicately, especially as far as the staff of GPA were concerned.

Finally, he requested clarification on the progress made in the establishment of the Programme Coordinating Board.

Mr THORPE (United Kingdom of Great Britain and Northern Ireland) remarked that the Director-General's report (document A48/34) made no mention of financial support from WHO for the measures envisaged. The recommendations made at the recent meeting of the GPA General Management Committee were particularly pertinent in that connection. It was to be hoped that WHO would continue to commit resources from the regular budget and that a minimum of US$ 20 million from the 1994-1995 income of GPA would be carried forward to support UNAIDS activities during the first quarter of 1996. Furthermore, it would be important to avoid an abrupt interruption in the support provided by WHO to national AIDS programmes, and he called upon the Director-General to work closely with UNAIDS to ensure optimal conditions for the transition from GPA to UNAIDS at country level. WHO should develop a strategy, in

close consultation with UNAIDS, enabling HIV/AIDS-related activities to be integrated into all of its relevant programmes.

Finally, he reiterated his country's support for the draft resolution and hoped that the work of the Programme Coordinating Board could begin as soon as possible.

Mr KASTBERG (Sweden) said that UNAIDS would constitute a common global policy programme on AIDS for Member States. The Health Assembly had realized that if every United Nations organization continued to develop its own HIV/AIDS programme, the health sector would be unable to coordinate the major efforts required to halt the pandemic. It was now time for the Health Assembly to lend its full support to UNAIDS, as any delay would jeopardize the smooth transition. However, Member States could not relinquish their "governance" responsibility, and for that reason a Programme Coordinating Board could govern the programme with the participation of the Committee of Cosponsoring Organizations and nongovernmental organizations. If the establishment of the Board was endorsed, it could meet in June. That would enable Member States to provide guidance on the future development of the programme under one roof, leading to considerable savings.

Sweden contested the view that responsibility in the matter of HIV/AIDS was being taken away from WHO. Other United Nations actors were simply being brought in to follow a common approach in response to the pandemic, and it was indeed to be hoped that other agencies would gradually become involved. Besides providing an administrative framework, WHO had to develop a strategy for incorporating the UNAIDS component into its regular activities, and Sweden would continue to support the efforts to that end.

Sweden warmly endorsed the draft resolution with the amendments proposed by the delegates of France and Japan. It also favoured the concepts behind the amendment put forward by the delegation of Argentina and suggested that it be amended further to read as follows:

> ENCOURAGES UNAIDS to promote the development of the basic elements of a common message for AIDS prevention, care and health education which considers the different social and cultural contexts of Member States.

Turning to the first operative paragraph proposed for insertion by the delegate of Qatar, he proposed that it be amended to read:

> ENDORSES the establishment of a joint United Nations programme on AIDS, for which WHO will provide an administrative framework.

As to the second, it was his understanding that the Committee on Cosponsoring Organizations would be invited to participate in the work of the Programme Coordinating Board. Member States could not, however, relinquish their sovereign responsibility to provide governance over the programme.

Mr ROSALES (Nicaragua) said that as a sponsor of the draft resolution, his country fully supported the proposal put forward by the delegate of Sweden regarding the amendment tabled by the delegation of Argentina, and would continue to support the joint programme. In his view, education, as well as attention and social care for those infected should be paramount in national and international campaigns to control the pandemic.

Mr MUYLLE (Belgium) said that the HIV/AIDS pandemic had now become so widespread and so complex that a multidisciplinary approach to it was essential. That would require increased cooperation between the various organizations involved, and UNAIDS was ideally suited to respond to that need.

WHO was duty-bound to play an important role in the new programme, because its expertise and capacities could only be exploited to the full in conjunction with other bodies which possessed equally vital expertise and capacities. In other words, WHO should not consider UNAIDS as an adversary or as a rival, but rather as an instrument for maximizing its own productive capacity that would allow it to play its legitimate role to the full. WHO's leadership in health matters could not fail to be strengthened by the alliance.

The solutions reached by the Economic and Social Council concerning the management of UNAIDS were entirely appropriate, and would in no way endanger the respected, recognized and well deserved position which WHO enjoyed. His delegation therefore offered strong backing to UNAIDS and its new Executive

Director, and was a cosponsor of the draft resolution under consideration; it agreed with the amendments proposed by the delegates of France (on behalf of the Members of the European Union), Japan and Brazil. It could not, however, accept the amendment proposed by the delegate of Qatar.

Dr DLAMINI (Swaziland) congratulated Dr Piot on his appointment as Executive Director of UNAIDS, and commended GPA staff for their valuable work in support of national AIDS prevention and control programmes.

She shared some of the concerns voiced by earlier speakers with regard to the new programme. It would be important, particularly during the interim period, to ensure that there was no disruption of AIDS control activities at country level, and also to ensure that such activities were linked with sexually transmitted disease control initiatives. WHO should maintain its leadership role in health aspects of the programme: she would not like to see that role being taken over by other agencies.

She supported the draft resolution in principle, but wished to see the amended version in written form.

Dr DURHAM (New Zealand) said that New Zealand wished to be included among the sponsors of the draft resolution.

Mrs TINCOPA (Peru), expressing concern at the advance of AIDS throughout the world, said that it was vital that both developed and developing countries should concentrate their efforts on controlling the disease and its consequences.

Since the first reported case of AIDS in Peru in 1980, fewer than 10 000 cases had been recorded. Peru was aware that that figure might be an underestimate, and accordingly saw its main task as one of education and prevention, in order to reduce the impact of AIDS on the individual and on society.

She therefore fully supported the joint programme, and would encourage the Director-General to take all necessary measures on WHO's side to put it into effect. The programme should work directly with ministries of health, which were the focal points for action at country level and were responsible for preparing national AIDS control strategies.

She endorsed the draft resolution, together with the amendment proposed by Argentina, as amended by the delegate of Sweden, and took note of what was stated in document A48/34 Add.1 on the composition of the Programme Coordinating Board.

Mr NGEDUP (Bhutan) said Member States needed to act collectively, using all their technical capabilities and shared experience, to combat the deadly scourge of AIDS. In their enthusiasm for the new joint programme, they should take care not to undermine an organization which until now had borne a heavy responsibility in combating, not only AIDS, but many other diseases that afflicted the world. A mechanism must be created which would ensure that WHO, its regional offices and its country representatives all had a role in the new programme in terms of decision-making, implementation, and shared efforts. He too was concerned that during the transition period nothing should be done to destroy what had been so laboriously built up.

Dr AL-AANBAKI (Iraq) observed that WHO had achieved considerable success in past years in combating AIDS, and had acquired a great deal of experience which should be put to good account in implementing the joint programme. The Organization should be entrusted with leadership in setting the programme in motion, as well as in the follow-up and monitoring of AIDS-related activities.

Mrs KIMLIKOVÁ (Slovakia) endorsed the establishment of what was a new and very important programme. Although few cases of HIV/AIDS had occurred in Slovakia, her delegation supported the draft resolution, as amended by the delegates of France, Japan and Sweden, and wished to be included among its sponsors.

Mr ILABACA (Chile) supported the draft resolution, with the amendments proposed by Argentina and France, and endorsed the joint programme. He shared the views expressed by the delegate of Sweden on the advantages of giving full support to the programme, and wished Dr Piot and his collaborators every success in the difficult task they had undertaken.

Provided that the amendments proposed by the delegates of Argentina and France were accepted, Chile would be prepared to sponsor the draft resolution.

Dr WINT (Jamaica), while welcoming the establishment of the joint programme and supporting the draft resolution under discussion, shared the preoccupations expressed by previous speakers. WHO should retain the lead with respect to the health aspects of the programme, and links with WHO activities related to the control of sexually transmitted diseases should not only be maintained, but strengthened. His main area of concern related to implementation at country level. The terms of reference drafted for the theme groups seemed to overlap with the existing terms of reference of national AIDS committees: it was vital for such groups to be carefully integrated into existing structures; they should follow the lead of national efforts, rather than seeking to impose themselves.

Many of Jamaica's health programmes were at a critical stage of development, and would be unable to cope with any disruptive change. The transition process should therefore be carefully planned and mutually agreed before being implemented.

Dr CHAMOV (Bulgaria) said he foresaw a number of difficulties in the transition from GPA to the joint programme, and in the implementation of the latter in the European Region, especially in countries of central and eastern Europe and in the newly independent States. For countries in transition, characterized by low HIV prevalence accompanied by rapid social change and economic and social instability, continuity was essential. WHO was the traditional partner for many of those countries, and any support, whether financial, technical, or in the form of expertise, had always been channelled through it. Although the Organization had a leadership role in combating AIDS at country level, it had no representatives at that level, apart from liaison officers. Moreover, WHO was the only international organization with a clear and traditional mandate in the health field.

He was concerned at the lack of appropriate regional structures on which UNAIDS activities could be based. The WHO Regional Office for Europe had played a pioneer role in the AIDS field, and he would propose that UNAIDS establish a regional group in Europe based on experienced Regional Office staff. In addition, to ensure continuity, a system of intercountry AIDS advisers should be set up. He hoped that the United Nations Economic and Social Council would appreciate the particular situation of the countries of central and eastern Europe, and would elect at least two of those countries to the future Programme Coordinating Board.

In conclusion, he hoped that UNAIDS would successfully accomplish its coordination functions, based on appropriate structures in the regions as well as in Member States.

Mr ÓLAFSSON (Iceland) supported the draft resolution, and hoped it would produce good results. He expressed disappointment that WHO's AIDS policy appeared to be focused more on therapeutic medicines than on developing a vaccine and noted with some concern that there was a possibility of a shift of AIDS funding to UNDP.

He was sorry that WHO had not been pursuing the policy launched some years earlier of focusing attention on the basic primary health care structures and on public health services. Immunization against disease, or its eradication, could not be achieved simply by intervening in a country with technical help, and then leaving without helping that country to build up a primary health care infrastructure. He hoped that the new process would lead to an improvement in the situation.

Professor OWONA (Cameroon) welcomed the establishment of the joint programme, which demonstrated that the United Nations system was serious in its determination to combat AIDS.

However, he hoped that the transition would go smoothly, and that WHO would know exactly what direction it was taking. There was a danger in having too many different organizations involved in the new initiative, and WHO must remain the lead agency. Because AIDS had had a severe impact on countries of the South, the countries of the South should play a part in combating it, and there should be sufficient decentralization to ensure cooperation at national level. He called on the newly appointed Executive Director of UNAIDS to ensure that the expertise available in all countries of the world was brought to bear in the combat against AIDS.

Cameroon wished to be included among the sponsors of the draft resolution.

Dr DESSER (Austria) said Austria was a sponsor of the draft resolution, and had expressed support for the establishment of the joint programme. Steps should be taken to enable UNAIDS to begin operation by 1 January 1996, as planned. Discussion of the membership and role of the Programme Coordinating Board in New York had taken a considerable time, and in his view it would not be wise for that discussion to be reopened. He agreed with the delegate of Sweden that WHO could and should play a major role in the new programme.

He supported the amendments proposed by the delegates of France and Sweden, but would see the amendment proposed by the delegate of Qatar as highly counterproductive.

Dr SURINDER SINGH (Malaysia) fully supported the draft resolution, and congratulated Dr Piot on his appointment as Executive Director of UNAIDS.

Dr PRETORIUS (South Africa) welcomed the progress made in establishing the UNAIDS programme, and congratulated Dr Piot on being chosen to head such an important initiative. He also thanked Dr Piot for the assistance he had given South Africa in developing its own HIV/AIDS programme. South Africa wished to be included as a sponsor of the draft resolution as amended by the delegate of Sweden. Although coordination between the major players in the field was a step forward, many other international organizations and institutions were involved in combating AIDS: UNAIDS should do all it could to eliminate any remaining fragmentation or duplication of efforts.

Dr TAPA (Tonga) congratulated Dr Piot on his appointment and commended GPA staff on their dedication. He protested that the Pacific was not specifically named as forming part of a region in relation to the formation of the Programme Coordinating Board (document A48/34 Add.1, paragraph 4). United Nations practice was to include the Pacific with Asia, as for example in the Economic and Social Commission for Asia and the Pacific. The Pacific Ocean covered two-thirds of the globe and its islands were entitled to representation on the Programme Coordinating Board; the omission should be rectified. Tonga supported the draft resolution as amended.

Dr LOUME (Senegal) announced that the matter of his country's arrears had been settled that morning.

He expressed his concern regarding the application at country level of the resolution establishing UNAIDS. The combat against HIV/AIDS was a global issue which affected the African countries in particular. Conflicts might arise between national AIDS-related programmes and the new programme. Even when it was working with other agencies or institutions, WHO ought to be the leader for all health programmes. He wished to see that emphasized in the draft resolution.

Professor SHAIKH (Pakistan) hoped that the joint programme would be launched as soon as possible, without waiting for January 1996. The cosponsoring agencies must quickly develop a clear-cut strategy setting out who did what and the relationships between them, in order to avert confusion in the future. Moreover, the whole programme needed to be based on mutual trust. Pakistan was striving, with its own modest resources, to prevent the spread of AIDS. Countries such as Pakistan, where there was not yet an epidemic of AIDS, needed greater attention and support and a more appropriate allocation of staff. Prevention was vitally important. Without going into the controversial issue of the governing body of UNAIDS, what was needed was a workable strategy which would produce results.

His delegation was concerned that the operative part of the draft resolution before the Committee requested the Director-General to facilitate implementation of the joint programme. Did that not suggest that WHO was to relinquish its leadership in the health field? That unfortunate impression ought to be corrected.

Professor SLIMANE TALEB (Algeria) congratulated Dr Piot on his appointment and commended the introductory report. Algeria supported the draft resolution. WHO had a leading role to play. Algeria therefore endorsed the suggestions made by Sweden and supported the amendments put forward by France and Japan.

Mr ULUSOY (Turkey) expressed appreciation of the efforts deployed by WHO and others in the fight against HIV/AIDS. Under the new arrangements, the role of WHO should be to continue to provide guidance

and technical support to Member States. Implementation at country level was also a major issue. He hoped to see cooperation between the United Nations organizations and the countries, with WHO remaining the main supporting organization.

Dr VOUMARD (United Nations Children's Fund) recalled UNICEF's involvement in preparations for the joint programme. In October 1994 it had assigned two staff members to work with the Geneva-based transition team. UNICEF looked to the joint programme to promote an effective, global response to the pandemic. It would incorporate the programme's strategies and guidelines into its mainstream policies and, more specifically, through multisectoral programmes and partnerships, seek to address the broader societal determinants of the spread of HIV. Priority would be given to activities at country level. The programme would provide a platform for action on a broader front. UNICEF would work within the framework of "governance" proposed by the United Nations Economic and Social Council; it welcomed the early establishment of the Programme Coordinating Board. UNICEF would second a senior staff member to the programme. It was actively participating in regional consultations to develop the programme's strategic plan. Working with the joint programme, it would review its experience in relation to HIV/AIDS in over 30 strategic countries. UNICEF and WHO had jointly published an information document entitled "Action for children affected by AIDS". UNICEF was playing an active role in the follow-up to the Paris AIDS Summit. It also looked forward to collaborating with the Executive Director of the joint programme and to playing an active part at country level in the theme groups on HIV/AIDS.

Dr DODD (United Nations Population Fund) said that UNFPA had also been involved in the development of the joint programme and looked forward to pursuing a close working relationship with its Executive Director. It expected to receive technical and normative guidance and to be involved in developing such guidance in UNFPA's areas of interest. It understood its responsibility for "mainstreaming". It had seconded a staff member to the programme, and its Executive Board would consider proposals for further support. UNFPA was supporting HIV/AIDS prevention in over 100 countries, in accordance with national policies and in coordination with its own information and service delivery programmes on reproductive health and family planning. It expected to pursue such work within the theme groups.

Dr SAMBA (Regional Director for Africa) pointed out that over 50% of the world's AIDS cases were in sub-Saharan Africa. AIDS was primarily a medical problem, albeit one with social and economic implications. WHO's mandate consequently obliged it to be involved at all levels, at headquarters, and in the regions and countries. All 46 countries coming under the Regional Office for Africa needed, used and had WHO officers. In the light of social emergencies in Africa, there was an increasing number of countries where the ministry of health was unable to operate without WHO support. Since January 1995, he had been discussing with Dr Piot how to pool efforts to provide effective support at country level, in collaboration with United Nations organizations and any other organizations interested, including nongovernmental organizations. Many requests had been made for WHO to allocate future funds from its regular budget to fight AIDS. He reminded the advocates of zero-growth budgets that in the African Region, with its many priorities and limited resources, that would mean depriving another priority area of funds.

Dr PIOT (Joint United Nations Programme on AIDS) thanked the many delegations that had expressed support for the joint programme. Some speakers had voiced anxiety over the continuity of support to national AIDS programmes: as he had said in his introduction, that was also his own principal concern. The joint programme was working actively to establish a series of measures ensuring the continuity of support, with GPA, to national AIDS programmes. Together with WHO and the other cosponsors, UNAIDS would work with each country concerned to ensure that there would be no interruption of financial and technical support to countries.

Questions had been asked about the precise role of the different agencies, and how they would integrate action on AIDS/STD into their respective programmes. That would be discussed at the next meeting of the Committee of Cosponsoring Organizations, as would the interaction between UNAIDS and its cosponsors.

Dr Hu Ching-Li, Assistant Director-General, would describe the role of WHO. He himself felt that one indicator of the success of the new programme would be the growing commitment of the cosponsors to the fight against AIDS and sexually transmitted diseases.

After consulting with the Committee of Cosponsoring Organizations and the principal donors, UNAIDS would be submitting a budget of about US$ 140 million for the 1996-1997 biennium to the Programme Coordinating Board for approval. Currently UNAIDS was operating with the financial support of WHO, UNFPA, Australia, Sweden and the United States of America. France was giving assistance in the framework of follow-up to the Paris AIDS Summit.

In reply to the concern expressed about the relative roles of Member States and the executive heads of the six cosponsoring organizations in UNAIDS governance, he said that the Committee of Cosponsoring Organizations - comprising the six executive heads - would be responsible for ensuring the articulation of UNAIDS policies/strategies with each cosponsor and between cosponsors. He would consult that Committee on all major aspects of the programme. The Programme Coordinating Board, which was the UNAIDS governing body, would be composed of Member States, the six cosponsors and representation from nongovernmental organizations. The Member States would be selected on the basis of geographical distribution, which should result in a fairer representation than was currently the case with the governing bodies of other cosponsored programmes, or even of GPA, where donor countries generally had the majority of seats.

With regard to the concern expressed about support from cosponsors other than WHO to the new programme, he recognized that working with six agencies was not easy, but said that progress was being made at every meeting of the Committee of Cosponsoring Organizations; his approach was to advance through action on a joint project rather than through endless discussions. He confirmed what the representatives of UNICEF and UNFPA had said concerning the excellent cooperation with those agencies. UNFPA had seconded staff and its active involvement was highly appreciated. Much progress had also been made in UNICEF during the previous four months; staff secondment was being identified and work was being done jointly on various projects, some of them in the framework of the follow-up to the Paris AIDS Summit.

He assured the delegate of Jamaica that the terms of reference of the theme groups were limited to improving support of United Nations cooperation in country responses to AIDS, and was in no way meant to replace national efforts either in coordination or in responding to the pandemic. As for the coordination mechanisms in the United Nations system in those countries without WHO Representatives or representatives of other agencies, UNAIDS would have to find a flexible solution. Indeed, flexibility would be a keynote of the joint programme.

He also assured delegates and the Regional Director for Africa that he fully appreciated the importance of working with WHO's decentralized structure at all levels and had already initiated discussions with each regional office, not only of WHO but also of the other cosponsors, to explore how best to collaborate in providing technical support to countries. UNAIDS would not have a regional administrative structure, which would be far too expensive to set up; on the other hand, providing support only out of Geneva would also be too expensive, and in many cases inappropriate. Working out of multicountry, intercountry or regional pools of expertise was the most cost-effective and appropriate way to deal with the epidemic. UNAIDS would therefore work closely with WHO's regional offices and those of the other cosponsors.

With regard to staffing, UNAIDS would have fewer professional staff in Geneva; it would rely on open recruitment, with full and expeditious consideration of applications from staff from all the cosponsors, of which WHO had by far the largest number working on HIV/AIDS and sexually transmitted diseases. A first series of 12 professional posts had just been advertised, but the constitutive first meeting of the Programme Coordinating Board had to take place before further staff could be recruited.

Finally, he said that he did not think that true leadership was exclusive. WHO should of course be a leader at all levels in the struggle against the AIDS pandemic; it had shown its leadership since the beginning, and had been vital in creating the new programme. UNAIDS should also be a leader, as should the other cosponsors and the Member States, and indeed, each individual.

Mr TOPPING (Office of the Legal Counsel), replying to delegates who had questioned the legality of the establishment of the Programme Coordinating Board by the United Nations Economic and Social Council, said that since WHO was an independent organization it was not legally possible for the Economic and Social Council to instruct WHO in the matter. However, Article 63 of the United Nations Charter gave the Economic and Social Council a coordinating role *vis-à-vis* the specialized agencies. Furthermore, in the agreement adopted at the first Health Assembly which brought WHO into relation with the United Nations

as a specialized agency, WHO had agreed to give great weight to the recommendations of the Economic and Social Council and to cooperate with its coordinating activities. It would therefore be in order for the Health Assembly to decide to go along with the decisions by the Economic and Social Council on the establishment of the Programme Coordinating Board.

Dr HU Ching-Li (Assistant Director-General) assured delegates that as Assistant Director-General in charge of liaison with the new joint programme and of overseeing GPA in the current transition period, he would ensure that WHO would not give up its leading role as a health agency. WHO would be working together closely with the other five United Nations organizations cosponsoring the new programme. Recently WHO had set up two committees to help in phasing out GPA and in establishing UNAIDS, one dealing with programme issues, the other with administrative ones. The committee on programme issues had already decided that GPA and UNAIDS would review each of WHO's programmes. There were 34 programmes which had some relation to HIV/AIDS, and the roles of WHO and UNAIDS in those activities had to be defined. For example, the vertical transmission of AIDS from mother to child was closely related to the programme on maternal and child health; safe blood transfusion was related not only to AIDS but also to hepatitis B, malaria and so on. WHO's programme on substance abuse was also related to AIDS, as were many others, such as the tuberculosis programme and the cosponsored Special Programme of Research, Development and Research Training in Human Reproduction. Those programme aspects should be defined as soon as possible.

The provision of administrative support to UNAIDS also had to be defined; at its last meeting the Committee of Cosponsoring Organizations had asked WHO to secure a memorandum of understanding with the other agencies that would be a legal instrument defining what support WHO should give. Support staff also had to be considered; about 200 professional and general staff whose contracts would terminate on 31 December 1995 had to be taken into account in future recruitment by WHO and UNAIDS. At present WHO had seconded to UNAIDS eight-and-a-half professional and eight general service staff to enable UNAIDS to start operation in 1996. It had also been decided at the last meeting of the GPA Global Management Committee that if there were enough funds US$ 20 million should be carried over to the new programme so that it could begin work on 1 January. In addition to the 13% of programme support costs, it was estimated that in future 10% of the UNAIDS budget, or about US$ 10 million, would be provided by WHO.

The CHAIRMAN drew the Committee's attention to the amendments that had been proposed to the draft resolution on the establishment of the joint and cosponsored United Nations programme on HIV/AIDS, and invited the delegates of Argentina, Australia, Brazil, France, India, Islamic Republic of Iran, Jamaica, Japan, Qatar, Senegal, Sweden and United States of America, together with Dr Piot, to prepare a new draft resolution taking those amendments into account.

(For approval of draft resolution, see page 260.)

International Conference on Population and Development: Item 32.3 of the Agenda (Document A48/35)

Dr NGO VAN HOP (representative of the Executive Board), introducing the item, said that the International Conference on Population and Development had been held in Cairo in September 1994. WHO had actively participated in both the preparatory stage and the Conference itself. The Conference had adopted a comprehensive Programme of Action endorsing a new strategy for tackling questions of population, health and development, which had been adopted by the United Nations General Assembly in December 1994 in resolution 49/128. Various aspects of that resolution concerned WHO. First, the Secretary-General was requested to consult various United Nations bodies and others with a view to an exchange of information on necessary international aid and to ensure that a maximum of resources should be available and used to best advantage. Secondly, specialized agencies and all United Nations bodies were requested to reconsider and, if necessary, rearrange their programmes and activities so as to take the desired steps to ensure fully and effectively the application of the Programme of Action, which had been harmonized with WHO's policies and programmes and thus constituted a logical continuation of the line followed by the Organization, i.e. the

adoption of a holistic approach to reproductive health in the context of primary health care. Thirdly, the decision to revitalize the United Nations Population Commission which would assume the name of Commission on Population and Development and meet in 1996 to consider reproductive health and human rights in that field. WHO would participate actively in those discussions. Fourthly, the United Nations Economic and Social Council was requested to consider setting up an interinstitutional mechanism of coordination, collaboration and harmonization to apply the programme of joint action; WHO would contribute by every means to that mechanism.

The Executive Board had adopted resolution EB95.R10 in which it stressed the need for close collaboration with other United Nations bodies to support the broader purposes of reproductive health; and requested the Director-General to report to the Economic and Social Council on the continued high priority given by WHO to reproductive health at all levels in accordance with United Nations General Assembly resolution 49/128.

Ms LOBBEZOO (Netherlands) noted that the concept of reproductive health had received broad support at the International Conference. The time had now come for WHO, in close cooperation with other United Nations organizations concerned, such as UNICEF and UNFPA, to define clearly its follow-up tasks and activities, and also to try to determine what type of activities should not be pursued by WHO but be left to others. WHO should provide a clear outline of the implications of the International Conference and the concept of reproductive health as developed at that Conference for the Organization's internal structure. How would the concept be implemented in the various WHO programmes and how would funds be distributed among them?

Dr SALMON (United States of America) said that her country attached the highest importance to effective follow-up of the International Conference. WHO had a special role to play in the implementation of chapter VIII on "Health, morbidity and mortality" of the Programme of Action adopted by the Conference. She noted with satisfaction that the Programme of Action covered not only the direct needs of women, but also the needs of men and of young people; the provision of education for adolescents that was appropriate to their age was very important.

WHO's flexible and pragmatic attitude to reproductive health had been displayed at the technical meeting on the development and delivery of reproductive health, held in March 1995. Subjects that merited priority attention included: maximum access to and quality of care in family planning services, including research and development of new methods of fertility regulation; prevention of HIV/AIDS and other sexually transmitted diseases, in collaboration with the joint and cosponsored United Nations programme on HIV/AIDS; the reduction of maternal mortality and the health effects of unsafe abortion; promoting women's overall health and nutrition; the promotion of breast-feeding for both child survival and birth-spacing; the needs of adolescents for reproductive health information and services; and the prevention of harmful traditional practices such as female genital mutilation.

If the targets of the International Conference were to be met, a truly cooperative and multisectoral effort would be required from the international community. Careful planning would be needed, and it would take time to determine the roles and administrative structures needed for optimal coordination within and among organizations. WHO should work closely with other United Nations agencies, including UNICEF, UNFPA and the World Bank.

Mr MARCH (Australia) said that follow-up action after the International Conference had indicated the need to integrate follow-up activities related to population, health, the empowerment of women, the fight against poverty, patterns of production and consumption, and environmental protection. No single agency had the capacity or the mandate to cover all those aspects, and WHO must ensure that its activities complemented recent initiatives rather than duplicating them.

It had been decided that the follow-up activities should be concentrated at country level or below. He requested details of WHO's plans in that regard. A major area for activity by WHO was covered by chapter XII of the Programme of Action of the International Conference, entitled "Technology, research and development". There was a particular need for research on new methods of male and female contraception and for careful monitoring of their testing and introduction in order to prevent abuses.

Australia had increased the financing it provided for family planning and reproductive health activities and was committed to effective programmes which would improve maternal and child health and promote safe, affordable and non-coercive family planning services. Its technical assistance programmes sought to improve quality of care, involve women and the rest of the community in programme development and train and support traditional health workers in order to provide sustainable, locally appropriate and acceptable services which would improve the overall quality of primary health care.

Dr HU Ching-Li (Assistant Director-General), responding to the points raised by delegates, said that WHO had continued to work closely with other United Nations organizations, Member States and nongovernmental organizations on follow-up activities since the International Conference. The conceptual and strategic framework for reproductive health submitted to the Executive Board in January 1995 (document EB95/1995/REC/1, Annex 15) and the meeting on the development and delivery of reproductive health (see document A48/10, paragraph 51) had culminated in the statement of WHO's role within the global reproductive health strategy outlined in document A48/10, which Committee A had discussed at its sixth and seventh meetings. Many parts of WHO were also involved in the process of developing the reproductive health strategy, including the regional offices, WHO Representatives, the Global Policy Council and the Global Management Development Committee.

The CHAIRMAN said that, if he saw no objection, he would take it that the Committee wished to take note of the report by the Director-General contained in document A48/35.

It was so agreed.

World Summit for Social Development: Item 32.4 of the Agenda (Document A48/36)

Dr NGO VAN HOP (representative of the Executive Board) said that the Board at its ninety-fifth session had been informed of WHO's preparations for the World Summit for Social Development in March 1995 and of efforts to highlight health problems in the context of the three themes of the World Summit, namely eradication of poverty, productive employment, and social integration. Some members had suggested that the WHO position paper prepared for the occasion should be sent to delegations in advance, to assist them in the preparation of their statements to the World Summit. The Health Assembly was invited to take note of those facts and the references to health concerns in the Declaration and Programme of Action adopted by the Summit.

Ms GIBB (United States of America) said that the World Summit had achieved a wide-ranging consensus on the action needed to improve social conditions throughout the world and had acknowledged the importance of health, both in itself and as a major contributor to sustainable development. She requested details of WHO's plans for follow-up action. The United States had begun to implement a US$ 100 million education programme for girls and women, which it had announced at the World Summit, as well as the "new partnerships initiative", under which 40% of the country's development assistance was to be channelled through nongovernmental organizations.

The United States would work with other Member States, WHO and other United Nations bodies to reinforce ways of measuring progress towards the health targets included in the Programme of Action of the World Summit. It was important to coordinate efforts to obtain, analyse and disseminate data, since the publication of unvalidated data in numerous United Nations publications would hinder rather than promote the accurate monitoring of progress.

Mrs PRADHAN (India) welcomed the adoption by the World Summit of "Commitment 6", which called upon States to promote universal and equitable access to quality education and primary health care.

Mr ROBERTSON (Australia) remarked that the Declaration and Programme of Action of the World Summit had helped to strengthen the profile of global social development. The World Summit had rightly located health and access to health services at the centre of strategies to combat poverty and promote social integration and productive employment. The conclusions of the World Summit were tantamount to a mandate

to increase the efficiency and effectiveness of United Nations and international organizations in the health sector in order to achieve stronger and better-coordinated global action against major diseases.

Mrs WU Jihong (China) submitted that the solving of social development problems was just as important as peace-keeping and security operations in preserving both national and regional stability. The Programme of Action of the World Summit incorporated specific health objectives and established health for all as an essential strategy for the eradication of poverty. She hoped that WHO and other agencies concerned would work closely together on that programme.

Dr HAMMAD (Adviser on Health and Development Policies), replying on the points raised by delegates, said that the United Nations was forming an interagency steering committee for follow-up to the World Summit; WHO would be a member and would be entrusted with monitoring follow-up on health issues and health data. The targets about which WHO would collect data were those of the Organization's own Ninth General Programme of Work: in other words, the information which the Organization gathered anyway would be made available to other United Nations organizations, becoming part of an integrated reporting system. A major goal of the World Summit was the eradication of poverty, which was already a major concern of WHO. In line with WHO policy it would be important to continue to focus on communities most in need, in partnership with other agencies. WHO and other parts of the United Nations system would be kept fully informed of progress towards the goals of the World Summit.

The CHAIRMAN said that, as he saw no objection, he would take it that the Committee wished to note the report by the Director-General contained in document A48/36.

It was so agreed.

Women, health and development and World Conference on Women: Item 32.5 of the Agenda (Resolution WHA45.25; Documents A48/37 and A48/INF.DOC./9)

Dr NGO VAN HOP (representative of the Executive Board) said that the Global Commission on Women's Health had been established by the Forty-fifth World Health Assembly in its resolution WHA45.25 as a mechanism to promote women's health. The resolution also called upon the Director-General to present a report to the Forty-eighth World Health Assembly. The Executive Board had been informed that the Global Commission was calling for increased attention to be paid to the most urgent health needs of women and, to that end, had listed steps to be taken to improve women's health, had encouraged decision-makers to become aware of women's health issues with a view to including them in development plans, and offered a forum for consultation and dialogue with women's organizations, women's health lobbies and those concerned with mobilizing women at all levels. The Interdivisional Steering Committee on Women, Health and Development had been strengthened in order to facilitate the achievement of the goals and objectives of the Ninth General Programme of Work that related to women's health and women's participation in health development and decision-making at all levels. The Executive Board had recognized that women's health had always been of special concern to WHO and had suggested that the Interdivisional Steering Committee could usefully provide guidance to programme managers and administrators with regard to issues of women, health and development at global level. The Board had noted the role of WHO and the Global Commission in ensuring the inclusion of women's health matters in regional and global draft platforms for action for the Fourth World Conference on Women to be held in Beijing in September 1995. The Board had been informed that WHO was drawing up a description of its policy and activities in support of women's health, including a visual presentation of current data on women's health, for the Conference. The Health Assembly was invited to note the report, no other action being required at the present stage.

Dr SALMON (United States of America) expressed high regard for the work of the Global Commission on Women's Health and its role in providing advocacy and advice, particularly through the drawing up and dissemination of documents, media products and statistical compilations on the six crucial areas relating to women's health, and looked forward to its contribution to the Fourth World Conference on Women. There was worldwide consensus that women were best able to contribute to society and their families when they

were healthy. There was little debate that the optimum state of health and well-being for women and girls could only be achieved by ensuring that their contributions to society were fully recognized and reflected in their status. Social actions and practices that were harmful to women and girls, such as female genital mutilation, should be eradicated, and all women and girls should have access to adequate services and nutrition throughout their life cycles. WHO had a special role to play in the complex spectrum of issues bearing on the health of women and girls, and she commended WHO for its work related to women's health, particularly its planning and advisory services. The Health Assembly and WHO should continue to place a high priority on women's health, which was of the utmost importance not only to women and girls, but also to the future of all people.

Ms INGRAM (Australia) said that the Australian Government had had the pleasure of hosting the third meeting of the Global Commission on Women's Health in Perth in April 1995, where the focus had been on women's health and aging. Australia had also been involved in other initiatives. The Commission on the Status of Women had endorsed the Australian initiative that the Beijing Conference should be a conference of commitments and should address specific health matters. The International Conference on Population and Development and the World Summit for Social Development had also indicated that women's health should be a major focus of the Fourth World Conference on Women.

Her Government was understandably proud of many activities it had undertaken domestically in relation to women's health but acknowledged that, despite its efforts, there remained gaps in knowledge about women's health and about the most appropriate health interventions for women. With the aim of providing high quality information, the Australian Government had allocated US$ 3.7 million for a major longitudinal study of women's health to identify those factors that promoted and those that were detrimental to good health in women, and to clarify the interaction between the health system and the health needs of women. The study was on not only the biological and psychological components of health, but also the social, economic and environmental factors, notably those related to women's role and position in society. The results were expected to provide guidance for women's health policy in the future and to contribute to the development of better health services for women.

Mr Jae Hong LIM (Republic of Korea) said that the role of women had recently become more important than ever because the perception of women in society had changed as a result of the rapid increase in their participation in socioeconomic activities throughout the world. Women's health should therefore be considered by all international conferences related to women. The Fourth World Conference on Women would provide a good opportunity to enhance public awareness about women's health. WHO's efforts to arouse interest in women's health matters throughout the world and its active participation in preparing for the Conference were greatly appreciated. He hoped that WHO would continue to contribute to the promotion of women's health through the Conference.

Mrs HERZOG (Israel) commended WHO and, in particular, its Division of Family Health on raising the awareness of governmental agencies and nongovernmental organizations with respect to the interdependence of women, health and development and its efforts to promote equality of the sexes and to attend to women's special needs. The report summarized all relevant aspects of women's health and development. She proposed, however, that, in future documents relating to women's health, women should not be referred to as a vulnerable group but rather as having special needs.

Dr DLAMINI (Swaziland) was delighted to note that WHO had been closely involved in preparing for the Fourth World Conference on Women and commended the work of the Global Commission on Women's Health in that context. Coming from the African Region, where the unacceptable health status of women and children was of particular concern, she welcomed WHO's efforts in support of maternal and child health and family planning, and she trusted that they would continue to be given priority in the future.

Mrs PRADHAN (India) acknowledged the work of the Global Commission on Women's Health and, in particular, recognized the importance of sex-specific data, special interventions to bring down maternal mortality, access to perinatal care, and other such essential matters. Recalling the regional consultation on women, health and development held in South-East Asia with the participation of representatives from

governments, nongovernmental organizations and other women's organizations, she urged WHO to continue its work for women, health and development and she congratulated the Organization on raising awareness about those matters throughout the world.

Dr LIU Hailin (China) said that the Fourth World Conference on Women would be important in helping to promote the status of women throughout the world. The Government and people of China, the host country, recognized the great opportunity presented by the Conference in that respect as well as in facilitating services for women. A preparatory committee for the Conference had been set up in August 1992 and his country had devoted human, financial, and other resources to preparatory work. Relations between China and the United Nations, including its specialized agencies, were good; two United Nations teams had visited China to investigate arrangements for the Conference and the Secretary-General of the United Nations had signed an agreement with the Chinese Government. China would continue to collaborate closely with all United Nations organizations and Member States in preparing for the Conference and would make every effort to ensure its success.

Dr HAMMAD (Adviser on Health and Development Policies) welcomed the expressions of support for WHO's increasing focus on women's health and the work of the Global Commission on Women's Health.

A working group had been set up to look into traditional practices, including female genital mutilation, that had harmful effects on women's health, and a technical meeting would be held in June 1995 to study those practices further and to make recommendations for appropriate follow-up action. The meeting would include the participation of nongovernmental organizations and would bring together representatives from all regions.

The Global Commission on Women's Health had benefited from the support of many organizations (including UNFPA and the Carnegie Foundation) as well as Member States, like Australia, which had enabled it to meet and explore further how to advocate and strengthen WHO's contribution to women's health. One specific aspect of the Global Commission's work had been its contribution to major conferences. It had had a marked impact on the World Summit for Social Development; there had been a special section on women's health in WHO's position paper, and activities focusing on women's health had been organized during the Summit. Furthermore, the Programme of Action of the Summit not only referred to women's health in the overall context of health, but also included some of the targets in WHO's programmes, particularly those related to maternal mortality, child health and communicable diseases. WHO's approach to women's health - not just focusing on one phase of the life cycle but considering all phases - had been adopted by Member States, sister agencies and international conferences. The Global Commission had emphasized the need for integrated services for women, and that view had been endorsed by the United Nations system and various conferences. The Global Commission had also emphasized the role of nongovernmental organizations, and she was pleased to inform the Committee in that context that the Global Commission itself brought together a wide range of experience and expertise, including that of a number of international nongovernmental organizations working in the area of women's health.

The Global Commission had carried out excellent work in preparation for the Fourth World Conference on Women by attending global and regional preparatory committees and mobilizing national communities. She hoped that delegations to the Beijing Conference would include health experts so that the necessary expertise would be available to take decisions and strengthen health references in the proposed "platform for action". The Global Commission had been given the status of observer. Some members of the Global Commission would also be part of their national delegations, while others would represent the Global Commission in its own right. WHO was pleased to participate in the planning and organizing of the Fourth World Conference on Women, with other entities of the United Nations family. WHO and others had participated in the recent Chinese nongovernmental organizations' health forum in Beijing. The Organization would be represented by a large group at the Beijing Conference which would reflect all regions and all its areas of technical expertise, as had been the case at the International Conference on Population and Development and the World Summit for Social Development. She hoped that the Beijing Conference would adopt a declaration that covered specific targets related to women's health, reaffirming and going beyond the few already adopted at previous conferences.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee wished to note the report by the Director-General contained in document A48/37.

It was so agreed.

The meeting rose at 17:50.

EIGHTH MEETING

Thursday, 11 May 1995, at 9:00

Chairman: Professor A. WOJTCZAK (Poland)

1. HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 31 of the Agenda (Documents A48/32, A48/INF.DOC./4, A48/INF.DOC./5 Rev.1 and A48/INF.DOC./6 and Corr.1)

The CHAIRMAN invited the Committee to consider the following draft resolution entitled "Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine", proposed by the delegations of Egypt, France, Norway, Russian Federation and United Arab Emirates:

The Forty-eighth 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 the convening of the International Peace Conference on the Middle East at Madrid on 30 October 1991, on the basis of Security Council resolutions 242 (1967) of 22 November 1967 and 338 (1973) of 22 October 1973, and the subsequent bilateral negotiations;

Expressing the hope that the peace talks among the parties concerned in the Middle East will lead to a just and comprehensive peace in the area;

Noting the signing in Washington D.C. on 13 September 1993 of the Declaration of Principles on Interim Self-Government Arrangements between the Government of Israel and the Palestine Liberation Organization, and the commencement of the implementation of the Declaration of Principles following the signing of the Cairo Accord on 4 May 1994, and the transfer of health services to the Palestinian Health Authority on 1 December 1994;

Emphasizing the need to accelerate the implementation of the Declaration of Principles and the Cairo Accord;

Recognizing the need for increased support and health assistance to the Arab populations in the occupied Arab territories, including the Palestinians as well as the Syrian Arab population;

Recognizing that the Palestinian people will have to make strenuous efforts to improve their health infrastructure, and expressing its satisfaction at the initiation of cooperation between the Israeli Ministry of Health and its Palestinian counterpart, emphasizing that health development is best enhanced under conditions of peace and stability;

Expressing its hope that the Palestinian patients will be able to benefit from health facilities available in the health institutions of Jerusalem;

Recognizing the need for support and health assistance to the Arab populations in the occupied territories, including the occupied Golan;

Having considered the report of the Director-General[1] on the subject,

1. EXPRESSES the hope that the peace talks will lead to the establishment of a just, lasting and comprehensive peace in the Middle East;

[1] Document A48/32.

2. EXPRESSES the hope that the Palestinian people, having assumed responsibility for their health services, will be able themselves to carry out health plans and projects in order to participate with the peoples of the world in the achievement of WHO's objective of health for all by the year 2000;

3. AFFIRMS the need to support the efforts of the Palestinian Authority in the field of health to enable it to develop its own health system which meets the needs of the Palestinian people, by administering their own affairs and supervising their own health services;

4. URGES Member States, intergovernmental organizations, nongovernmental organizations and regional organizations to provide speedy and generous assistance to help in the achievement of health development for the Palestinian people;

5. THANKS the Director-General for his efforts and requests him:
(1) to continue to provide the necessary technical assistance for supporting health programmes and projects for the Palestinian people in the transitional period;
(2) to take the necessary steps and make the contacts needed to obtain funding from various available sources and extrabudgetary sources to meet the urgent health needs of the Palestinian people during the transitional period;
(3) to continue his efforts to implement the special health assistance programme and adapt it to the health needs of the Palestinian people, taking into account the health plan of the Palestinian people;
(4) to activate the organizational unit at WHO headquarters concerned with the health of the Palestinian people, and continue to provide health assistance to improve the health conditions of the Palestinian people;
(5) to report on the implementation of this resolution to the Forty-ninth World Health Assembly;

6. 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.

He noted that Argentina, Austria, Bangladesh, Belgium, Bulgaria, Cambodia, Canada, Chile, Cyprus, Denmark, Finland, Germany, Greece, Hungary, Iceland, India, Ireland, Italy, Japan, Kenya, Luxembourg, Maldives, Malta, Mauritius, Morocco, Netherlands, Nicaragua, Oman, Poland, Portugal, Romania, Slovakia, South Africa, Spain, Sri Lanka, Sweden, Switzerland, Tonga and the United Kingdom of Great Britain and Northern Ireland wished to be included among the sponsors of the draft resolution, which was a great victory for the spirit of consensus, mutual understanding and reconciliation.

Mr SKOGMO (Norway), introducing the draft resolution, paid tribute to Israel and Palestine for the manner in which they had conducted the negotiations that had produced the consensus text before the Committee. The draft resolution mentioned the peace process but also drew attention to the important issue of the health needs of the Arab population in the occupied Arab territories. He hoped that it would be adopted by consensus when it came before the plenary Health Assembly.

Miss CHEHABI (Syrian Arab Republic) thanked the Director-General for his report on the health situation in the occupied Arab territories (document A48/32). The Health Assembly had adopted a number of resolutions in previous years condemning the inhumane and criminal treatment of the Arab population by the Israeli authorities, and the international community had called on Israel in many different forums to withdraw from the occupied territories, but Israel had failed to respond. As noted in the annual report of UNRWA (document A48/INF.DOC./4) and in the report of the Palestine Ministry of Health (document A48/INF.DOC./5 Rev.1), the health situation in the occupied Arab territories was still deteriorating as a result of, *inter alia*, the stealing of water and obstruction of the building of hospitals and other health facilities.

Her country took the peace process very seriously, sparing no effort to recover its territory. It aspired to a full and comprehensive peace based on Security Council resolutions 242 (1967), 338 (1973) and 425 (1978).

In a spirit of consensus and with a view to moving the peace process forward, a draft resolution had been proposed which affirmed the importance of continuing WHO's role in promoting health development for the population of the occupied Arab territories and in providing the requisite assistance to the Palestinian people. She urged the Director-General to continue submitting reports on the subject until such time as all the occupied territories were liberated.

The draft resolution was approved.[1]

Dr SAMARA (Palestine) said that for the second consecutive year consensus had been achieved on a draft resolution concerning the health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine. That consensus reflected a sincere desire for cooperation in support of the peace process despite the obstacles impeding progress in the implementation of the Washington and Cairo agreements.

Existing cooperation between the Ministry of Health of Israel and the Palestine Ministry of Health and with Israeli nongovernmental organizations was commendable but needed to be intensified.

The establishment of a Palestinian health system was closely related to progress in the peace process. He was deeply concerned by the deteriorating economic and health conditions of his people as a result of the continued closure of the Palestinian territories. How could the peace process win support when the Palestinian people were unable to take advantage of the facilities of Palestinian hospitals in Jerusalem? Thousands were still in prisons and detention camps awaiting release, and many were in need of treatment for both physical and mental ailments resulting from the conditions in which they were held.

He thanked the delegations that had helped to achieve the existing consensus and the Director-General and staff of WHO. He further thanked the Member States and intergovernmental and nongovernmental organizations that had provided assistance to his people, which he hoped would be intensified in the future so that Palestine could catch up with other countries in the joint effort to achieve health for all by the year 2000.

Mr MOEINI-MEYBODI (Islamic Republic of Iran) requested that his country's reservations regarding those paragraphs of the resolution referring to the recognition of the occupier regime and the peace process should be included in the records of the Committee.

2. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (continued)

GENERAL REVIEW:[2] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95/58) (continued from the eleventh meeting of Committee A)

Appropriation section 6: Administrative services

6.1 Personnel

Professor KUMATE (representative of the Executive Board) said that the Board had noted that, as part of WHO's response to global change, a report of the development team on WHO's personnel policy would be submitted to the ninety-seventh session of the Board to be held in January 1996. Both in that area and

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA48.29.

[2] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

in the areas covered by headings 6.2 and 6.3 the Board had proposed that reductions should be made so that funds could be redirected to priority programme activities.

6.2 General administration

Professor KUMATE (representative of the Executive Board) said that, during the Board's review, one member had suggested that more detailed information should be provided under the heading so as to ensure better understanding of administrative procedures. In that way it would be possible to explain more clearly how resources under the heading were spent, and thus facilitate the Board's examination of the proposals.

6.3 Budget and finance

Professor KUMATE (representative of the Executive Board) said that no specific issues had been raised during discussion by the Board. However, it should be noted that for appropriation section 6 as a whole a saving of US$ 5.4 million had been identified by the Director-General for transfer to priority programmes.

The CHAIRMAN invited the Committee to approve the draft resolution entitled "Consolidating budgetary reform" proposed by the delegations of Argentina, Australia, Austria, Belgium, Brazil, Cambodia, Canada, Chile, China, Denmark, Finland, France, Germany, India, Japan, Mexico, Netherlands, New Zealand, Nicaragua, Norway, Russian Federation, Sweden, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America and Uruguay, which read as follows:

> The Forty-eighth World Health Assembly,
>
> Recalling resolutions WHA46.35 and WHA47.8, which set out a number of matters of concern to Member States relating to the budgetary process;
>
> Reiterating the importance of achieving the highest standards of accountability and transparency in the programme budget of the Organization;
>
> Reaffirming the fundamental importance of realistic programme targets and measurable outcomes;
>
> Thanking the Director-General for the initial efforts made to respond to these resolutions in the preparation of the proposed programme budget for 1996-1997;
>
> Welcoming the first steps in developing a strategic approach to the programme budget process and in preparing a clearer, simpler, and more "user-friendly" document than previous programme budget documents;
>
> Recognizing that other provisions of resolutions WHA46.35 and WHA47.8 still need to be fulfilled;
>
> Considering that the preparation of each programme budget should be a continuous process building on the achievements of preceding programme budgets;
>
> Convinced of the need to take greater account of the relation between regular and extrabudgetary funds in budget preparation;
>
> Noting the need for greater harmonization of budget policies and programme budgeting procedures in all areas and at all levels of the Organization,
>
> REQUESTS the Director-General:
>
> (1) to involve Member States and the Executive Board at an early stage in translating the strategic budget into detailed, annual, operational plans of action, including indications of extrabudgetary resources;
>
> (2) to enhance the process of strategic budgeting for future bienniums along the following lines:
>
> (a) provide greater opportunity for Member States' involvement, in the appropriate forums, in the establishment of priorities at each stage and every level, for the development of the programme budget;
>
> (b) ensure sufficient flexibility in the process to permit the continuous assessment of priorities and programmes and appropriate adjustments in implementations;

(c) at the strategic level, continue to clarify objectives, including health outcomes, for the programme budget;

(d) strengthen the principle of accountability at the programme level, through the establishment of qualitative and quantitative performance targets for programme managers to be reached during the period of the programme budget, and report to the Member States on the results achieved during the biennium;

(e) present financial statements and schedules in a format that permits comparison of expenditure against the programme budget and the operational plans of action;

(3) to present, in future programme budgets, data on actual expenditure for comparison with the most recently completed biennium, and data on forecasted final expenditure for the current biennium;

(4) to continue to identify areas of duplication, overlapping, and redundant procedures in budget planning, with a view to improving efficiency and productivity, in order that WHO resources may be used in the areas of highest priority;

(5) to present to the Executive Board at its ninety-seventh session, a progress report on the experiences thus far with the strategic programme budget approach, including evidence of consistency of programme budgeting procedures and policies in all areas and at all levels of WHO, and an analysis of the ways in which these experiences and any deficiencies in the new approach may be taken into account when preparing the 1998-1999 biennial programme budget; and to request the Executive Board to present to the Forty-ninth World Health Assembly its recommendations on this subject.

The draft resolution was approved.[1]

The CHAIRMAN then drew the Committee's attention to the draft resolution entitled "Reorientation of allocations" proposed by the delegations of Bahrain, Egypt, Guinea-Bissau, India, Indonesia, Kiribati, Kuwait, Morocco, Nepal, Oman, Pakistan, Philippines, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, United Arab Emirates, United Republic of Tanzania, Zambia and Zimbabwe, which read as follows:

The Forty-eighth World Health Assembly,

Aware of the great inequities persisting between developed and developing countries where health status is concerned, and the lack of human, material and financial resources in the developing countries to cope with their urgent health problems and establish national health services;

Noting with deep concern that there has been no real growth in the WHO budget for the last ten years, and that the instability of financial markets is causing unforeseeable cost increases;

Recalling resolution WHA29.48, whereby the Director-General was requested to cut down "all avoidable and non-essential expenditure on establishment and administration", and the effect of that resolution in achieving an orientation of 60% of the regular budget towards technical cooperation,

REQUESTS the Director-General:

(1) to transfer 2% of the proposed regular budget from global and interregional activities to priority health programmes at country level, starting with the 1998-1999 programme budget, and to continue this practice for the subsequent four bienniums, in order to achieve a cumulative transfer of 10% of resources to countries in ten years;

(2) to ensure that the respective proposed programme budgets show from which programme areas the transfer has been effected;

(3) to report to the Forty-ninth World Health Assembly on steps taken in implementing this resolution.

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA48.25.

Dr LARIVIÈRE (Canada), supported by Mr VAN REENEN (Netherlands) and Ms O'SULLIVAN (Ireland), said that, although he had no objection to a reallocation of resources in support of country activities, during the Ninth General Programme of Work covering the period 1996-2001 WHO's performance would be assessed through the results achieved both in and by countries and the Organization, and the Executive Board had already been requested to undertake an in-depth review of regional and country allocations in connection with the broader reform process; by adopting the draft resolution at the present time, the Health Assembly would be pre-empting that fuller examination. The draft resolution should therefore be deferred until it could be considered by the Board in connection with the reform process.

Dr AL-SAIF (Kuwait) said that the sponsors had presented the draft resolution because there had been no real increase in the WHO budget in the past 10 years, while many developing countries had had to cope with their health problems in that period with shrinking financial and human resources. The sponsors considered that the reallocation of 2% of the proposed regular budget from global and interregional activities to priority health programmes at country level, rather than to regional offices, would enable the countries concerned to improve their health conditions. The proposal had been approved by ministers of health of the Movement of Non-Aligned Countries, and his delegation therefore appealed to the Health Assembly to adopt the draft resolution.

Mr AITKEN (Assistant Director-General) said it was difficult to select the basis for the transfer figure of 2% - which in any event was somewhat arbitrary in nature - when there was no overall guidance in respect of priority-setting; that would come from the review of the health-for-all strategy, as well as from the Executive Board, which for the first time for many years had the subject of regional allocations on the agenda for its forthcoming session. However, certain countries clearly felt that some reallocation of resources was needed urgently. It was worth bearing in mind that the Organization had important constitutional and normative obligations.

Dr YACOUB (Bahrain), supported by Dr AMMAR (Lebanon), associated himself with the appeal made by the delegate of Kuwait, and called for a vote on the draft resolution.

Dr BOUFFORD (United States of America) joined those supporting the linkage of the draft resolution with the Executive Board's review of regional allocations. During its ninety-fifth session the Board had expressed strong support for moving resources to the country level to the greatest extent possible, and had stressed the need for a strong basis for allocations to regions and countries. In her view, the intent and desire of the sponsors of the draft resolution was in the spirit in which the Board would be considering regional and country allocations at its forthcoming session.

Dr LARIVIÈRE (Canada) said that his delegation was not opposing the draft resolution, and certainly would not wish to make it the subject of a vote; it was important that it should be adopted by consensus. However, the draft resolution covered a period of 10 years, and within that period there might be a desire to transfer more of the overall budget to countries. It might not be in anyone's interest to be locked into a mathematical formula on the issue.

Dr BOUFFORD (United States of America) suggested that a drafting group should be established to try to find a way of satisfying the concerns and sense of urgency of the sponsors of the draft resolution, and to link it to the approach that the Board was adopting.

Dr YACOUB (Bahrain) and Dr AMMAR (Lebanon), in reply to a question by the CHAIRMAN, agreed with the proposal to establish a drafting group (see section 8, below).

3. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 32 of the Agenda (continued)

Establishment of the joint and cosponsored United Nations programme on HIV/AIDS: Item 32.2 of the Agenda (Resolutions WHA46.37, EB93.R5 and EB95.R13; Documents A48/34 and Add.1) (continued from the seventh meeting)

The CHAIRMAN drew the attention of the Committee to the draft resolution entitled "Establishment of the joint and cosponsored United Nations programme on HIV/AIDS ("UNAIDS")", as amended by a drafting group, which read as follows:

The Forty-eighth World Health Assembly,

Stressing the increasingly grave implications of the HIV/AIDS epidemic for health and the provision of adequate and appropriate health services, as well as for many other economic and social sectors;

Recalling that resolution EB93.R5 recommends the development and establishment of a joint and cosponsored United Nations programme on HIV/AIDS ("UNAIDS") administered by WHO, in keeping with the consensus option as presented in the report of the Director-General on this issue;

Further recalling that resolution EB95.R13 requests the Director-General to pursue efforts towards establishing the programme;

Having examined the report of the Director-General on progress to this end;

Welcoming the endorsement of the programme's establishment by the governing bodies of the other cosponsoring organizations;

Taking note of resolution 1994/24 adopted by the Economic and Social Council at its July 1994 session;

Considering the support given to the programme in the Declaration of the Paris AIDS Summit;

Taking note of the report of the Committee of Cosponsoring Organizations to the Economic and Social Council;

Welcoming the appointment of an Executive Director for the programme, with effect from 1 January 1995;

Aware of the urgent need to proceed with the establishment of the programme in order to ensure that it is fully operational by 1 January 1996;

Considering that the programme must play a central normative and coordinating role in the development, at national and global levels, of common strategies whose activities concerning HIV/AIDS will be supported by the cosponsoring organizations;

Recognizing that substantial capacity has been built up within WHO to respond to the HIV/AIDS epidemic, primarily through its Global Programme on AIDS;

Reaffirming the importance of the role of the national authorities as principal coordinators of national response to the HIV/AIDS epidemic;

Stressing that an important function of the programme will be to strengthen national capacities to plan, coordinate, implement and monitor the overall response to HIV/AIDS;

Welcoming the progress made towards establishing the joint United Nations programme on HIV/AIDS,

1. ENDORSES the establishment of UNAIDS, to which WHO will provide the administrative framework as described in the report of the Director-General;[1]

2. ENCOURAGES UNAIDS to promote the development of the basic elements of a common message for HIV/AIDS prevention, care and health education which considers the different social and cultural contexts of Member States;

[1] Document A48/34.

3. URGES Member States elected to the Programme Coordinating Board (PCB) of UNAIDS to consider the importance of maintaining public health experience and expertise on HIV/AIDS/STD when selecting their representatives to PCB;

4. URGES Member States to pursue in the respective governing bodies of cosponsoring organizations the provision to the programme of financial support from their regular/core budget, as well as staff support in accordance with the requirements of the programme;

5. REQUESTS the Director-General:
(1) to facilitate implementation of the programme in accordance with resolutions EB93.R5 and EB95.R13, taking into account the report of the Committee of Cosponsoring Organizations to the Economic and Social Council;
(2) to provide administrative support to the Executive Director of the programme and his staff during the transition period and to arrange for WHO to meet the administrative needs of the programme once it is operational, in the light of the Organization's role as administering agency;
(3) to provide the programme with financial support from the regular budget of WHO and with staff support;
(4) to give the WHO Representatives the necessary instructions to ensure close collaboration at country level with the other cosponsoring organizations;
(5) to ensure continuation of the work of the Global Programme on AIDS during the period of transition until the joint programme is fully operational;
(6) to ensure that strategies are developed, in close collaboration with UNAIDS, for integrating HIV/AIDS/STD into the work of WHO;
(7) to report on progress made towards establishment of the programme to the Forty-ninth World Health Assembly in May 1996.

Mr VAN REENEN (Netherlands) said that, although his delegation had cosponsored the initial draft, it was not able to cosponsor the present version. Apart from a few minor editorial changes it was concerned mainly about the substance of the amended text of paragraph 3 with its emphasis on the importance of maintaining public health experience and expertise on HIV/AIDS/sexually transmitted diseases when Member States selected their representatives on the Programme Coordinating Board, since that would lead to its becoming a technical body rather than one responsible for the management and establishment of policies. Such emphasis on public health experience and expertise would be perceived as a denial of the multisectoral nature of the fight against HIV/AIDS and of UNAIDS itself. Nevertheless, his delegation would support the approval of the draft resolution, as amended.

The CHAIRMAN said that the sponsors of the draft resolution were Algeria, Argentina, Australia, Austria, Belgium, Bhutan, Botswana, Brazil, Bulgaria, Burkina Faso, Cambodia, Cameroon, Canada, Central African Republic, Chile, China, Congo, Côte d'Ivoire, Croatia, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Ghana, Greece, Guinea-Bissau, Iceland, India, Ireland, Italy, Japan, Kenya, Kiribati, Lao People's Democratic Republic, Luxembourg, Madagascar, Malawi, Maldives, Mali, Mauritius, Morocco, Nepal, New Zealand, Niger, Norway, Oman, Palau, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Romania, Russian Federation, Rwanda, Saudi Arabia, Senegal, Singapore, Slovakia, South Africa, Spain, Sri Lanka, Swaziland, Sweden, Switzerland, Thailand, Togo, Tonga, United Kingdom of Great Britain and Northern Ireland, and United States of America.

The draft resolution was approved.[1]

(For continuation of the discussion on collaboration with other organizations, see section 6 below.)

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA48.30.

4. IMPLEMENTATION OF RESOLUTIONS (PROGRESS REPORTS BY THE DIRECTOR-GENERAL): Item 19 of the Agenda

Global strategy for the prevention and control of AIDS (Resolutions WHA40.26, WHA41.24, WHA42.33, WHA42.34, WHA45.35 and EB95.R14; Document A48/14)

The CHAIRMAN drew attention to the draft resolution entitled "Paris AIDS Summit" proposed by the Executive Board in resolution EB95.R14.

Ms LOBBEZOO (Netherlands), commenting on document A48/14, said that it described interesting developments, such as the preparation in Ghana of a handbook on integrating AIDS care into district health services. However, there was no mention of the International Conference on Population and Development or of reproductive health. HIV/AIDS and sexually transmitted diseases were serious threats to reproductive health, and WHO had a responsibility to devise integrated measures against them. She welcomed the reference to human rights and strongly supported the intent to combat discrimination.

Mrs FLEMING (United States of America) drew attention to paragraph 31 of the document, which referred to the work on the development of effective vaginal microbicides carried out by an interagency working group, and to sexually-transmitted-disease prophylactic measures among women, and asked for further information on that work, which would be a significant contribution to AIDS prevention in women. She particularly appreciated the information on human rights activities mentioned in paragraph 48, and called upon UNAIDS to make human rights a high priority in its new strategy. As one of the participants in the Paris AIDS Summit, her Government was endeavouring to implement the recommendations made at that Summit and to put into practice the principles embodied in the Paris Declaration. She drew attention, in particular, to the need for greater involvement of people "living with" HIV/AIDS, international, national and community-based nongovernmental organizations, in responding to the epidemic. In the United States, the involvement of such people and organizations in the decision-making process was rejuvenating care and prevention that had been previously too remote from the people served. There was a particular need to mobilize organizations assisting children and young people, since large numbers of them were, if not infected, otherwise affected by the epidemic. The empowerment of women and the elimination of adverse cultural, economic and social factors, would help to reduce their vulnerability to HIV/AIDS. They should also be involved as full participants in all decision-making processes which concerned them. Sexism, racism and homophobia were all as much cofactors in HIV infection as any medical condition.

She pledged her country's continued collaboration with GPA and UNAIDS and supported the draft resolution.

Mr DEBRUS (Germany) proposed that, in the fourth preambular paragraph of the draft resolution, the words "vulnerability of women" should be changed to "the reduction of the vulnerability", in keeping with the Paris Declaration.

Dr HU Ching-Li (Assistant Director-General), replying to the delegate of the Netherlands, said that document A48/10 specified that GPA, the Special Programme of Research, Development and Research Training in Human Reproduction, and Family Health were the three principal programmes concerned with reproductive health. He agreed that it would be appropriate to integrate the prevention and control of HIV/AIDS and sexually transmitted diseases into reproductive health programmes.

Dr BERTOZZI (Global Programme on AIDS) reassured the delegate of the United States of America that the development of female-controlled methods of HIV/AIDS prevention, especially microbicides, was a priority, and GPA's Clinical Research and Product Development unit was currently facilitating coordination with organizations supporting research in that area. A safety study of a vaginal microbicide containing a low dose of the spermicide nonoxynol-9, which had been tested in Europe, had just been completed in collaboration with researchers in Thailand, and a safety trial for multiple-dose application was being developed. Multiple-site efficacy trials were also proposed in Thailand, and preparation of a similar protocol was being undertaken with investigators in Côte d'Ivoire. Other groups in different countries were evaluating

different products. The unit previously referred to was also working with industry to encourage novel approaches to vaginal microbicides.

Professor GIRARD (France) said that the Paris Summit had clearly shown that measures against AIDS were the responsibility above all of politicians. If they failed to give their full support to the scientific community, the resources that it would be possible to devote to the fight against AIDS would never be enough, whatever the results of research or the efforts of health professionals. AIDS was too complex a matter for other sectors not to be involved but it should not be forgotten that it was a health problem. The transition from GPA to UNAIDS implied a sharing, not a transfer, of responsibilities, and coordination. That transition must be effected as quickly as possible in the interest of those with AIDS.

The draft resolution recommended by the Executive Board in resolution EB95.R14, as amended, was approved.[1]

5. SECOND REPORT OF COMMITTEE B

Dr EL KALA (Egypt), Rapporteur, read out the draft second report of Committee B.

The report was adopted.[2]

6. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 32 of the Agenda (resumed)

Health assistance to specific countries: Item 32.6 of the Agenda (Document A48/38)

The CHAIRMAN invited the Committee to consider the draft resolution entitled "Collaboration within the United Nations system and with other intergovernmental organizations: Health assistance to specific countries", proposed by the delegations of Algeria, Bahrain, Cyprus, Democratic People's Republic of Korea, Greece, India, Kuwait, Lebanon, Lesotho, Morocco, Oman, Qatar, Seychelles, Solomon Islands, Sudan, Swaziland, Syrian Arab Republic and United Arab Emirates, which read as follows:

> The Forty-eighth World Health Assembly,
>
> Recalling and confirming the previous resolutions of the Health Assembly on health assistance to specific countries, the most recent being resolution WHA47.28, which includes reference to earlier resolutions WHA44.37 (Health and medical assistance to Lebanon); WHA44.38 (Health assistance to refugees and displaced persons in Cyprus); WHA44.39 (Assistance to Lesotho and Swaziland); WHA44.40 (Reconstruction and development of the health sector in Namibia); and WHA44.43 (Health and medical assistance to Somalia);
>
> Noting the increasing number of countries and areas stricken by natural and man-made disasters and the subsequent numerous reports submitted for discussion during the Health Assembly;
>
> Taking note of United Nations General Assembly resolution 46/182, "Strengthening of the coordination of humanitarian assistance of the United Nations";
>
> Recalling resolution WHA35.1 on method of work of the Health Assembly, which draws attention to the desirability of a full discussion at regional level of all matters dealing with specific countries before such items are referred to the Health Assembly, and the recent decision on this matter by the Regional Committee for the Eastern Mediterranean (resolution EM/RC39/R.11),

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[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA48.27.

[2] See page 277.

1. EXPRESSES its appreciation to the Director-General for his continued efforts to strengthen the Organization's capacity to respond promptly and efficiently to country-specific emergencies;

2. URGES the Director-General to continue to give high priority to countries mentioned in the above resolutions and to coordinate these and other WHO efforts in emergency preparedness and humanitarian assistance with the humanitarian affairs programmes of the United Nations system, including mobilization of extrabudgetary resources;

3. CALLS UPON the Director-General to report to the Forty-ninth World Health Assembly on the implementation of this resolution.

Ms KIZILDELI (Turkey) recalled that the Health Assembly had adopted resolution WHA48.2 entitled "Emergency and humanitarian action", in which reference was made to resolution WHA47.28 on collaboration within the United Nations system and with other intergovernmental organizations, as well as to resolutions 46/182 and 48/57 of the General Assembly of the United Nations on strengthening of the coordination of humanitarian assistance of the United Nations. In its operative paragraphs, resolution WHA48.2 called for measures to strengthen WHO's capacity to respond to country-specific emergencies. It was therefore similar in nature to the draft resolution before the Committee and her delegation considered that such duplication was unnecessary.

Some of the emergency situations which had led to the adoption of the resolutions mentioned in the draft resolution no longer existed; in that context, she referred to the situation in Cyprus. She doubted that the Greek Cypriot administration was entitled to a share of the emergency and humanitarian assistance taken from the scarce extrabudgetary resources raised with great difficulty by WHO. With its annual per capita GNP of US$ 9820, its life expectancy at birth of 74.6 years for males and 79.1 years for females and an infant mortality rate of nine per 1000 live births, the Greek Cypriot community simply did not qualify for such assistance.

Furthermore that administration had no right to claim assistance for the whole of the island, as had been stressed in a letter from the Minister of Foreign Affairs of the Turkish Republic of Northern Cyprus to the Director-General prior to the Forty-eighth World Health Assembly. Although her country appreciated the efforts made by WHO to include the Turkish Cypriot community in its activities, it felt that those efforts had always fallen short of the community's requirements in view of the fact that it was confronted with an unacceptable economic blockade by the Greek Cypriot administration. The total financial contribution provided by WHO in 1994 to the Turkish Cypriot community had been slightly over US$ 3000 - a sum which it could easily do without.

It should be borne in mind that the draft resolution not only constituted a duplication, but also a morally unjustifiable attempt to appropriate scarce resources.

Mr MACRIS (Cyprus) said that it had been the consistent policy of his Government to use international assistance for the benefit of the Cypriot population as a whole, despite the continued occupation of a part of the territory. The Turkish Cypriot community benefited to a considerable extent from WHO assistance, as indicated in paragraph 17 of document A48/38.

Health assistance was a humanitarian matter and ought not to be used as an instrument for promoting political objectives. The Turkish Government was in favour of international aid being provided directly to the illegal regime in the occupied area, as a means of obtaining recognition of the secessionist entity, whereas a score of United Nations General Assembly resolutions on Cyprus had stressed the latter's sovereignty and territorial integrity.

With regard to assistance to refugees and displaced persons in Cyprus, he drew attention to the fact that, if large numbers of Turkish Cypriots did not benefit from WHO's assistance, that was because they were prevented by the Turkish army from visiting the medical centres situated in government-controlled areas. Medical facilities in the occupied area had been supplied with electrical energy free of charge by the Cypriot Government from 1974 onwards.

The complaints of the Turkish delegate about health assistance to the Turkish community in Cyprus were therefore unfounded; only the reunification of Cyprus could overcome the obstacles and rehabilitate that community. Expressing the hope that WHO would continue to provide assistance to the refugees and

displaced persons in Cyprus, he called for the approval of the draft resolution, which was now cosponsored by a further seven countries, namely, Egypt, Islamic Republic of Iran, Jamaica, Kenya, Namibia, Saudi Arabia and Zimbabwe.

Mr QUAUNINE (Bangladesh) expressed his appreciation for WHO's health assistance to specific countries, as reflected in document A48/38. Bangladesh, as a country often struck by natural disasters, had to cope with the burden of the subsequent impact on public health, including frequent outbreaks of epidemics. Delegations at the Forty-fourth World Health Assembly, recognizing the special situation of Bangladesh as a disaster-prone country, had unanimously adopted resolution WHA44.41.

His country strongly supported the draft resolution before the Committee but wished to propose a minor amendment, namely to add a reference to resolution WHA44.41 at the end of the first preambular paragraph. If that amendment was accepted, Bangladesh wished to be included as a sponsor of the draft resolution.

Dr JARDEL (Assistant Director-General) pointed out that the draft resolution before the Committee was not in fact a duplication of the one already adopted by the Health Assembly as resolution WHA48.2. The objective of document A48/38 and the draft resolution referring to it was to provide information on WHO's response to earlier resolutions in regard to specific countries as well as to invite the Director-General to give high priority to those activities.

To accommodate the proposal of the delegate of Bangladesh, the words "and also resolution WHA44.41 (Emergency relief for Bangladesh)" could be added to the first preambular paragraph.

The CHAIRMAN said that, in the absence of any further comments, he took it that the Committee wished to note document A48/38.

It was so decided.

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

7. PERSONNEL MATTERS: Item 29 of the Agenda (continued)

Recruitment of international staff in WHO: biennial report: Item 29.1 of the Agenda (Resolutions WHA46.23, WHA46.24, EB93.R17 and EB95.R19) (continued from the sixth meeting, page 224)

The CHAIRMAN said that discussion of the draft resolution recommended in resolution EB95.R19 had been completed. In answer to a query by Mr DEBRUS (Germany), he confirmed that the latter's proposed amendment had been accepted.

The draft resolution, recommended by the Executive Board in resolution EB95.R19, as amended, was approved.[2]

The CHAIRMAN invited the Committee to consider the following draft resolution entitled "Recruitment of international staff in WHO: Global leadership", proposed by the delegations of Namibia and Zambia, which read as follows:

> The Forty-eighth World Health Assembly,
> Aware of the charges of racism levelled against the current Director-General;

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA48.31.

[2] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA48.28.

Concerned about the negative effects of such charges on the nature of future cooperation with developing countries particularly in Africa, South Asia and the Caribbean;

Recognizing that the Director-General, while not repudiating the charges, nevertheless regrets the remarks assigned to him;

Further recognizing that the effectiveness of the Director-General to be a world health leader will be necessarily limited in the future with adverse effects on the leadership role of the Organization;

Aware that other organizations and agencies are already usurping the legitimate role of the World Health Organization to be the coordinating and directing authority in international health matters;

Convinced that the damage to the Organization must be limited at all costs,

1. REQUESTS the Director-General to relinquish his responsibilities on 21 July 1996 and permit a new, duly elected Director-General to assume such responsibilities thereafter;

2. FURTHER REQUESTS the Director-General to set in motion the process of nomination of such a new Director-General by the ninety-seventh session of the Executive Board in January 1996 to be confirmed by the Forty-ninth World Health Assembly;

3. APPOINTS him as Director-General Emeritus as of 21 July 1996 with all privileges appertaining thereto;

4. DECIDES to maintain the privileges of the present Director-General until 20 July 1998;

5. THANKS the present Director-General for the services he has rendered to the Member States during his long career with the Organization.

Dr IYAMBO (Namibia), introducing the draft resolution, said that the cosponsors were deeply concerned about the image of WHO which, in recent years, had been plagued by a combination of unfortunate factors, including loss of credibility; relinquishment of important tasks; a financial crisis resulting from non-payment by Member States of assessed contributions to the WHO regular budget; cuts in extrabudgetary funding to certain key WHO programmes by some donor countries, as well as racial slanders which had been associated with senior management within the Organization.

The constitutional mandate of WHO as the directing and coordinating authority on international health work, simultaneously responsible for establishing effective collaboration with the organizations of the United Nations system, governments and professional groups, was widely recognized and universally respected. However, in view of the current leadership, its role had been called in question several times in the recent past and it was doubtful whether WHO would in future be in a position to fulfil that mandate.

The Director-General, while enjoying wide respect as a public health professional, had not succeeded in providing the desired and expected leadership. The consequences of that inability had been clearly expressed at the beginning of his statement, although the latter ought not to be in any way interpreted as challenging the country of origin. On the contrary, his country enjoyed cordial and friendly relations with all countries, and the resolution should be seen in that light.

Coming from a part of the world that had suffered from colonialism, social hardships and racism for far too long, he wished to state that it was a constitutional principle in Namibia not to condone racism anywhere in the world.

He proposed that any vote taken on the resolution or procedural matters related thereto should be by secret ballot.

Mr SATA (Zambia) seconded the proposal and reserved the right to speak later.

Dr STAMPS (Zimbabwe) began by quoting a passage from the lamentations of Jeremiah in the Old Testament which referred to the suffering of a people who received no comfort and were left destitute when the enemy prevailed and its allies had betrayed it.

While the number of African staff at professional level at WHO headquarters was reported by the Director-General to have been increased from 27 to 36 since he had taken office, the total number of

discretionary posts - in grade P6 and above - had increased from 66 in 1988 to 114, indicating that Africans had been seriously discriminated against with respect to career opportunities. There was increasingly persuasive evidence of racism and economic preference rather than appropriate experience and ability in the selection of persons for senior positions. African officers did not serve in regions other than the African Region, while in the latter there were officers from all the other regions.

The issue of personnel was of paramount importance because WHO's principal role in health was advocacy. Its technical advisory role depended entirely on staff activities. Some programmes had collapsed for want of the right personnel, and some extrabudgetary programmes seemed to be at the discretion of the donor in terms of both input and agenda. The attempts to establish what had been called a "new paradigm for health" had floundered in a maze of incomprehension, with the result that sectional interests, such as those of certain multinationals, had been able to take advantage of the confused and sometimes contradictory advice of the Organization on essential international health issues such as AIDS and the control of diarrhoeal diseases. Another negative indicator was the number of staff disputes and the increasing number of tribunal findings in such cases against WHO.

All those developments showed a failure of management and directorship of an organization which was regarded in Africa as one of the most important bastions against neo-servitude - the new slavery which was the current policy of the developed world towards the African people. It appeared to Africans that there was to be no end to its 3000 year history of slavery. It was incomprehensible to Africans that there was thought to be nobody in Africa capable of running the Global Programme on AIDS or the water and sanitation initiative.

He had been astonished to hear a head of a European delegation state that his country could cope quite well without WHO but that it was essential for Zimbabwe. That that delegate had apparently taken umbrage at his own suggestion that on purely selfish grounds affluent western countries needed to make sure that their tourists and entrepreneurs were protected from health risks in African countries indicated that he had perhaps been victim of the same lack of ability to adapt to the local culture and the problem of language attributed by the Director-General to the African staff, whom he had insulted on 21 January 1995 with direct remarks during the review and evaluation of the programme on human resources for health. International cooperation in health was as essential today as it had been in 1892 when the first International Sanitary Convention had been adopted in Paris.

He regretted that the debate on those fundamental issues under agenda item 22 had been guillotined. WHO's response to global change diverted attention from the receding hope of WHO's fulfilling its pledge for health for all by the year 2000; meanwhile, it failed to secure support for budgetary allocations for urgent needs in the African Region relating to such problems as tuberculosis, vaccine-controllable diseases and the poor health of women. The vultures were circling the ailing body of WHO. WHO had acquiesced in the dilution of its AIDS strategy, and in nutrition it took an International Conference on Nutrition to provoke a reaction from the Organization. WHO relied on UNICEF activities to promote the iodization of salt.

In that context effective leadership was paramount. Although the current Director-General was politically astute and well-connected, he lacked credibility and the capacity to effect change. It was difficult for him to bring about major change after so long a term in office. The Director-General appeared to fail to comprehend that beyond command and control, leadership required vision and the ability to motivate people to achieve it.

There had never been so much pressure and so many personal approaches on matters of internal politics in the Organization. The African countries had also been subjected to innuendo alleging, for instance, that contracts had been awarded as an inducement to voting in a particular way during the re-election of the Director-General, or that "all" African countries had supported the Director-General's re-election, as though Africa were an insignificant, homogeneous group to be manipulated. During the current Health Assembly, the African countries had established their sovereign right to express themselves without external pressure and also the right to vote according to conscience. The issues of credibility, transparency and accountability in WHO must now be faced squarely. Zimbabwe supported the draft resolution and commended it to other Member States for serious consideration.

Mr MSWANE (Swaziland) said that as an African he saw the Director-General's remarks as having been directed against Africa. The management and leadership style in WHO inevitably affected the health status of the population of the countries represented at the Health Assembly. It was the duty of anyone who

had made a mistake, by commission or omission, to correct it unconditionally, especially when his or her attention had been drawn to it.

Anyone in a position of leadership must accept the remitting responsibility. The leadership of the United Nations organizations should uphold and reflect the fundamental aims of the Charter of the United Nations. He trusted that the outcome of the debate would serve as a warning to ensure better management of WHO, better geographical representation of staff, a better reflection of the fundamental principles of the United Nations, and, most important of all, a better health delivery system that would reach the most affected areas and regions where the population looked up to WHO as its best hope.

Mr DABIRÉ (Burkina Faso) said that his delegation would reserve its position on the Director-General's technical competence until it had all the evidence to form an opinion.

Like all other African Ministers of Health present at the current session of the Health Assembly, he had subscribed to the statement made by the delegation of Zimbabwe at the opening meeting expressing indignation at the Director-General's remarks regarding the competence and skills of Africans working for the Organization. Likewise, Burkina Faso had subscribed to the decision to send a letter to the Director-General stating the position of the African Ministers of Health on that issue. Those representations had been intended to close the case, taking note of the Director-General's repeated apologies. That approach had been the course of wisdom dictated by the need to concentrate on the future of the continent and its grave health problems. As the Ministers had stated in their declaration of 5 May addressed to the Director-General, Africa must be given priority to reduce health disparities, further efforts should be made to mobilize the international community on behalf of the African continent, and the African Region should be more equitably represented at the strategic and decision-making levels of Organization. Burkina Faso had taken note of the Director-General's firm intention to implement the measures proposed by the African Ministers and to report to them at the Forty-ninth World Health Assembly. It therefore abided by the consensus and the common position adopted by the Ministers of Health of the African group and, while respecting the initiative of the sponsors of the draft resolution, was unable to associate itself with it, or to support it.

Professor OWONA (Cameroon) expressed surprise that an item on staff matters should have turned into what amounted to a motion of censure against the Director-General. The many congratulatory statements that had been heard during the Health Assembly's proceedings, many of them addressed to the Director-General, and now the severe indictment just heard suggested that hypocrisy prevailed. He also questioned the procedural propriety of the measures proposed in the draft resolution, requesting the resignation of the Director-General and at the same time proposing that he should remain in office and even be honoured.

On the subject of the comments made by the Director-General, the whole of Africa had been insulted. That had been followed by an important consensus declaration by African Ministers of Health, and the Director-General had responded by apologizing on three occasions, recognizing his mistakes and committing himself to taking certain steps. Cameroon stressed the need for recruitment at WHO to be effected on an equitable basis, having due regard for WHO's rules and regulations, which meant that Africa, especially sub-Saharan Africa, should be adequately represented; and for priority to be given to African programmes.

In conclusion, he appealed to those who had spoken in favour of the draft resolution, who had just emerged from the liberation struggle and whose concerns he could well understand, to act in a spirit of conciliation and forgiveness, to take note of the apologies given, and to consider that the matter was settled.

Dr FIO-NGAINDIRO (Central African Republic) said that he associated himself with the two previous statements and adhered to the consensus that had been reached at the time of the debate on relations between the Director-General and the African Region.

Mr NGOM (Senegal) said that Senegal's position was quite clear. There seemed to be an attempt to push through a resolution on a matter which should be handled democratically according to the proper procedures, allowing for the person charged to present his case and for all the evidence to be adduced in order to assess the full facts of the case. It was not a matter that could be dealt with in haste.

As previous speakers had said, Africa as a whole was concerned, and no one could fail to be shocked when an African, or indeed any human being was the victim of discrimination or racism. In the case in question, the African group had officially and formally made representations to the Director-General, who

had equally officially replied to the African group, committing himself to taking a number of measures within specified deadlines. It could be considered, therefore, that the issue had been properly addressed; the Director-General should be judged on the results achieved within that time-limit, at which point conclusions could be drawn. Until the necessary procedures for verifying the accuracy of the charges laid had been exhausted, it was premature to attempt to secure the adoption of a draft resolution seeking the Director-General's forcible removal from office. Senegal was unable, therefore, to associate itself with the draft resolution, wished to abide by the consensus decision adopted by the African group and called upon the cosponsors to do likewise.

Mr SATA (Zambia) reminded delegates that he had been in parliament for over 10 years and parliament did not accept the contents of private discussions as something binding. He pointed out that the African consultative meeting had no legal authority in WHO, and that the letter written to his colleague from Burkina Faso had not been addressed to the African Ministers, but written to one man. However, he had heard about it, and understood that it was meant for other African States.

He stated that the resolution proposed was not directed against an individual; no African was in the running for the post of Director-General. The matter was regarded as an African issue, and he thought absence of opposition from elsewhere would mean overwhelming support for the resolution. If a secret vote were held the consequences would become evident.

Discrimination on grounds of colour was a serious offence, punishable even by death in some countries. If an Englishman criticized his English, he would forgive him because the Englishman had been the teacher of his own language. However, he took strong offence when someone who was in the same situation with regard to the language criticized him.

Africans were known for their kindness and conciliation. They forgave but they did not forget. He reminded delegates that 500 years ago Africans had been transported from Africa, packed like sardines, and there had never been any compensation. During the First and Second World Wars there had been discrimination in that Africans could not reach a rank higher than non-commissioned officer (NCO); the highest had been a Regimental Sergeant Major. After 1945 the Africans had got nothing, and the division had become even more apparent.

Yet it was the Africans who were now demonstrating democratic principles in objective discussion of the resolution. It was not a simple one, since it had political implications for WHO, the United Nations and all other international organizations. If there were a vote and it were lost it would appear that the Health Assembly endorsed racism; if the Assembly condemned racism, even if it did not vote to remove the Director-General himself, it would avoid having to alter the Constitution.

He was very concerned, since equitable representation and responsibility could not be expected for those of whom it had been said that they were unable to write, edit or adapt culturally. That was the issue at stake. This time the discrimination had been against Africans; against others it might have caused a tremendous fuss in the western world.

On the question of recruitment of international staff it had not been mentioned how many of the professional 65 women were African or black. To insist would also be discriminatory. Discrimination was like a cancer. As the Director-General had never before faced the anger of the Africans directly, his offence could be regarded as a first offence and he might be given the benefit of the doubt.

The current Committee meeting, unlike the private meetings of the African group, would remain on record for generations to come. He had not received a copy of the correspondence with Burkina Faso, and that in itself might be considered discriminatory, although all Africa would have heard about it.

No one had objected formally to the resolution, and thus its purpose had been achieved; he would withdraw it subject to the agreement of the other sponsor.

Dr IYAMBO (Namibia) agreed.

The CHAIRMAN asked if there were any further comments on the subject of the draft resolution.

Mr SATA (Zambia), rising to a point of order, said that since the resolution had been withdrawn that would be inappropriate.

Mr VIGNES (Legal Counsel) confirmed that was legally correct.

Mr DABIRÉ (Burkina Faso), exercising his delegation's right of reply, said that the delegate of Zambia had misunderstood his position; as representative of Burkina Faso at the session in 1994 of the Regional Committee for Africa he had been Vice-Chairman, and it was in that capacity that he had chaired meetings of the African group and handled correspondence on behalf of African Ministers of Health.

8. PROPOSED PROGRAMME BUDGET FOR THE FINANCIAL PERIOD 1996-1997: Item 18 of the Agenda (resumed)

GENERAL REVIEW:[1] Item 18.2 of the Agenda (Documents PB/96-97, A48/17 and Corr.1 and Corr.2, A48/17 Add.1, A48/INF.DOC./7 and EB95.58) (resumed)

The CHAIRMAN drew attention to the revised draft resolution on "reorientation of allocations" prepared by a drafting group, and invited Mr Aitken to read out the new text.

Mr AITKEN (Assistant Director-General) did so, giving the assurance that it could be approved in written form later when the Committee considered its final report. The two proposed amendments to the draft resolution were as follows: the operative paragraph should begin:

REQUESTS the Executive Board and the Director-General ...

Subparagraph (1) should read:

(1) to initiate as part of the process of budgetary reform, a process of biennial budgetary transfers from global and interregional activities to priority health programmes at country level, in the context of priorities recommended by the Board, starting with a 2% transfer in the 1998-1999 programme budget, and to regularly review this need in every biennium in order to achieve maximum transfer of resources to priority health programmes at country level;.

The draft resolution, as amended, was approved.[2]

The meeting rose at 12:30.

[1] Taken in conjunction with item 19, Implementation of resolutions (progress reports by the Director-General).

[2] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA48.26.

NINTH MEETING

Friday, 12 May 1995, at 9:00

Chairman: Professor A. WOJTCZAK (Poland)

1. THIRD REPORT OF COMMITTEE B

Dr EL KALA (Egypt), Rapporteur, read out the draft third report of Committee B, contained in document A48/54.

The report was adopted.[1]

2. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 9:25.

[1] See page 277.

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 WHA48/1995/REC/1. The verbatim records of plenary meeting at which these reports were approved are reproduced in document WHA48/1995/REC/2. Summary records of the meetings of the General Committee, Committee A and Committee B appear in this volume.

COMMITTEE ON CREDENTIALS

First report[1]

[A48/47 - 3 May 1995]

1. The Committee on Credentials met on 2 May 1995. Delegates of the following Member States were present: Bahrain, Belize, Bulgaria, Comoros, Eritrea, Finland, Malta, Mauritania, Pakistan, Peru, Sri Lanka, Tuvalu.

2. The Committee elected the following officers: Mr A. S. Chaudhry (Pakistan) - Chairman; Mr Sennay Kifleyesus (Eritrea) - Vice-Chairman; Mr J. Sormunen (Finland) - Rapporteur.

3. The Committee examined the credentials delivered to the Director-General in accordance with Rule 22 of the Rules of Procedure of the World Health Assembly.

4. The credentials of the delegates of the Member States shown in the list at the end of this report were found to be in conformity with the Rules of Procedure; the Committee therefore proposes that the Health Assembly should recognize their validity.

5. The Committee examined notifications from the Member States listed below, which, while indicating the names of the delegates concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee recommends to the 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: Angola, Armenia, Bosnia and Herzegovina, Canada, Djibouti, Equatorial Guinea, Iran (Islamic Republic of), Ireland, Latvia, Lithuania, Mali, Philippines, Republic of Moldova, Sierra Leone, Sweden, Uzbekistan, Vanuatu.

States whose credentials it was recommended should be recognized as valid (see paragraph 4 above)

Afghanistan; Albania; Algeria; Argentina; Australia; Austria; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Cape Verde; Central African Republic; Chile; China;

[1] Approved by the Health Assembly at its fifth plenary meeting.

Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Denmark; Dominican Republic; Ecuador; Egypt; El Salvador; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Guatemala; Guinea; Guinea-Bissau; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iraq; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Malta; Mauritania; Mauritius; Mexico; Micronesia, Federated States of; Monaco; Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Paraguay; Peru; Poland; Portugal; Qatar; Republic of Korea; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Samoa; San Marino; Saudi Arabia; Senegal; Seychelles; Singapore; Slovakia; Slovenia; Solomon Islands; South Africa; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Switzerland; Syrian Arab Republic; Thailand; The Former Yugoslav Republic of Macedonia; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Venezuela; Viet Nam; Zaire; Zambia; Zimbabwe.

Second report[1]

[A48/51 - 5 May 1995]

1. The Committee on Credentials met on 5 May 1995, under the chairmanship of Mr A. S. Chaudhry (Pakistan). Mr J. Sormunen (Finland) was Rapporteur. Delegates of the following Members were present: Bahrain, Belize, Bulgaria, Comoros, Finland, Malta, Mauritania, Pakistan, Peru, Tuvalu.

2. The Committee examined the formal credentials of the delegates of Angola, Armenia, Bosnia and Herzegovina, Canada, Djibouti, Ireland, Islamic Republic of Iran, Lithuania, Mali, Philippines, Republic of Moldova, Sierra Leone and Sweden, who had been seated provisionally in the World Health Assembly pending the arrival of their formal credentials. These credentials were found to be in conformity with the Rules of Procedure, and the Committee therefore proposes that the World Health Assembly recognize their validity.

3. The Committee examined the formal credentials of Sao Tome and Principe, and Yemen, which were found to be in conformity with the Rules of Procedure, and the Committee therefore proposes that the Health Assembly recognize their validity, thus enabling the delegations of Sao Tome and Principe, and Yemen to participate with full rights in the World Health Assembly.

4. The Committee also examined the notification from Azerbaijan, which, while indicating the name of the delegate concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee therefore recommends to the World Health Assembly that the delegate of Azerbaijan be provisionally seated with all rights in the Assembly pending the arrival of formal credentials.

[1] Approved by the Health Assembly at its eleventh plenary meeting.

Third report[1]

1. On 11 May 1995, in accordance with Rule 23 of the Rules of Procedure, a meeting was held of the Bureau of the Committee on Credentials, consisting of Mr A. S. Chaudhry (Pakistan) Chairman, Mr S. Kifleyesus (Eritrea) Vice-Chairman, and Mr J. Sormunen (Finland) Rapporteur.

2. The Bureau examined the formal credentials of the delegation of Equatorial Guinea who had been seated provisionally in the Health Assembly pending the arrival of their formal credentials. These credentials were found to be in conformity with the Rules of Procedure and the Bureau of the Committee therefore recommends that the Health Assembly recognize their validity.

COMMITTEE ON NOMINATIONS

First report[2]

[A48/40 - 1 May 1995]

The Committee on Nominations, consisting of delegates of the following Member States: Bhutan, Canada, Chad, Chile, China, Cook Islands, Cyprus, Democratic People's Republic of Korea, Djibouti, Ecuador, France, Ghana, Guinea, Jamaica, Lebanon, Namibia, New Zealand, Nicaragua, Qatar, Russian Federation, Sao Tome and Principe, Slovakia, South Africa, Turkey and the United Kingdom of Great Britain and Northern Ireland met on 1 May 1995. Dr P. Phillips (Jamaica) was elected Chairman.

In accordance with Rule 25 of the Rules of Procedure of the Health Assembly and respecting the practice of regional rotation that the Assembly has followed for many years in this regard, the Committee decided to propose to the Assembly the nomination of Dato Dr Haji Johar Noordin (Brunei Darussalam) for the Office of President of the Forty-eighth World Health Assembly.

Second report[2]

[A48/41 - 1 May 1995]

At its first meeting, held on 1 May 1995, the Committee on Nominations decided to propose to the Assembly, in accordance with Rule 25 of the Rules of Procedure of the Assembly, the following nominations:

Vice-Presidents of the Health Assembly: Mr C. Dabiré (Burkina Faso), Dr J. R. de la Fuente Ramírez (Mexico), Dr A. Marandi (Islamic Republic of Iran), Mrs I. Drobyshevskaya (Belarus), Mr Than Nyunt (Myanmar);

Committee A: Chairman - Dr Fatma H. Mrisho (United Republic of Tanzania);

Committee B: Chairman - Professor A. Wojtczak (Poland).

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[1] Approved by the Health Assembly at its twelfth plenary meeting.

[2] Approved by the Health Assembly at its second plenary meeting.

Concerning the members of the General Committee to be elected under Rule 31 of the Rules of Procedure of the Assembly, the Committee decided to nominate the delegates of the following 17 countries: Bolivia, Botswana, China, Cuba, France, Indonesia, Japan, Kenya, Malawi, Morocco, Mozambique, Oman, Panama, Russian Federation, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland and United States of America.

Third report[1]

[A48/42 - 1 May 1995]

At its first meeting, held on 1 May 1995, the Committee on Nominations decided to propose to each of the main Committees, in accordance with Rule 25 of the Rules of Procedure of the Assembly, the following nominations for the Offices of Vice-Chairmen and Rapporteur:

Committee A: Vice-Chairmen: Professor N. Fikri Benbrahim (Morocco) and Dr E. Nukuro (Solomon Islands); Rapporteur: Dr D. Hansen-Koenig (Luxembourg);

Committee B: Vice-Chairmen: Mr M. S. Dayal (India) and Dr J. E. Samoyoa (Honduras); Rapporteur: Dr H. El Kala (Egypt).

GENERAL COMMITTEE

Report[2]

[A48/52 - 8 May 1995]

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting held on 5 May 1995, the General Committee, in accordance with Rule 102 of the Rules of Procedure 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: Algeria, Argentina, Australia, Bahrain, Barbados, Bhutan, Brazil, Croatia, Egypt, Ireland, Republic of Korea, Zimbabwe.

In the General Committee's opinion these 12 Members would provide, if elected, a balanced distribution on the Board as a whole.

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[1] See summary records of the first meetings of Committees A and B (pp. 9 and 171).

[2] See document WHA48/1995/REC/2, verbatim record of the eleventh plenary meeting, section 6.

COMMITTEE A

First report[1]

[A48/50 - 8 May 1995]

On the proposal of the Committee on Nominations,[2] Professor N. Fikri Benbrahim (Morocco) and Dr E. Nukuro (Solomon Islands) were elected Vice-Chairmen, and Dr D. Hansen-Koenig (Luxembourg) Rapporteur.

Committee A held its first four meetings on 2, 3, 4, 5 May 1995 under the chairmanship of Dr Fatma H. Mrisho (United Republic of Tanzania) and its fifth meeting on 6 May 1995 under the chairmanship of Dr E. Nukuro (Solomon Islands).

It was decided to recommend to the Forty-eighth World Health Assembly the adoption of resolutions relating to the following agenda item:

19. Implementation of resolutions (progress reports by the Director-General)
    Emergency and humanitarian action [WHA48.2]
    Intensified cooperation with countries in greatest need [WHA48.3].

Second report[3]

[A48/55 - 12 May 1995]

Committee A held its fifth meeting on 6 May 1995 under the chairmanship of Dr E. Nukuro (Solomon Islands), its sixth and seventh meetings on 8 May 1995 under the chairmanship of Dr Fatma H. Mrisho (United Republic of Tanzania), its eighth and ninth meetings on 9 May 1995 under the chairmanship of Professor N. Fikri Benbrahim (Morocco) and Dr E. Nukuro (Solomon Islands), its tenth and eleventh meetings on 11 May 1995 under the chairmanship of Professor N. Fikri Benbrahim (Morocco) and Dr Fatma H. Mrisho (United Republic of Tanzania).

It was decided to recommend to the Forty-eighth World Health Assembly the adoption of resolutions relating to the following agenda items:

18. Proposed programme budget for the financial period 1996-1997
    18.2 General review
        Revision and updating of the International Health Regulations [WHA48.7]
        Reorientating medical education and medical practice for health for all [WHA48.8]
        Prevention of hearing impairment [WHA48.9]
19. Implementation of resolutions (progress reports by the Director-General)
    Reproductive health: WHO's role in the global strategy [WHA48.10]
    An international strategy for tobacco control [WHA48.11]

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[1] Approved by the Health Assembly at its eleventh plenary meeting.

[2] See the third report of the Committee on Nominations, above.

[3] Approved by the Health Assembly at its twelfth plenary meeting.

Control of diarrhoeal diseases and acute respiratory infections: integrated management of the sick child [WHA48.12]
Communicable diseases prevention and control: new, emerging, and re-emerging infectious diseases [WHA48.13].

Third report[1]

[A48/56 - 12 May 1995]

Committee A held its twelfth meeting on 12 May under the chairmanship of Dr Fatma H. Mrisho (United Republic of Tanzania).

It was decided to recommend to the Forty-eighth World Health Assembly the adoption of a resolution relating to the following agenda item:

18. Proposed programme budget for the financial period 1996-1997
    18.3 Financial review
        Proposed appropriation resolution for the financial period 1996-1997 [WHA48.32].

COMMITTEE B

First report[2]

[A48/48 - 6 May 1995]

Committee B held its first meeting on 3 May 1995 under the chairmanship of Professor A. Wojtczak (Poland). On the proposal of the Committee on Nominations,[3] Mr M. S. Dayal (India) and Dr J. E. Samoyoa (Honduras) were elected Vice-Chairmen and Dr H. El Kala (Egypt) Rapporteur.

It was decided to recommend to the Forty-eighth World Health Assembly the adoption of resolutions relating to the following agenda items:

21. Review of the financial position of the Organization
    21.1 Interim financial report on the accounts of WHO for 1994 and comments thereon of the Administration, Budget and Finance Committee [WHA48.4]
    21.2 Status of collection of assessed contributions and status of advances to the Working Capital Fund [WHA48.5]
    21.3 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution [WHA48.6].

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[1] Approved by the Health Assembly at its twelfth plenary meeting.

[2] Approved by the Health Assembly at its eleventh plenary meeting.

[3] See the third report of the Committee on Nominations, above.

Second report[1]

[A48/53 - 11 May 1995]

Committee B held its second to seventh meetings from 4 to 9 May 1995 under the chairmanship of Professor A. Wojtczak (Poland) and Mr M. S. Dayal (India).

It was decided to recommend to the Forty-eighth World Health Assembly the adoption of resolutions and decisions relating to the following agenda items:

22. WHO response to global change
    Review of the Constitution of the World Health Organization [WHA48.14]
    22.1 Progress reports on implementation of recommendations
        WHO response to global change [WHA48.15]
    22.2 Renewing the health-for-all strategy [WHA48.16]
    22.3 Technical discussions [WHA48.17]
24. Appointment of External Auditor [WHA48.18]
26. Scale of assessments
    26.1 Assessment of new Members and Associate Members
        Assessment of Palau [WHA48.19]
    26.2 Scale of assessments for the financial period 1996-1997 [WHA48.20]
27. Review of the Working Capital Fund [WHA48.21]
28. Real Estate Fund [WHA48.22]
29. Personnel matters
    29.2 Confirmation of amendments to the Staff Rules
        Salaries of ungraded posts and the Director-General [WHA48.23]
30. United Nations Joint Staff Pension Fund
    30.1 Annual report of the United Nations Joint Staff Pension Board [WHA48(10)]
    30.2 Appointment of representatives to the WHO Staff Pension Committee [WHA48(11)]
32. Collaboration within the United Nations system and with other intergovernmental organizations
    32.1 General matters
        International Decade of the World's Indigenous People [WHA48.24].

Third report[1]

[A48/54 - 12 May 1995]

Committee B held its eighth and ninth meetings on 11 and 12 May 1995 under the chairmanship of Professor A. Wojtczak (Poland).

It was decided to recommend to the Forty-eighth World Health Assembly the adoption of resolutions relating to the following agenda items:

18. Proposed programme budget for the financial period 1996-1997
    18.2 General review
        Consolidating budgetary reform [WHA48.25]
        Reorientation of allocations [WHA48.26]

[1] Approved by the Health Assembly at its twelfth plenary meeting.

19. Implementation of resolutions (progress reports by the Director-General)
    Paris AIDS Summit [WHA48.27]
29. Personnel matters
    29.1 Recruitment of international staff in WHO: biennial report
        Recruitment of international staff in WHO: geographical representation [WHA48.28]
31. Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine [WHA48.29]
32. Collaboration within the United Nations system and with other intergovernmental organizations
    32.2 Establishment of the joint and cosponsored United Nations programme on HIV/AIDS
        Establishment of the joint and cosponsored United Nations programme on HIV/AIDS ("UNAIDS") [WHA48.30]
    32.6 Health assistance to specific countries [WHA48.31].

REPORT OF COMMITTEE B TO COMMITTEE A[1]

[A48/49 - 6 May 1995]

During the course of its first meeting, held on 3 May 1995, Committee B considered the first report of the meeting held on 1 May 1995 of the Administration, Budget and Finance Committee of the Executive Board *inter alia* to review the proposed use of casual income available at 31 December 1994. In that context the Committee endorsed the Director-General's proposal to appropriate US$ 10 947 000 of available casual income to help finance the 1996-1997 regular budget.

[1] See document WHA48/1995/REC/3.

INDEX OF NAMES

This index contains the names of speakers reported in the present volume. A full list of delegates and other participants attending the Forty-eighth World Health Assembly appears in document WHA48/1995/REC/1.

INDEX OF COUNTRIES AND ORGANIZATIONS

This index lists the countries, organizations and bodies represented by the speakers whose names appear in the index on the preceding pages.