WHA48/1995/REC/1

WORLD HEALTH ORGANIZATION

FORTY-EIGHTH WORLD HEALTH ASSEMBLY

GENEVA, 1-12 MAY 1995

RESOLUTIONS AND DECISIONS
ANNEXES

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).

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

[2] Item referred to Committee B.

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

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[1] Issued in English and French.

[2] Also available in Arabic.

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

RESOLUTIONS

WHA48.1 Transfer of Mongolia to the Western Pacific Region

The Forty-eighth World Health Assembly,

Having considered the request from the Government of Mongolia for the inclusion of that country in the Western Pacific Region,

RESOLVES that Mongolia shall form part of the Western Pacific Region.[1]

Hbk Res., Vol. III (3rd ed.), 4.1.3 (Seventh plenary meeting, 4 May 1995)

WHA48.2 Emergency and humanitarian action

The Forty-eighth World Health Assembly,

Recalling resolution WHA42.16 on the International Decade for Natural Disaster Reduction; resolutions WHA44.41 and WHA46.6 on emergency and humanitarian relief operations; resolution WHA46.39 on health and medical services in times of armed conflicts; resolution WHA47.28 on collaboration within the United Nations system and with other intergovernmental organizations; and resolution WHA47.29 on Rwanda;

Recalling United Nations General Assembly resolutions 46/182 and 48/57 on strengthening of the coordination of humanitarian emergency assistance of the United Nations;

Recalling also United Nations General Assembly resolution 49/22 of 13 December 1994 on the International Decade for Natural Disaster Reduction, which calls upon all United Nations bodies and specialized agencies to participate actively in the implementation of the plan of action contained in the Yokohama Strategy for a Safer World and to consider this issue at the forthcoming sessions of their respective governing bodies;

Recognizing that disaster reduction is an integral part of sustainable development and consequently each country bears the primary responsibility for strengthening its capacity to protect its people from various hazards;

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;

Convinced that the primary role of the United Nations and its specialized agencies is to support national efforts in accordance with their respective sectoral responsibilities and to assist Member States in strengthening their capacity to deal with the humanitarian and socioeconomic effects of complex emergency situations,

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[1] The transfer became effective on 4 May 1995.

1. THANKS the Director-General for his reports on emergency and humanitarian action;

2. ADOPTS the strategy described in the report of the Director-General on emergency and humanitarian action;[1]

3. COMMENDS WHO for its role in promoting disaster reduction and in implementing related emergency prevention and preparedness strategies, and for improving its capacity to respond quickly and efficiently to urgent health needs arising from complex emergency situations;

4. ENDORSES the provisions of United Nations General Assembly resolution 49/22 of 13 December 1994 on the International Decade for Natural Disaster Reduction as they relate to the health sector;

5. URGES Member States:

(1) to include disaster reduction and emergency preparedness regularly in their national and subnational development plans and to allocate national budgetary resources for this purpose;

(2) to ensure permanent national and subnational mechanisms for intersectoral emergency management which include the health sector;

6. CALLS ON donors to give greater priority to health and nutrition aspects in the humanitarian assistance programmes which they carry out either on a bilateral or a multilateral basis, taking into consideration the coordinating role of WHO in all international health-related matters;

7. REQUESTS the Director-General within available resources:

A. in emergency preparedness and disaster reduction

1. to continue to support the efforts of Member States to strengthen their capacity in the field of emergency preparedness so as to protect the development achievements of countries and reduce the vulnerability of communities at risk;

2. to seek extrabudgetary resources which will complement regular budgetary funds for this purpose;

3. to promote and support the development of regional, bilateral and country emergency-preparedness programmes;

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

5. to continue to promote and actively take part in establishing, with appropriate partners in the United Nations system, a comprehensive, integrated and institutionalized approach to disaster reduction with the objective of ensuring comprehensive support to country programmes and related technical activities;

6. to ensure the coordinated participation of appropriate WHO technical programmes in disaster reduction and preparedness;

7. to strengthen further the technical and structural capability of regional and interregional emergency preparedness centres;

[1] See Annex 1.

B. in emergency response and humanitarian action

1. to emphasize the Organization's responsibility for technical and normative guidance while retaining the necessary flexibility to carry out certain operational activities, when necessary;

2. to strengthen its partnership with governments, local authorities, organizations of the United Nations system, particularly with the Department of Humanitarian Affairs, and with other humanitarian organizations, in the planning, implementation and monitoring of emergency, rehabilitation and recovery programmes;

3. to improve WHO's internal coordination and its capacity to provide effective coordination of health sector activities undertaken in response to emergencies in the field;

4. to strengthen the ability of WHO field offices, particularly in disaster-prone countries, to respond to early warning signals;

C. in humanitarian advocacy

1. to strengthen WHO's advocacy for the respect and protection of health personnel and infrastructure in conflict situations, in accordance with the concept of health as an investment for peace;

2. to advocate the protection of non-combatants and the setting-up of effective treatment and rehabilitation programmes for the victims of anti-personnel mines, as well as the systematic management of delayed health effects of mental and physical injuries in situations of collective violence;

3. to present a progress report to the Executive Board at its ninety-ninth session.

Hbk Res., Vol. III (3rd ed.), 1.2.2.3

(Eleventh plenary meeting, 8 May 1995 - Committee A, first report)

WHA48.3 Intensified cooperation with countries in greatest need

The Forty-eighth World Health Assembly,

Noting the Director-General's report;[1]

Recognizing that poverty is the most fundamental obstacle to health and overall development and a permanent menace to world peace;

Emphasizing that an effective response is dependent on country-specific approaches;

Recalling resolutions WHA42.3, WHA43.17 and WHA46.30 on strengthening technical and economic support to countries facing serious economic constraints;

Recognizing the essential role of coordinated technical support from all levels of the Organization in intensified cooperation with countries in greatest need,

[1] Document A48/7.

1. URGES Member States:

(1) to consider measures to alleviate poverty and its health effects as essential to progress towards health for all and development;

(2) to give much greater attention to strengthening their capacity for health development, setting time-limits and targets for achievement;

(3) to establish integrated strategies for health development, to institutionalize effective systems to coordinate all efforts and resources, internal and external, mobilized for their implementation, and to develop more effective management tools in order to maximize efficiency;

2. CALLS ON the international community:

(1) to mobilize additional resources for health development in countries in greatest need, reversing the current trend of diminishing development assistance;

(2) to place particular emphasis on strengthening the capacity of countries in greatest need to initiate the process of health development, drawing in the first instance on national expertise and in addition on that of other developing and developed countries with appropriate experience;

(3) to strengthen collaboration with countries and with WHO in ensuring that resources made available are used to meet national priorities as determined by the countries themselves;

3. REQUESTS the Director-General:

(1) to accord high priority to providing a well-coordinated, country-specific WHO response to more countries in greatest need, allocating financial and technical resources according to criteria of income, health status, and national capacity and willingness of governments to meet health development needs, setting clearly defined strategies, time-limits and targets for achievement, and strengthening the WHO country offices in those countries, so that the staff have the technical competence and expertise to provide the necessary advice and leadership to the national governments;

(2) to continue to reorient the structure and functions at all levels of the Organization and strengthen technical and managerial capacities in order to support WHO's intensified cooperation with countries, using the country-centred approach in the process of reform;

(3) to place renewed emphasis on cooperation with these countries in strengthening their capacity to develop and implement health development policies based on community participation which remove inequities in the health field, using intersectoral measures to promote economic and social development and improve financing and management of the health system at all levels;

(4) to intensify efforts to mobilize, coordinate and manage external resources, including human resources from countries that have emerged successfully from the state of a developing country to a developed one, and to make available maximum resources for health development in the countries in greatest need;

(5) to report at regular intervals to the Executive Board and Health Assembly on progress achieved in implementing this resolution.

Hbk Res., Vol. III (3rd ed.), 1.2.2.2; 1.7

(Eleventh plenary meeting, 8 May 1995 - Committee A, first report)

WHA48.4 Interim financial report for the year 1994

The Forty-eighth World Health Assembly,

Having examined the interim financial report for the year 1994;[1]

Having noted the report of the Administration, Budget and Finance Committee of the Executive Board,[2]

ACCEPTS the Director-General's interim financial report for the year 1994.

Hbk Res., Vol. III (3rd ed.), 6.1.10.3

(Eleventh plenary meeting, 8 May 1995 - Committee B, first report)

WHA48.5 Status of collection of assessed contributions and status of advances to the Working Capital Fund

The Forty-eighth World Health Assembly,

Noting with concern that, as at 31 December 1994:

(a) the rate of collection in 1994 of contributions to the effective working budget for that year amounted to 80.32%, leaving US$ 79 846 675 unpaid;

(b) only 99 Members had paid their contributions to the effective working budget for that year in full, and 72 Members had made no payment;

(c) unpaid arrears of contributions to the effective working budget in respect of 1993 and prior years exceeded US$ 52 million,

1. EXPRESSES concern at the level of outstanding contributions, which has had a deleterious effect on programmes and on the financial situation;

2. CALLS THE ATTENTION of all Members to Financial Regulation 5.6, which provides that instalments of contributions and advances shall be considered as due and payable in full by the first day of the year to which they relate, and to the importance of paying contributions as early as possible to enable the Director-General to implement the programme budget in an orderly manner;

3. REMINDS Members that, as a result of the adoption, by resolution WHA41.12, of an incentive scheme to promote the timely payment of assessed contributions, those that pay their assessed contributions early in the year in which they are due will have their contributions payable for a subsequent programme budget

[1] Documents A48/18 and Add.1.

[2] Document A48/43.

reduced appreciably, whereas Members paying later will have their contributions payable for that subsequent programme budget reduced only marginally or not at all;

4. URGES Members that are regularly late in the payment of their contributions to take as rapidly as possible all steps necessary to ensure prompt and regular payment;

5. REQUESTS the Director-General to draw this resolution to the attention of all Members.

Hbk Res., Vol. III (3rd ed.), 6.1.2.4

(Eleventh plenary meeting, 8 May 1995 - Committee B, first report)

WHA48.6 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution

The Forty-eighth World Health Assembly,

Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board on Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution;[1]

Having been informed that the voting rights of Burundi had been restored as a result of a payment made which reduced its unpaid prior years' arrears of contributions to a level below that indicated in resolution WHA41.7;

Noting that, at the time of opening of the Forty-eighth World Health Assembly, the voting rights of Antigua and Barbuda, Cambodia, Chad, Comoros, Congo, Dominican Republic, Equatorial Guinea, Guinea-Bissau, Haiti, Iraq, Liberia, Somalia and Zaire remained suspended, such suspension to continue until the arrears of the Member State concerned have been reduced, at the present or future Health Assemblies, to a level below the amount which would justify invoking Article 7 of the Constitution;

Noting that, in accordance with resolution WHA47.18, the voting privileges of Burkina Faso, Guatemala, Senegal, Yemen and Yugoslavia have been suspended as from 1 May 1995, such suspension to continue until the arrears of the Member State concerned have been reduced, at the present or future Health Assemblies, to a level below the amount which would justify invoking Article 7 of the Constitution;

Noting that Angola, Armenia, Azerbaijan, Bosnia and Herzegovina, Cuba, Djibouti, Ecuador, Gabon, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Niger, Nigeria, Peru, Republic of Moldova, Rwanda, Seychelles, Suriname, Tajikistan, Turkmenistan, Ukraine, Uruguay and Uzbekistan were in arrears at the time of the opening of the Forty-eighth World Health Assembly to such an extent that it is necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of these Members should be suspended at the opening of the Forty-ninth World Health Assembly;

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,

1. EXPRESSES serious concern at the increasingly large number of Members that have been in arrears in the payment of their contributions in recent years to an extent which would justify invoking Article 7 of the Constitution, and at the unprecedented level of contributions owed by them;

[1] Document A48/20.

2. URGES the Members concerned to regularize their position at the earliest possible date;

3. FURTHER URGES Members that have not communicated their intention to settle their arrears to do so as a matter of urgency;

4. REQUESTS the Director-General to approach the Members in arrears to an extent which would justify invoking Article 7 of the Constitution, with a view to pursuing the question with the governments concerned;

5. REQUESTS the Executive Board, in the light of the Director-General's report to the Board at its ninety-seventh session and after the Members concerned have had an opportunity to explain their situation to the Board, to report to the Forty-ninth World Health Assembly on the status of payment of contributions;

6. DECIDES:

(1) that in accordance with the statement of principles in resolution WHA41.7 if, by the time of the opening of the Forty-ninth World Health Assembly, Angola, Armenia, Azerbaijan, Bosnia and Herzegovina, Cuba, Djibouti, Ecuador, Gabon, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Niger, Nigeria, Peru, Republic of Moldova, Rwanda, Seychelles, Tajikistan, Turkmenistan, Ukraine and Uzbekistan are still in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;

(2) that any suspension which takes effect as aforesaid shall continue at the Forty-ninth and subsequent Health Assemblies, until the arrears of the Member concerned have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution;

(3) that this decision shall be without prejudice to the right of any Member to request restoration of its voting privileges in accordance with Article 7 of the Constitution.

Hbk Res., Vol. III (3rd ed.), 6.1.2.4

(Eleventh plenary meeting, 8 May 1995 - Committee B, first report)

WHA48.7 Revision and updating of the International Health Regulations

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;[1]

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;

[1] Resolutions WHA22.46, WHA26.55 and WHA34.13, respectively.

Noting that there is a continuous evolution in the public health threat posed by infectious diseases related to the agents themselves, to their easier transmission in changing physical and social environments, and to diagnostic and treatment capacities;

Noting that regulations should be based on sound epidemiological and public health expertise;

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 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.

Hbk Res., Vol. III (3rd ed.), 1.6.1.3

(Twelfth plenary meeting, 12 May 1995 - Committee A, second report)

WHA48.8 Reorientation of medical education and medical practice for health for all

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 care providers to achieve optimal health care delivery, of the reorientation of the education and practice of all health care providers for health for all, and of the need to begin systematic consideration of each;

Recognizing that it is important to place medical education in the context of multidisciplinary education and to provide primary health care 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 attaining 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 in order 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 to take account of the contribution made by general practitioners to primary health care-oriented services;

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, and to respond to, the health needs of the people they serve in order 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 to reorient their research, clinical and community health activities in order 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 and by 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 train 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 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, respectively.

Hbk Res., Vol. III (3rd ed.), 1.8

(Twelfth plenary meeting, 12 May 1995 - Committee A, second report)

WHA48.9 Prevention of hearing impairment

The Forty-eighth World Health Assembly,

Recalling resolution WHA38.19 on prevention of hearing impairment and deafness, and WHA42.28 on disability prevention and rehabilitation;

Concerned at the growing problem of largely preventable hearing impairment in the world, where at present 120 million people are estimated to have disabling hearing difficulties;

Recognizing that severe hearing impairment in children constitutes a particularly serious obstacle to optimal development and education, including language acquisition, and that hearing difficulties leading to communication problems are a major subject of concern in the elderly and thus one of growing worldwide importance in view of the aging of populations;

Aware of the significant public health aspects of avoidable hearing loss, related to causes such as congenital disorders and infectious diseases, as well as use of ototoxic drugs and exposure to excessive noise;

Noting the persistent inadequacy of resources for hearing impairment prevention, despite the increasing commitment of international nongovernmental organizations,

1. URGES Member States:

(1) to prepare national plans for the prevention and control of major causes of avoidable hearing loss, and for early detection in babies, toddlers, and children, as well as in the elderly, within the framework of primary health care;

(2) to take advantage of existing guidelines and regulations or to introduce appropriate legislation for the proper management of particularly important causes of deafness and hearing impairment, such as otitis media, use of ototoxic drugs and harmful exposure to noise, including noise in the work environment and loud music;

(3) to ensure the highest possible coverage of childhood immunization against the target diseases of the Expanded Programme on Immunization and against mumps, rubella and (meningococcal) meningitis whenever possible;

(4) to consider the setting-up of mechanisms for collaboration with nongovernmental or other organizations for support to, and coordination of, action to prevent hearing impairment at country level, including the detection of hereditary factors, by genetic counselling;

(5) to ensure appropriate public information and education for hearing protection and conservation in particularly vulnerable or exposed population groups;

2. REQUESTS the Director-General:

(1) to further technical cooperation in the prevention of hearing impairments, including the development of appropriate technical guidelines;

(2) to cooperate with countries in the assessment of hearing loss as a public health problem;

(3) to support, to the extent that resources are available, the planning, implementation, monitoring and evaluation of measures in countries to prevent hearing impairment;

(4) to develop further collaboration and coordination with nongovernmental and other interested organizations and institutions;

(5) to promote and support, to the extent feasible, applied and operations research for the optimal prevention and treatment of major causes of hearing impairment;

(6) to mobilize extrabudgetary resources to strengthen technical cooperation in hearing impairment prevention, including possible support from organizations concerned;

(7) to keep the Executive Board and the Health Assembly informed of progress, as appropriate.

Hbk Res., Vol. III (3rd ed.), 1.16.15

(Twelfth plenary meeting, 12 May 1995 - Committee A, second report)

WHA48.10 Reproductive health: WHO's role in the global strategy

The Forty-eighth World Health Assembly,

Noting the report by the Director-General, "Maternal and child health and family planning: quality of care - Reproductive health: WHO's role in the global strategy";[1]

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, "Collaboration within the United Nations system: International Conference on Population and Development, 1994",[2] 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, 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 programmes 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;

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;[1]

2. REAFFIRMS the unique role of the Organization with respect to advocacy, normative functions, research and technical cooperation in the area of reproductive health;

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[1] See Annex 2.

[2] Document A48/35.

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 International Conference on Population and Development, and in particular with full respect for the various religious and ethical values and cultural backgrounds and in conformity with universally recognized international 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 to 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 capability 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 Executive Board at its ninety-seventh session and the Forty-ninth World Health Assembly;

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

Hbk Res., Vol. III (3rd ed.), 1.12.2

(Twelfth plenary meeting, 12 May 1995 - Committee A, second report)

WHA48.11 An international strategy for tobacco control

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 that 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 in the current year;

Noting that the Director-General and his staff 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 that field: curbing of 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's 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 UNCTAD), 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 advocacy role and capacity in the field of tobacco or health and to submit to the Forty-ninth World Health Assembly a plan of action for the tobacco or health programme for the period 1996-2000.

Hbk Res., Vol. III (3rd ed.), 1.11.4

(Twelfth plenary meeting, 12 May 1995 - Committee A, second report)

WHA48.12 Control of diarrhoeal diseases and acute respiratory infections: integrated management of the sick child

The Forty-eighth World Health Assembly,

Recalling resolutions WHA40.34 and WHA44.7 concerning the strengthening of national programmes for the prevention and case management of diarrhoeal diseases and acute respiratory infections in children;

Mindful of the target for reduction of infant and child mortality rates by the year 2000 set at the World Summit for Children in 1990, and of WHO's commitment to ensuring survival and healthy development of children, as reflected in the Ninth General Programme of Work;

Noting with appreciation the progress made in the implementation of national programmes for control of diarrhoeal diseases and acute respiratory infections and the effect they are likely to have on the global reduction of mortality in children under five years of age;

Concerned, however, at the fact that diarrhoeal diseases and acute respiratory infections remain the two major causes of child mortality, accounting, together with malaria, measles and malnutrition, for seven out of 10 deaths in children less than five years of age in the developing world;

Considering, also, that significantly intensified efforts and increased resources at global level will be needed to meet the end-of-decade target for reduction of infant and child mortality;

Noting that WHO has pioneered research and the development of guidelines and training materials for integrated case management of major childhood illness at first-level health facilities;

Recognizing that UNICEF, agencies for bilateral cooperation and national research institutions in developed and developing countries have committed themselves to supporting the WHO research and development initiative on integrated management of childhood illness,

1. ENDORSES the integrated management of the sick child as a more cost-effective approach to ensuring the survival and healthy development of children;

2. URGES governments of countries which have not yet reached the infant and child mortality reduction targets for the year 2000:

(1) to accelerate and sustain the programmes for control of diarrhoeal diseases and acute respiratory infections in order to reach those targets;

(2) to apply existing technical guidelines for integrated management of the sick child, and to plan for the transition from specific programmes against childhood diseases to an integrated approach to illness in children while continuing efforts to prevent sickness among young children, using, where available, logistic support for primary health care;

(3) to strengthen the existing health system mechanisms for disease prevention, in-service training, logistics, communication, supervision, monitoring and evaluation in order to provide a solid basis for integrated management of the sick child;

(4) to strengthen and maintain managerial activities for the prevention and control of diarrhoea and acute respiratory infections and activities to tackle the underlying problems of malnutrition in children during the transition to the integrated approach;

3. REQUESTS the Director-General:

(1) to continue the development of managerial tools, including technical guidelines, planning guides, training courses, communication materials, and manuals for the planning, supervision, monitoring and evaluation of national activities for integrated management of the sick child;

(2) to promote prevention of the major causes of child mortality;

(3) to promote, coordinate and support research and development on activities to overcome technical and operational problems arising during development of managerial tools and initial implementation of integrated management of the sick child;

(4) to facilitate the provision in the near future of tools for prevention of acute respiratory infections, such as *Haemophilus influenzae* type b vaccine and a conjugate pneumococcal vaccine for children in developing countries;

(5) to promote rational use of antimicrobials as an essential element of integrated management of the sick child and to monitor the evolution and antimicrobial resistance of the main causative organisms of the major infectious diseases of children, in close coordination with the Organization's efforts in relation to new, emerging, and re-emerging infectious diseases;

(6) to cooperate with Member States in formulating technical guidelines, based on the WHO managerial tools, for planning and implementation of national activities for integrated management of the sick child;

(7) to maintain close and effective collaboration with other interested agencies and organizations, in particular UNICEF, UNDP and the World Bank, in order to promote the concept and practice of integrated management of the sick child;

(8) to step up the search for the extrabudgetary funds required for implementation of integrated management of the sick child;

(9) to keep the Executive Board and the Health Assembly informed of the progress made, as appropriate.

Hbk Res., Vol. III (3rd ed.), 1.16.5; 1.16.6

(Twelfth plenary meeting, 12 May 1995 - Committee A, second report)

WHA48.13 Communicable diseases prevention and control: new, emerging, and re-emerging infectious diseases

The Forty-eighth World Health Assembly,

Having considered the report of the Director-General on new, emerging, and re-emerging infectious diseases;[1]

Recalling resolutions WHA39.27 on rational use of drugs, WHA44.8 and WHA46.36 on tuberculosis, WHA45.35 on human immunodeficiency virus, WHA46.31 on dengue prevention and control, WHA46.32 on malaria, and WHA46.6 on emergency and humanitarian relief;

Aware that with the increasing global population many are forced to live under conditions of overcrowding, inadequate housing, and poor hygiene; that more frequent international travel leads to rapid global exchange of human pathogens; that changes in health technology and food production, as well as its distribution (including international trade) and handling, create new opportunities for human pathogens; that human behavioural changes expose large segments of the global population to diseases not previously experienced; that expanding areas of human habitation expose thousands of people to enzootic pathogens previously unknown as causes of human disease; and that microbes continue to evolve and adapt to their environment, leading to the appearance of new pathogens;

Aware also of the continued threat of well-known diseases such as influenza and meningococcal infections, and of tuberculosis, cholera and plague, once thought to be conquered, and the growing danger of diseases transmitted by vectors no longer controlled, such as dengue haemorrhagic fever and yellow fever;

Concerned at the lack of coordinated global surveillance to monitor, report and respond to new, emerging, and re-emerging infectious diseases, the general absence of the diagnostic capabilities necessary to identify accurately pathogenic microorganisms, and the insufficient numbers of trained health care professionals to investigate these infectious diseases;

Alarmed by the increasing frequency of antimicrobial resistance in bacterial pathogens, which can make some diseases such as tuberculosis virtually untreatable with currently available antibiotics,

[1] See Annex 3.

1. URGES Member States:

(1) to strengthen national and local programmes of active surveillance for infectious diseases, ensuring that efforts are directed to early detection of outbreaks and prompt identification of new, emerging, and re-emerging infectious diseases;

(2) to improve routine diagnostic capabilities for common microbial pathogens so that outbreaks due to infectious diseases may be more easily identified and accurately diagnosed;

(3) to enhance, and to participate actively in, communications between national and international services involved in disease detection, early notification, surveillance, control and response;

(4) to encourage routine testing of antimicrobial sensitivity, and to foster practices for rational prescription, availability and administration of antimicrobial agents in order to limit the development of resistance in microbial pathogens;

(5) to increase the number of staff skilled in both epidemiological and laboratory investigations of infectious diseases, and to promote such specialization;

(6) to foster more applied research in such areas as the development of sensitive, specific and inexpensive diagnostics, the setting of standards for basic public health procedures, and the establishment of fundamental disease prevention strategies;

(7) to control outbreaks and to promote accurate and timely reporting of cases at national and international levels;

2. URGES other specialized agencies and organizations of the United Nations system, bilateral development agencies, nongovernmental organizations and other groups concerned to increase their cooperation in the recognition, prevention and control of new, emerging, and re-emerging infectious diseases both through continued support for general social and health development and through specific support to national and international programmes to recognize and respond to those diseases;

3. REQUESTS the Director-General:

(1) to establish, in consultation with Member States, strategies to improve recognition and response to new, emerging, and re-emerging infectious diseases in a manner sustainable by all countries and prompt dissemination of relevant information among all Member States;

(2) to draw up plans for improved national, regional and international surveillance of infectious diseases and their causative agents, including accurate laboratory diagnosis and prompt dissemination of case definition, and surveillance information, and to coordinate their implementation among interested Member States, agencies and other groups;

(3) to increase WHO's capacity, within available resources, for directing and strengthening applied research for prevention and control of those diseases, and to ensure that reference facilities remain available for safely characterizing new or unusual pathogens;

(4) to establish strategies enabling rapid national and international action to investigate and to combat infectious disease outbreaks and epidemics, including identification of 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 the Global Programme for Vaccines and Immunization, the Action Programme on Essential Drugs, and drug management and policy;

(5) to coordinate WHO's initiative on new, emerging, and re-emerging infectious diseases in cooperation with other specialized agencies and organizations of the United Nations system, bilateral development agencies, nongovernmental organizations, Member States, and other groups concerned;

(6) to improve programme monitoring and evaluation at national, regional and global levels;

(7) to keep the Executive Board and the Health Assembly informed of progress in the implementation of this resolution.

Hbk Res., Vol. III (3rd ed.), 1.16

(Twelfth plenary meeting, 12 May 1995 - Committee A, second report)

WHA48.14 WHO response to global change: review of the Constitution of the World Health Organization

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 Board concludes there is a need for a review of the Constitution, to consider the best way for the review of the Constitution to be carried forward;

2. REQUESTS the Director-General to report to the Forty-ninth World Health Assembly in 1996 on progress on this matter.

Hbk Res., Vol. III (3rd ed.), 5.1

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

WHA48.15 WHO response to global change

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[1];

Having also considered the Executive Board's decision on the subject;[2]

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 successful 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 policy and mission, WHO's personnel policy and WHO country offices;

(2) to strengthen the structural capability 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 on 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;

3. REQUESTS the Regional Directors to pursue vigorously the implementation of reform and to report regularly to the Executive Board on progress and on any obstacles encountered in 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.

Hbk Res., Vol. III (3rd ed.), 3.2.4

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

[1] Document A48/23.

[2] Decision EB95(2).

WHA48.16 WHO response to global change: renewing the health-for-all strategy

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 awareness of the general public, political leaders, ministries and other partners concerned with social and economic development policy of 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 national consultations to serve as a basis for the elaboration of the global health policy;

(3) to adapt the global health policy, after its adoption, to national or subnational contexts 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 elaboration of the global health policy, to define their role in carrying it out, and to join forces with WHO for its implementation;

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[1] Documents A48/4 and Corr.1, and A48/INF.DOC./1.

[2] Document EB95/1995/REC/1, Annex 5.

[3] Document EB92/1993/REC/1, Annex 1.

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 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 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 that effect:

(4) to support Member States in 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 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 updating of global, regional and national health-for-all strategies and for 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 plans for securing that endorsement to the Forty-ninth World Health Assembly.

Hbk Res., Vol. III (3rd ed.), 1.1; 1.4

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

WHA48.17 WHO response to global change: Technical Discussions

The Forty-eighth World Health Assembly,

Having considered the report of the Director-General on Technical Discussions at the Forty-ninth World Health Assembly (1996);[1]

Recalling the recommendations of the Executive Board Working Group on the WHO Response to Global Change and the report by the Director-General on implementation of the Working Group's recommendations on methods of work of the World Health Assembly;[2]

[1] Document EB94/1994/REC/1, Annex 1.

[2] Document EB93/1994/REC/1, Annex 1, Part 2, section IV.

Acknowledging the need to further streamline and improve methods of work of the Health Assembly and the desirability of providing Member States with technical briefings focusing on important health problems in a flexible and innovative manner,

1. DECIDES that, from the Forty-ninth World Health Assembly in May 1996, and on a trial basis, Technical Discussions will be replaced by a limited number of well-organized technical briefings and by informal forums for dialogue;

2. REQUESTS the Director-General to continue to review methods of work of the Health Assembly with a view to further savings.

Hbk Res., Vol. III (3rd ed.), 3.1.3; 3.1.4

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

WHA48.18 Appointment of External Auditor

The Forty-eighth World Health Assembly

1. RESOLVES that the holder of the Office of the Auditor-General of the Republic of South Africa shall be appointed External Auditor of the accounts of the World Health Organization for the financial periods 1996-1997 and 1998-1999 and that he/she shall conduct his/her audits in accordance with the principles incorporated in Article XII of the Financial Regulations, provided that, should the necessity arise, he/she may designate a representative to act in his/her absence;

2. EXPRESSES its thanks to the Comptroller and Auditor General of the United Kingdom of Great Britain and Northern Ireland for the work he has performed as External Auditor of the accounts for the financial periods 1992-1993 and 1994-1995.

Hbk Res., Vol. III (3rd ed.), 6.1.10.1

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

WHA48.19 Assessment of Palau

The Forty-eighth World Health Assembly,

Noting that Palau became a Member of the World Health Organization on 9 March 1995;

Noting that the United Nations General Assembly has not yet established an assessment rate for Palau;

Recalling that the Twenty-second World Health Assembly, in resolution WHA22.6, decided that from 1968 new Members shall be assessed in accordance with the practice followed by the United Nations in assessing new Members for their year of admission,

DECIDES:

(1) that Palau shall be assessed for the second year of the financial period 1994-1995 and for future financial periods at a rate to be fixed by the Health Assembly, as and when an assessment rate for this country has been established by the United Nations General Assembly;

(2) that Palau shall be assessed at the provisional rate of 0.01% for the second year of the financial period 1994-1995 and for future financial periods, to be adjusted to the definitive assessment rate when established by the Health Assembly;

(3) that the 1995 instalment of the assessment shall be reduced to nine-twelfths of 0.01%.

Hbk Res., Vol. III (3rd ed.), 6.1.2.2

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

WHA48.20 Scale of assessments for the financial period 1996-1997

The Forty-eighth World Health Assembly

1. DECIDES that the scales of assessments for the years 1996 and 1997 shall, subject to the provisions of paragraph 2 below, be as follows:

(1)	(2)	(3)	(4)	(5)
Members and Associate Members	**WHO scales**		**United Nations scales**	
	1996	**1997**	**1996**	**1997**
	%	%	%	%
Afghanistan	0.0100	0.01	0.0100	0.01
Albania	0.0100	0.01	0.0100	0.01
Algeria	0.1573	0.16	0.1600	0.16
Angola	0.0100	0.01	0.0100	0.01
Antigua and Barbuda	0.0100	0.01	0.0100	0.01
Argentina	0.4719	0.47	0.4800	0.48
Armenia	0.0541	0.05	0.0550	0.05
Australia	1.4550	1.45	1.4800	1.48
Austria	0.8504	0.85	0.8650	0.87
Azerbaijan	0.1155	0.11	0.1175	0.11
Bahamas	0.0197	0.02	0.0200	0.02
Bahrain	0.0197	0.02	0.0200	0.02
Bangladesh	0.0100	0.01	0.0100	0.01
Barbados	0.0100	0.01	0.0100	0.01
Belarus	0.2876	0.27	0.2925	0.28
Belgium	0.9905	0.99	1.0075	1.01
Belize	0.0100	0.01	0.0100	0.01
Benin	0.0100	0.01	0.0100	0.01
Bhutan	0.0100	0.01	0.0100	0.01
Bolivia	0.0100	0.01	0.0100	0.01
Bosnia and Herzegovina	0.0123	0.01	0.0125	0.01
Botswana	0.0100	0.01	0.0100	0.01
Brazil	1.5927	1.59	1.6200	1.62
Brunei Darussalam	0.0197	0.02	0.0200	0.02
Bulgaria	0.0811	0.08	0.0825	0.08
Burkina Faso	0.0100	0.01	0.0100	0.01
Burundi	0.0100	0.01	0.0100	0.01
Cambodia	0.0100	0.01	0.0100	0.01
Cameroon	0.0100	0.01	0.0100	0.01
Canada	3.0501	3.06	3.1025	3.11
Cape Verde	0.0100	0.01	0.0100	0.01

(1) Members and Associate Members	(2) WHO scales 1996 %	(3) WHO scales 1997 %	(4) United Nations scales 1996 %	(5) United Nations scales 1997 %
Central African Republic	0.0100	0.01	0.0100	0.01
Chad	0.0100	0.01	0.0100	0.01
Chile	0.0786	0.08	0.0800	0.08
China	0.7226	0.73	0.7350	0.74
Colombia	0.0983	0.10	0.1000	0.10
Comoros	0.0100	0.01	0.0100	0.01
Congo	0.0100	0.01	0.0100	0.01
Cook Islands[a]	0.0100	0.01	0.0100[b]	0.01[b]
Costa Rica	0.0100	0.01	0.0100	0.01
Côte d'Ivoire	0.0100	0.01	0.0100	0.01
Croatia	0.0885	0.09	0.0900	0.09
Cuba	0.0516	0.05	0.0525	0.05
Cyprus	0.0295	0.03	0.0300	0.03
Czech Republic	0.2556	0.24	0.2600	0.25
Democratic People's Republic of Korea	0.0492	0.05	0.0500	0.05
Denmark	0.7054	0.71	0.7175	0.72
Djibouti	0.0100	0.01	0.0100	0.01
Dominica	0.0100	0.01	0.0100	0.01
Dominican Republic	0.0100	0.01	0.0100	0.01
Ecuador	0.0197	0.02	0.0200	0.02
Egypt	0.0688	0.08	0.0700	0.08
El Salvador	0.0100	0.01	0.0100	0.01
Equatorial Guinea	0.0100	0.01	0.0100	0.01
Eritrea	0.0100	0.01	0.0100	0.01
Estonia	0.0418	0.04	0.0425	0.04
Ethiopia	0.0100	0.01	0.0100	0.01
Fiji	0.0100	0.01	0.0100	0.01
Finland	0.6071	0.61	0.6175	0.62
France	6.2994	6.31	6.4075	6.42
Gabon	0.0100	0.01	0.0100	0.01
Gambia	0.0100	0.01	0.0100	0.01
Georgia	0.1155	0.11	0.1175	0.11
Germany	8.8899	8.91	9.0425	9.06
Ghana	0.0100	0.01	0.0100	0.01
Greece	0.3736	0.37	0.3800	0.38
Grenada	0.0100	0.01	0.0100	0.01
Guatemala	0.0197	0.02	0.0200	0.02
Guinea	0.0100	0.01	0.0100	0.01
Guinea-Bissau	0.0100	0.01	0.0100	0.01

[a] Not a Member of the United Nations.

[b] Assumed United Nations rate if State or territory had been a Member of the United Nations.

(1) Members and Associate Members	(2) WHO scales 1996 %	(3) WHO scales 1997 %	(4) United Nations scales 1996 %	(5) United Nations scales 1997 %
Guyana	0.0100	0.01	0.0100	0.01
Haiti	0.0100	0.01	0.0100	0.01
Honduras	0.0100	0.01	0.0100	0.01
Hungary	0.1376	0.14	0.1400	0.14
Iceland	0.0295	0.03	0.0300	0.03
India	0.3048	0.30	0.3100	0.31
Indonesia	0.1376	0.14	0.1400	0.14
Iran (Islamic Republic of)	0.4596	0.44	0.4675	0.45
Iraq	0.1376	0.14	0.1400	0.14
Ireland	0.2065	0.21	0.2100	0.21
Israel	0.2630	0.26	0.2675	0.27
Italy	5.1098	5.16	5.1975	5.25
Jamaica	0.0100	0.01	0.0100	0.01
Japan	15.1746	15.38	15.4350	15.65
Jordan	0.0100	0.01	0.0100	0.01
Kazakhstan	0.1966	0.19	0.2000	0.19
Kenya	0.0100	0.01	0.0100	0.01
Kiribati[a]	0.0100	0.01	0.0100[b]	0.01[b]
Kuwait	0.1868	0.19	0.1900	0.19
Kyrgyzstan	0.0319	0.03	0.0325	0.03
Lao People's Democratic Republic	0.0100	0.01	0.0100	0.01
Latvia	0.0811	0.08	0.0825	0.08
Lebanon	0.0100	0.01	0.0100	0.01
Lesotho	0.0100	0.01	0.0100	0.01
Liberia	0.0100	0.01	0.0100	0.01
Libyan Arab Jamahiriya	0.1991	0.20	0.2025	0.20
Lithuania	0.0836	0.08	0.0850	0.08
Luxembourg	0.0688	0.07	0.0700	0.07
Madagascar	0.0100	0.01	0.0100	0.01
Malawi	0.0100	0.01	0.0100	0.01
Malaysia	0.1376	0.14	0.1400	0.14
Maldives	0.0100	0.01	0.0100	0.01
Mali	0.0100	0.01	0.0100	0.01
Malta	0.0100	0.01	0.0100	0.01
Marshall Islands	0.0100	0.01	0.0100	0.01
Mauritania	0.0100	0.01	0.0100	0.01
Mauritius	0.0100	0.01	0.0100	0.01
Mexico	0.7742	0.78	0.7875	0.79
Micronesia (Federated States of)	0.0100	0.01	0.0100	0.01

[a] Not a Member of the United Nations.

[b] Assumed United Nations rate if State or territory had been a Member of the United Nations.

(1) Members and Associate Members	(2) WHO scales 1996 %	(3) WHO scales 1997 %	(4) United Nations scales 1996 %	(5) United Nations scales 1997 %
Monaco	0.0100	0.01	0.0100	0.01
Mongolia	0.0100	0.01	0.0100	0.01
Morocco	0.0295	0.03	0.0300	0.03
Mozambique	0.0100	0.01	0.0100	0.01
Myanmar	0.0100	0.01	0.0100	0.01
Namibia	0.0100	0.01	0.0100	0.01
Nauru[a]	0.0100	0.01	0.0100[b]	0.01[b]
Nepal	0.0100	0.01	0.0100	0.01
Netherlands	1.5607	1.56	1.5875	1.59
New Zealand	0.2359	0.23	0.2400	0.24
Nicaragua	0.0100	0.01	0.0100	0.01
Niger	0.0100	0.01	0.0100	0.01
Nigeria	0.1131	0.11	0.1150	0.11
Niue[a]	0.0100	0.01	0.0100[c]	0.01[c]
Norway	0.5505	0.55	0.5600	0.56
Oman	0.0393	0.04	0.0400	0.04
Pakistan	0.0590	0.06	0.0600	0.06
Panama	0.0100	0.01	0.0100	0.01
Papua New Guinea	0.0100	0.01	0.0100	0.01
Paraguay	0.0100	0.01	0.0100	0.01
Peru	0.0590	0.06	0.0600	0.06
Philippines	0.0590	0.06	0.0600	0.06
Poland	0.3318	0.32	0.3375	0.33
Portugal	0.2704	0.27	0.2750	0.28
Puerto Rico[a,d]	0.0100	0.01	0.0100[c]	0.01[c]
Qatar	0.0393	0.04	0.0400	0.04
Republic of Korea	0.8037	0.80	0.8175	0.82
Republic of Moldova	0.0836	0.08	0.0850	0.08
Romania	0.1475	0.15	0.1500	0.15
Russian Federation	4.3749	4.20	4.4500	4.27
Rwanda	0.0100	0.01	0.0100	0.01
Saint Kitts and Nevis	0.0100	0.01	0.0100	0.01
Saint Lucia	0.0100	0.01	0.0100	0.01
Saint Vincent and the Grenadines	0.0100	0.01	0.0100	0.01
Samoa	0.0100	0.01	0.0100	0.01
San Marino	0.0100	0.01	0.0100	0.01

[a] Not a Member of the United Nations.

[b] Assessment imposed on a State which is not a Member of the United Nations but participates in certain of its activities.

[c] Assumed United Nations rate if State or territory had been a Member of the United Nations.

[d] Associate Member of WHO.

(1) Members and Associate Members	(2) WHO scales 1996 %	(3) WHO scales 1997 %	(4) United Nations scales 1996 %	(5) United Nations scales 1997 %
Sao Tome and Principe	0.0100	0.01	0.0100	0.01
Saudi Arabia	0.7078	0.70	0.7200	0.71
Senegal	0.0100	0.01	0.0100	0.01
Seychelles	0.0100	0.01	0.0100	0.01
Sierra Leone	0.0100	0.01	0.0100	0.01
Singapore	0.1376	0.14	0.1400	0.14
Slovakia	0.0811	0.08	0.0825	0.08
Slovenia	0.0688	0.07	0.0700	0.07
Solomon Islands	0.0100	0.01	0.0100	0.01
Somalia	0.0100	0.01	0.0100	0.01
South Africa	0.3171	0.31	0.3225	0.32
Spain	2.3226	2.34	2.3625	2.38
Sri Lanka	0.0100	0.01	0.0100	0.01
Sudan	0.0100	0.01	0.0100	0.01
Suriname	0.0100	0.01	0.0100	0.01
Swaziland	0.0100	0.01	0.0100	0.01
Sweden	1.2068	1.21	1.2275	1.23
Switzerland[a]	1.1896	1.19	1.2100[b]	1.21[b]
Syrian Arab Republic	0.0492	0.05	0.0500	0.05
Tajikistan	0.0197	0.02	0.0200	0.02
Thailand	0.1278	0.13	0.1300	0.13
The Former Yugoslav Republic of Macedonia	0.0100	0.01	0.0100	0.01
Togo	0.0100	0.01	0.0100	0.01
Tokelau[a,c]	0.0100	0.01	0.0100[d]	0.01[d]
Tonga[a]	0.0100	0.01	0.0100[b]	0.01[b]
Trinidad and Tobago	0.0319	0.03	0.0325	0.03
Tunisia	0.0295	0.03	0.0300	0.03
Turkey	0.3687	0.37	0.3750	0.38
Turkmenistan	0.0319	0.03	0.0325	0.03
Tuvalu[a]	0.0100	0.01	0.0100[d]	0.01[d]
Uganda	0.0100	0.01	0.0100	0.01
Ukraine	1.1208	1.07	1.1400	1.09
United Arab Emirates	0.1868	0.19	0.1900	0.19
United Kingdom of Great Britain and Northern Ireland	5.2253	5.23	5.3150	5.32
United Republic of Tanzania	0.0100	0.01	0.0100	0.01

[a] Not a Member of the United Nations.

[b] Assessment imposed on a State which is not a Member of the United Nations but participates in certain of its activities.

[c] Associate Member of WHO.

[d] Assumed United Nations rate if State or territory had been a Member of the United Nations.

(1) Members and Associate Members	(2) WHO scales 1996 %	(3) WHO scales 1997 %	(4) United Nations scales 1996 %	(5) United Nations scales 1997 %
United States of America	25.0000	25.00	25.0000	25.00
Uruguay	0.0393	0.04	0.0400	0.04
Uzbekistan	0.1352	0.13	0.1375	0.13
Vanuatu	0.0100	0.01	0.0100	0.01
Venezuela	0.3318	0.32	0.3375	0.33
Viet Nam	0.0100	0.01	0.0100	0.01
Yemen	0.0100	0.01	0.0100	0.01
Yugoslavia	0.1008	0.10	0.1025	0.10
Zaire	0.0100	0.01	0.0100	0.01
Zambia	0.0100	0.01	0.0100	0.01
Zimbabwe	0.0100	0.01	0.0100	0.01

2. REQUESTS the Director-General, in the event that assessments are fixed provisionally or definitively by the present Health Assembly for any new Members not already included in the scales, to adjust the scales as set forth in paragraph 1.

Hbk Res., Vol. III (3rd ed.), 2.3; 6.1.2.1

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

WHA48.21 Review of the Working Capital Fund

The Forty-eighth World Health Assembly,

Having considered the recommendation of the Executive Board on the Working Capital Fund,

1. DECIDES that:

(1) Parts I and II of the Working Capital Fund shall be consolidated into one single Working Capital Fund with effect from 1 January 1996;

(2) the amount standing to the credit of each Member or Associate Member in the present Part I of the Working Capital Fund shall be refunded on 1 January 1996 by offsetting this amount against any regular budget contributions due by that date;

(3) an amount of US$ 5 million shall be transferred by the Director-General on 1 January 1996 from casual income to the Working Capital Fund to compensate partly for the refund of advances to Members and Associate Members;

2. DECIDES to amend the Financial Regulations with effect from 1 January 1996 accordingly, as shown in the report of the Director-General;[1]

[1] Document EB95/1995/REC/1, Annex 12, Appendix 1.

3. REQUESTS the Director-General to make consequent amendments to the Financial Rules at an appropriate time.

Hbk Res., Vol. III (3rd ed.), 6.1.3

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

WHA48.22 Real Estate Fund

The Forty-eighth World Health Assembly,

Having considered the report of the Director-General on the status of projects financed from the Real Estate Fund and the estimated requirements of the Fund for the period 1 June 1995 to 31 May 1996;[1]

Recognizing that certain estimates must necessarily remain provisional because of the fluctuation of exchange rates,

1. AUTHORIZES the financing from the Real Estate Fund of the expenditures summarized in part III of the Director-General's report, at an estimated cost of US$ 9 295 000;

2. APPROPRIATES to the Real Estate Fund, from casual income, the sum of US$ 7 691 000.

Hbk Res., Vol. III (3rd ed.), 6.1.7

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

WHA48.23 Salaries for ungraded posts and the Director-General

The Forty-eighth World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in the ungraded posts and of the Director-General,

1. ESTABLISHES the salary for the posts of Assistant Directors-General and Regional Directors at US$ 131 617 per annum before staff assessment, resulting in a modified net salary of US$ 85 972 (dependency rate) or US$ 77 763 (single rate);

2. ESTABLISHES the salary for the post of Deputy Director-General at US$ 145 236 per annum before staff assessment, resulting in a modified salary of US$ 93 735 (dependency rate) or US$ 84 232 (single rate);

3. ESTABLISHES the salary for the Director-General at US$ 179 537 per annum before staff assessment, resulting in a modified net salary of US$ 113 286 (dependency rate) or US$ 100 525 (single rate);

4. DECIDES that these adjustments in remuneration shall come into effect on 1 March 1995.

Hbk Res., Vol. III (3rd ed.), 6.2.4.3

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

[1] See Annex 4.

WHA48.24 International Decade of the World's Indigenous People

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 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 details for contacting the focal point.

Hbk Res., Vol. III (3rd ed.), 7.1.1

(Twelfth plenary meeting, 12 May 1995 - Committee B, second report)

WHA48.25 Consolidating budgetary reform

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 those 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 establishment of priorities at each stage and every level, for development of the programme budget;

(b) ensure sufficient flexibility in the process to permit continuous assessment of priorities and programmes and appropriate adjustments in implementation;

(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 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 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.

Hbk Res., Vol. III (3rd ed.), 2.1

(Twelfth plenary meeting, 12 May 1995 - Committee B, third report)

WHA48.26 Reorientation of allocations

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 to establish national health services;

Noting with deep concern that there has been no real growth in the WHO budget for the past 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 Executive Board and the Director-General:

(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 review this need in every biennium in order to achieve maximum transfer of resources to priority health programmes at country level;

(2) to ensure that each proposed programme budget shows 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.

Hbk Res., Vol. III (3rd ed.), 2.1

(Twelfth plenary meeting, 12 May 1995 - Committee B, third report)

WHA48.27 Paris AIDS Summit

The Forty-eighth World Health Assembly,

Having considered the reports of the Director-General on the global strategy for prevention and control of AIDS,[1] expressing the exemplary role of WHO, and on implementation of the joint and cosponsored United Nations programme on HIV/AIDS;[2]

Mindful that, among its objectives, the programme must not only obtain and facilitate a worldwide consensus on policies and programmes, but must also strengthen the capacity of the United Nations system to follow up trends and to ensure that appropriate and effective policies and strategies are implemented at national level;

Having in mind the seven initiatives contained in the declaration of the AIDS Summit adopted in Paris on 1 December 1994[3] with regard to involvement of people living with HIV/AIDS; global collaboration for HIV/AIDS research; international collaboration for blood transfusion safety; care of affected persons;

[1] Document A48/14.

[2] See Annex 5.

[3] Document EB95/1995/REC/1, Annex 7.

mobilization in favour of children, young people and orphans; reduction of the vulnerability of women; and respect for human rights and ethics related to HIV/AIDS;

Emphasizing that improved coordination of the activities conducted by governments, multilateral and intergovernmental organizations, and community-based organizations, including people living with HIV/AIDS, will make possible more effective control of the pandemic,

1. WELCOMES the declaration of the AIDS Summit adopted by the Heads of Government or representatives of the 42 States meeting in Paris on 1 December 1994;

2. INVITES governments which have not signed the declaration to do so;

3. INVITES the organizations cosponsoring the joint United Nations programme on HIV/AIDS to include in their programmes the provisions defined in the declaration adopted at the Paris Summit;

4. REQUESTS the Director-General, within the framework of the joint and cosponsored United Nations programme on HIV/AIDS, and in close cooperation with its Director, to contribute to implementation of the priority initiatives set out in the declaration of the Paris Summit.

Hbk Res., Vol. III (3rd ed.), 1.16.13; 7.1.3

(Twelfth plenary meeting, 12 May 1995 - Committee B, third report)

WHA48.28 Recruitment of international staff in WHO: geographical representation

The Forty-eighth World Health Assembly,

Noting the report and proposals of the Director-General and the views of the Executive Board with regard to the recruitment of international staff in WHO;[1]

Recalling earlier resolutions of the Health Assembly and the Board on the same subject, the last of which was WHA46.23;

Noting that recruitment of nationals from unrepresented and under-represented countries and countries below the mid-point of the desirable range has exceeded the target of 40% and reached 48%;

Reaffirming that the principles embodied in Articles 4.2, 4.3 and 4.4 of the Staff Regulations remain the paramount consideration in staff recruitment,

1. DECIDES to set a target of 60% of all vacancies arising in professional and higher-graded posts subject to geographical distribution during the period ending September 1996 for the appointment of nationals of unrepresented and under-represented countries and those below the mid-point of the desirable range;

2. CALLS UPON the Director-General and the Regional Directors to pursue energetically their efforts to continue to improve geographical representation;

3. REQUESTS the Director-General to report on the recruitment of international staff in WHO to the Executive Board and the Health Assembly in 1998.

Hbk Res., Vol. III (3rd ed.), 6.2.2.1

(Twelfth plenary meeting, 12 May 1995 - Committee B, third report)

[1] See documents EB95/1995/REC/1, Annex 8 and EB95/1995/REC/2, pages 244-248.

WHA48.29 Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine

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 (Madrid, 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 commencement of the implementation of the Declaration of Principles following 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 and 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]

1. EXPRESSES the hope that the peace talks will lead to establishment of a just, lasting and comprehensive peace in the Middle East;

2. EXPRESSES the hope that the Palestinian people, having assumed responsibility for their health services, will be able themselves to carry out health plans and projects in order to participate with the peoples of the world in achievement of WHO's objective of health for all by the year 2000;

3. AFFIRMS the need to support the efforts of the Palestinian Authority in the field of health 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;

[1] Document A48/32.

4. URGES Member States, intergovernmental organizations, nongovernmental organizations and regional organizations to provide speedy and generous assistance to help in 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 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.

Hbk Res., Vol. III (3rd ed.), 7.1.4.4

(Twelfth plenary meeting, 12 May 1995 - Committee B, third report)

WHA48.30 Establishment of the joint and cosponsored United Nations programme on HIV/AIDS

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;[1]

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;[2]

Welcoming the endorsement of the programme's establishment by the governing bodies of the other cosponsoring organizations;

[1] Document EB93/1994/REC/1, Annex 3, Part 1.

[2] See Annex 5.

Taking note of resolution 1994/24 adopted by the United Nations Economic and Social Council at its session in July 1994;

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 United Nations 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 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 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 and cosponsored United Nations programme on HIV/AIDS,

1. ENDORSES establishment of the Joint United Nations Programme on AIDS (UNAIDS), to which WHO will provide the administrative framework as described in the reports of the Director-General;

2. ENCOURAGES UNAIDS to promote 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;

3. URGES Member States elected to the Programme Coordinating Board of UNAIDS to consider the importance of maintaining public health experience and expertise on HIV/AIDS and sexually transmitted diseases when selecting their representatives to the Coordinating Board;

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 United Nations 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 UNAIDS is fully operational;

(6) to ensure that strategies are developed, in close collaboration with UNAIDS, for integrating activities against HIV/AIDS and sexually transmitted diseases 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.

Hbk Res., Vol. III (3rd ed.), 1.16.13; 7.1.3

(Twelfth plenary meeting, 12 May 1995 - Committee B, third report)

WHA48.31 Collaboration within the United Nations system and with other intergovernmental organizations: health assistance to specific countries

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 (on 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); and also resolution WHA44.41 (Emergency relief operations) which refers to a natural disaster in Bangladesh;

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),

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.

Hbk Res., Vol. III (3rd ed.), 1.2.2.2; 1.2.2.3; 7.1.4.5 (Twelfth plenary meeting, 12 May 1995 - Committee B, third report)

WHA48.32 Appropriation resolution for the financial period 1996-1997[1]

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

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.

[1] Taking into account the financing proposals contained in document A48/17.

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) in the amount of	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.

Hbk Res., Vol. III (3rd ed.), 2.3

(Twelfth plenary meeting, 12 May 1995 - Committee A, third report)

DECISIONS

WHA48(1) Composition of the Committee on Credentials

The Forty-eighth World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Bahrain, Belize, Bulgaria, Comoros, Eritrea, Finland, Malta, Mauritania, Pakistan, Peru, Sri Lanka, Tuvalu.

(First plenary meeting, 1 May 1995)

WHA48(2) Composition of the Committee on Nominations

The Forty-eighth World Health Assembly elected a Committee on Nominations consisting of delegates of the following 25 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, United Kingdom of Great Britain and Northern Ireland.

(First plenary meeting, 1 May 1995)

WHA48(3) Election of officers of the Forty-eighth World Health Assembly

The Forty-eighth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers:

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)

(Second plenary meeting, 1 May 1995)

WHA48(4) Election of officers of the main committees

The Forty-eighth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the following officers of the main committees:

Committee A: **Chairman** Dr Fatma H. Mrisho (United Republic of Tanzania)

Committee B: **Chairman** Professor A. Wojtczak (Poland)

(Second plenary meeting, 1 May 1995)

The main committees subsequently elected the following officers:

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 E. Samayoa (Honduras)
	Rapporteur	Dr H. El Kala (Egypt)

(First meetings of Committees A and B, 2 and 3 May 1995)

WHA48(5) Establishment of the General Committee

The Forty-eighth World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the delegates of the following 17 countries as members of the General Committee: 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 the United States of America.

(Second plenary meeting, 1 May 1995)

WHA48(6) Adoption of the agenda

The Forty-eighth World Health Assembly adopted the provisional agenda prepared by the Executive Board at its ninety-fifth session with the deletion of two items, the addition of a supplementary item and a change in title of one item.

(Third and eleventh plenary meetings, 2 and 8 May 1995)

WHA48(7) Verification of credentials

The Forty-eighth World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Angola; Argentina; Armenia; Australia; Austria; Azerbaijan;[1] Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Guatemala; Guinea; Guinea-Bissau; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia;[1] Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; 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; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian

[1] Credentials provisionally accepted.

Federation; Rwanda; Saint Kitts and Nevis; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; South Africa; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; The former Yugoslav Republic of Macedonia; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan;[1] Vanuatu;[1] Venezuela; Viet Nam; Yemen; Zaire; Zambia; Zimbabwe.

(Fifth, eleventh and twelfth plenary meetings, 3, 8 and 12 May 1995)

WHA48(8) Review of *The world health report 1995*, incorporating the Director-General's report on the work of WHO

The Forty-eighth World Health Assembly, after reviewing *The world health report 1995*, incorporating the Director-General's report on the work of the Organization in 1994,[2] commended the Director-General for the new approach to reporting on the world health situation and expressed its satisfaction with the manner in which the programme of the Organization was being implemented.

(Tenth plenary meeting, 5 May 1995)

WHA48(9) Election of Members entitled to designate a person to serve on the Executive Board

The Forty-eighth World Health Assembly, after considering the recommendations of the General Committee,[3] elected the following as 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.

(Eleventh plenary meeting, 8 May 1995)

WHA48(10) Annual report of the United Nations Joint Staff Pension Board

The Forty-eighth World Health Assembly noted the information contained in the annual report of the United Nations Joint Staff Pension Board,[4] including the status of the United Nations Joint Staff Pension Fund.

(Twelfth plenary meeting, 12 May 1995)

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[1] Credentials provisionally accepted.

[2] *The world health report 1995.* Geneva, World Health Organization, 1995.

[3] For report of the General Committee, see document WHA48/1995/REC/3.

[4] Document A48/30.

WHA48(11) Appointment of representatives to the WHO Staff Pension Committee

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 alternate member of the Committee, the appointments being for a period of three years.

(Twelfth plenary meeting, 12 May 1995)

WHA48(12) Reports of the Executive Board on its ninety-fourth and ninety-fifth sessions

The Forty-eighth World Health Assembly, after reviewing the Executive Board's reports on its ninety-fourth[1] and ninety-fifth[2] sessions, took note of the reports; commended the Board on the work it had performed; and expressed its appreciation of the dedication with which the Board had carried out the tasks entrusted to it.

(Twelfth plenary meeting, 12 May 1995)

WHA48(13) Selection of the country in which the Forty-ninth World Health Assembly will be held

The Forty-eighth World Health Assembly, in accordance with Article 14 of the Constitution, decided that the Forty-ninth World Health Assembly would be held in Switzerland.

(Twelfth plenary meeting, 12 May 1995)

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[1] Document EB94/1994/REC/1.

[2] Documents EB95/1995/REC/1 and EB95/1995/REC/2.

ANNEXES

ANNEX 1

Emergency and humanitarian action[1]

Report by the Director-General

[A48/5 - 27 February 1995]

CONTENTS

I. INTRODUCTION

1. Emergency management, which includes emergency prevention, preparedness and response, is currently amongst the highest priorities of the international community. In any disaster situation, whether natural or man-made, human health is invariably at risk. WHO, through its existing technical and managerial expertise in health care and development, is ideally placed to analyse needs in the health sector in crisis situations and thus to advise governments and international agencies on the handling of health issues in emergencies.

2. The number of people affected by natural and man-made disasters, including "complex emergencies", escalated further in 1994. Although no accurate figures are yet available for that year, it is estimated that the number may be as high as 250 million to 300 million people, among whom at least 40 million will have

[1] See resolution WHA48.2.

become refugees or internally displaced persons as a result of wars, complex emergencies involving internal strife or natural disasters throughout the world. Complex emergencies appear to be on the rise, largely as a result of the ethnic and sociopolitical tensions that have surfaced in the post-cold-war era. In response to this global trend for emergency and humanitarian assistance needs to increase in the 1990s, a number of resolutions has been endorsed by the United Nations General Assembly and the Health Assembly, including resolution WHA46.6 on Emergency and humanitarian relief operations (10 May 1993).[1]

II. ROLE OF WHO IN EMERGENCY AND HUMANITARIAN ACTION

3. Within the global efforts aimed at emergency preparedness and disaster relief in the United Nations system, WHO's primary responsibility is to assume the health coordination role under its mandate and taking advantage of its scientific and technical expertise in medicine, public health and health development. In asserting this role, WHO works primarily with the United Nations Department of Humanitarian Affairs (DHA), established in early 1992 in order to enhance coordination in complex emergencies. As a member of the Interagency Standing Committee (IASC) and the IASC Working Group, WHO has become increasingly active in United Nations emergency and humanitarian activities.

4. Its role in these endeavours is twofold:

- in emergency preparedness, WHO considers it its responsibility to continue and to expand further its traditional role of strengthening the capacity of Member States and promoting their self-reliance at national and district levels;

- in humanitarian action, Article 2(d) and (e) of the WHO Constitution require it "to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments" and "to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories".

5. During the first nine months of 1994, WHO collaborated in the issuing of 16 consolidated interagency humanitarian appeals. Donor contributions to the programme for emergency and humanitarian action for the same period totalled US$ 38.6 million.

6. WHO has been developing additional cooperative links, *inter alia*, with UNHCR, UNICEF and the International Committee of the Red Cross to ensure that the extensive medical knowledge that WHO can mobilize at headquarters and through its regional offices is effectively applied in responses to emergencies.

III. REVIEW OF PROGRAMME ACTIVITIES IN 1994

Emergency preparedness

7. WHO and PAHO played a major role in the World Conference on Natural Disaster Reduction (Yokohama, Japan, 1994), collaborating closely with the Secretariat of the International Decade for Natural Disaster Reduction and their regional office for Latin America and the Caribbean. PAHO/WHO coordinated two of three sessions of the main committee at which regional reports were presented. These two reports focused on regional examples of projects that addressed common vulnerabilities and developed shared

[1] Other resolutions are: United Nations General Assembly resolutions 46/182, on Strengthening of the coordination of humanitarian emergency assistance of the United Nations (19 December 1991), and 48/57, on Strengthening of the coordination of humanitarian emergency assistance of the United Nations (31 January 1994), and Health Assembly resolutions WHA46.39, on Health and medical services in times of armed conflict (14 May 1993), WHA47.28, on Collaboration within the United Nations system and with other intergovernmental organizations: health assistance to specific countries (12 May 1994), and WHA47.29, on Rwanda (12 May 1994).

solutions. WHO headquarters coordinated the other session on ways in which the public sector, private sector and voluntary organizations can work together.

8. PAHO/WHO also played a significant role in the Global Conference on Sustainable Development of Small Island Developing States, where environmentalists and other non-health professionals paid increasing attention to the impact of disasters on development. Their recommendations specifically relate to and will reinforce such activities as disaster mitigation for hospitals and health facilities, and the establishment of subregional electronic disaster information networks.

9. Training activities, including briefing sessions and interregional seminars on emergency management, were organized for WHO staff at regional and country levels. Among joint activities, WHO participated in a course on health emergencies in large populations (HELP) and the United Nations disaster management training programme. Training activities of the WHO Pan-African Centre for Emergency Preparedness and Response included formulation of a curriculum with computerized models including "risk mapping" and other material for use in national training workshops. Preparations for one-month international training courses on emergency management for the health sector are being completed. The first course will be held in Geneva in June 1995.

10. WHO, in collaboration with other organizations, continued to support community-level research-oriented activities in Croatia, Mozambique and Sri Lanka through the Health and Development for Displaced Populations Programme (HEDIP). The Programme's activities have been regularly documented and disseminated through a newsletter, "HEDIP Forum".

11. PAHO/WHO's relief supply management project, SUMA (Medical Supply Management in the Aftermath of Disasters in Latin America and the Caribbean), provides an information tool at national level with which disaster-stricken countries can classify, sort and inventory donations in the aftermath of a disaster. By the end of 1994 more than 800 persons in Latin America and the Caribbean had been trained in the SUMA methodology. A new release of the SUMA software (version 4.2) was also designed and distributed throughout the region, and is available in English, French and Spanish. Managing incoming relief supplies and pledges from the donor community requires specialized attention, not only in the aftermath of natural disasters but also in humanitarian assistance operations. A regional team of SUMA experts was on hand in Haiti in 1994 to assist the Haitian authorities, UNDP and DHA in this particularly complex situation. A module to manage pledges was added to the software, and the mobilization of SUMA left a trained cadre of Haitian nationals in place to manage the programme in the future. The experience in Haiti confirms that the SUMA methodology is appropriate for use in both natural disasters and complex emergencies.

12. PAHO/WHO has placed particular emphasis on fostering collaboration with parliamentarians to promote the passage of legislation on disaster prevention, mitigation and response. In 1994 the Ecuadorian parliament officially created a special commission to discuss legislative issues, and Ecuador sponsored a regional parliamentarian meeting for the Andean countries. PAHO/WHO played a major role when a special workshop for Central American parliamentarians and national directors of health was held during the Inter-American Conference on Natural Disaster Reduction (Cartagena, Colombia, 1994), which discussed the need to create appropriate disaster legislation, at least in the most vulnerable countries. Later in 1994 during a meeting of Latin American parliaments (PARLATINO), the subject of disaster prevention and mitigation was also discussed.

13. Strong efforts are being made to develop an early warning and emergency information system for support to WHO humanitarian action. Consultations within the Organization and with WHO collaborating centres are under way to finalize the implementation strategy for this project, as part of the wider effort of DHA to establish a comprehensive early warning system. WHO will use the wealth of information that Member States and WHO have at their disposal for reporting on diseases, but adapted to suit areas vulnerable to disasters.

Emergency relief and humanitarian assistance

14. With the complex emergency situation existing in Rwanda and neighbouring countries since April 1994, WHO joined in international relief efforts to bring assistance to Rwandan refugees as well as to internally displaced populations. In the early stages of the crisis, WHO carried out an epidemiological assessment, delivered emergency health supplies and deployed teams. In July, as a consequence of the mass exodus, WHO deployed other teams of epidemiologists, primarily along the Zairian border, where, among other things, WHO identified the precise strain of cholera and other pathogens that had been decimating the refugee population. In Goma, WHO provided support for the collection and analysis of epidemiological data, laboratory support, and necessary drugs and materials to help control the further spread of cholera, dysentery and meningitis.

15. In August a Special Coordinator of the Director-General was sent to Kigali to reopen the country office and to coordinate WHO emergency and rehabilitation assistance in Rwanda, as well as in Rwandan refugee camps in neighbouring countries. WHO continues to help to rebuild the shattered health infrastructure in Rwanda.

16. In former Yugoslavia, WHO activities were carried out through offices in Belgrade, Sarajevo, Skopje, Split, Tuzla, Zagreb and Zenica, with the help of over 80 international and local staff. Activities included assessing health needs; advising health authorities, other organizations of the United Nations system and nongovernmental organizations on public health matters and the nutritional content of food supplies; supporting health care institutions with medical and other supplies; and physical and psychosocial rehabilitation of war victims.

17. WHO continued to cooperate with the governments of the newly independent States in coordinating activities in the health sector. For example, in 1994, WHO participated in the interagency missions to Tajikistan and the Caucasus (Armenia, Azerbaijan, Georgia) and in the subsequent elaboration of consolidated interagency appeals for such countries or areas. WHO currently maintains a presence in Tajikistan through its Special Representative and has liaison offices in Armenia, Azerbaijan and Georgia.

18. In the Self-Rule Areas, WHO implemented special technical assistance programmes to improve the health conditions of the Palestinian people and assisted in the smooth transition of health services in Gaza and Jericho. Basic drugs, medical supplies and equipment as well as technical assistance in primary health care, sanitation and environmental activities were provided to the Palestinian Health Council.

19. WHO activities in Iraq, including in its northern governorates, included provision of life-saving drugs and basic medical supplies, epidemiological surveillance and malaria control.

20. The spread of cholera in Somalia was controlled by June 1994 with the help of a team of 10 WHO staff members. The withdrawal of UNOSOM (United Nations Operations in Somalia) forces in March 1995 will aggravate the security situation in the country.

21. WHO continued to coordinate health care programmes in Afghanistan, including those in the camps for displaced and returning refugees, and delivered large amounts of medical and surgical supplies and equipment to health centres and hospitals in the country.

22. In addition, WHO emergency and humanitarian activities included support to the following countries: Angola, Armenia, Azerbaijan, Bolivia, Burundi, Colombia, Djibouti, Eritrea, Ethiopia, Georgia, Haiti, Islamic Republic of Iran, Lebanon, Liberia, Mozambique, Saint Lucia, Sudan, Swaziland, Tajikistan, Uganda, United Republic of Tanzania, Yemen and Zaire.

IV. TASK FORCE STUDY

23. In August 1993, recognizing the strategic importance of a strong WHO role in emergencies, the Director-General decided to establish a task force on emergency and humanitarian action, chaired by an Assistant Director-General, to determine the best way to adapt to current requirements in this fast-evolving field.

24. The report of the task force, whose recommendations are intended to serve as the blue-print for WHO's restructuring in this important area, is available on request. Its main findings and recommendations are summarized below:

(1) **Mandate.** The task force recommended that both WHO's overall mandate for emergency and humanitarian action and the related responsibilities and tasks should be revised and updated. This has been accomplished through broad consultation which has reaffirmed WHO's strong constitutional mandate for the activities which had, hitherto, been given insufficient attention. For the full text of the proposed WHO mandate, see the Appendix.

(2) **Roles of headquarters, regional offices and country offices.** Normal WHO practice should be observed for emergency preparedness, which is of a similar nature to development activities. For humanitarian action, however, effective response depends on rapid reaction and requires a special distribution of responsibilities, whereby the WHO Representative must have simultaneous liaison with headquarters and the regional office, and a more active part in the United Nations disaster management team chaired by the UNDP Resident Representative.

(3) **Reorganization.** The task force has proposed a new structure which includes a strengthening of core staff, essential support services, regrouped and strengthened emergency relief sections, a fully-integrated office in Addis Ababa which will focus on training, incorporation of the formerly separate injury prevention programme, and creation of a post for an emergency coordinator to ensure smooth coordination within WHO.

(4) **New procedures.** In response to the need for special emergency procedures for WHO as provided in United Nations General Assembly resolutions 46/182 and 48/57, a reform process has been started which aims, *inter alia*, at the harmonization of WHO's field emergency procedures with those of other organizations of the United Nations system, wider use of standard agreements and supply lists, simplified recruitment and clearance procedures, a more transparent and "user-friendly" donor reporting system, and a strengthening of the role of the WHO Representative.

(5) **Resource mobilization.** If it is to secure the funds needed for effective emergency management, WHO must widen its circle of donors, collaborate more closely with its Members at all stages of resource mobilization, and encourage closer involvement of donors, with shared assessments, contributions in kind, staff secondment, etc. WHO is reviewing its overall policies relating to fund-raising for emergency activities; this includes a clarification of its responsibilities, the need for new specialized expertise and a reaffirmation primary role and responsibility of headquarters in fund-raising for complex emergencies.

V. WHO'S NEW STRATEGY FOR EMERGENCY AND HUMANITARIAN ACTION

25. Given WHO's broad constitutional mandate in emergency and humanitarian action, and the need to concentrate efforts both on areas where the Organization is particularly well equipped for such action and on new forms of cooperation so as to increase further the effectiveness of its operations, the new strategy will build on the key lines described below.

(1) **Emphasize normative functions and technical guidance** rather than operational response requiring extensive logistic support and staff in the field. This will be achieved by:

- establishing focal points in regional offices for the implementation of emergency preparedness programmes at country level;
- holding regular meetings of responsible officers from regional offices to develop common strategies and approaches for emergency management;
- developing projects and activities at global level which reflect the needs of the regions and Member States, including, *inter alia*, preparation of technical publications, organization of technical meetings and conferences, and development and implementation of training programmes;
- establishing a focal point in each of the technical divisions at headquarters;
- providing technical support to regional offices when requested;
- strengthening WHO's capabilities for immediate assessment of health aspects of emergencies, *inter alia*, through the timely mobilization of "emergency health assessment" teams;
- strengthening WHO's capacity to monitor and enhance collaboration between the parties responding to health needs in complex emergencies.

(2) **Adopt a "partnership" approach**, i.e., much closer collaboration from the planning stage onwards, not only with the governments concerned and the main bilateral donor agencies, but also with other organizations of the United Nations system and nongovernmental organizations, in a spirit of full cooperation and with a view to ensuring complementarity of action under a common plan.

(3) **Emphasize on the "development continuum"**, i.e., the need to ensure an "unbroken chain of congruent activities during emergency preparedness, emergency relief, rehabilitation and long-term health development"; this presupposes a high level of technical expertise in emergency health management, sound planning and effective interagency coordination.

(4) **Distinguish clearly between natural and technological disasters and health emergencies on the one hand and complex emergencies on the other**: in the former, WHO's regional offices, with support and broad strategic directions from headquarters, will continue to play the main role in WHO's relief efforts; in the latter, the establishment of special highly centralized coordination mechanisms under DHA will be the direct responsibility of the Director-General and involve headquarters and regional offices.

(5) **Intensify or extend relations within WHO and with WHO collaborating centres for emergency and humanitarian action** so as to strengthen capabilities through shared expertise; the focal point for the preparation of WHO's response to complex emergencies will ensure the effective mobilization and contribution of others concerned within WHO, and facilitate the optimal use of collaborating centres' contributions.

(6) **Focus on a few specific areas of concern to WHO's governing bodies and providers of funds**, notably establishment of an epidemiological early warning system and training in emergency health management, for staff of WHO and its partners, including institutions in Member States.

(7) **Re-enforce WHO's technical and coordinating role in promotion of safety and protection against violence** (which are included in the Ninth General programme of Work) with appropriate

adjustment of activities of the injury prevention programme, to maximize WHO's technical capacity in this field.

(8) **Strengthening WHO's advocacy for the respect and protection of health personnel and infrastructure in situations of conflict**, in accordance with the concept of health as an investment for peace. WHO will advocate protection of non-combatants and setting-up of effective treatment and rehabilitation programmes for the victims of anti-personnel mines, and the systemic management of delayed health effects of mental and physical injuries in situations of collective violence.

VI. MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

26. [This paragraph invited the Health Assembly to consider the resolution recommended in resolution EB95.R17. The recommended resolution, with amendments, was adopted at the eleventh plenary meeting as resolution WHA48.2.]

Appendix

PROPOSED WHO MANDATE FOR EMERGENCY AND HUMANITARIAN ACTION

1. BACKGROUND AND BASIC CONSTITUTIONAL MANDATE

Humanitarian assistance, which includes emergency prevention, preparedness and response, has a very high priority for the international community. In any disaster, whether natural or man-made, human health is invariably at risk. As the United Nations agency for health, WHO has the mandate for, and responsibility of leadership in, planning, coordinating and managing international emergency assistance programmes where health is concerned. Health can be an instrument for peace. Thus, the Organization intends to make its specific contribution to the Secretary-General's "Agenda for Peace" and a more peaceful world.

Article 2 of the Constitution of WHO states that WHO shall "act as the directing and co-ordinating authority on international health work", "furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments" and "provide, or assist in providing, upon the request of the United Nations, health services and facilities to special groups ...". These groups do not necessarily fall within political boundaries, nor do they always follow the classical distinction between soldiers and civilians. Those eligible for WHO emergency health assistance include people suffering from disease, injury or malnutrition, be they civilians, military personnel or refugees.

Since its inception, WHO's many technical programmes, such as those for communicable diseases prevention and control, immunization, water and sanitation, mental health, or essential drugs, have incorporated elements of emergency preparedness in specific activities for health development in Member States.

WHO formally established an emergency unit in the 1970s to coordinate the technical support of other divisions to regional offices for emergency preparedness activities at country level. In the 1980s, when natural disasters, "technological" disasters and complex emergencies increased in number and importance, Member States called on WHO to tackle disaster relief as well. Several Health Assembly resolutions have

been adopted to strengthen emergency response.[1] An expanded Division of Emergency Relief Operations was formed in 1989, incorporating the former emergency preparedness and response programme and a newly created emergency relief programme.

WHO's involvement in emergency preparedness received an important boost with the International Decade for Natural Disaster Reduction (1989).[2] UNESCO and WHO were the only organizations in the United Nations system to have passed a specific resolution of their governing bodies on the Decade, urging increased contribution to related national and international efforts.[3] An interagency working group for the Decade was subsequently created, of which WHO is a member.

The new Division focused on relief and reconstruction talks in Afghanistan, Namibia and the occupied Arab territories. However, it quickly expanded its operations to other countries and areas such as Angola, Cambodia, Iraq, the Horn of Africa, Lebanon, Liberia, Malawi, Mozambique, and the republics of the former Yugoslavia and of the former Soviet Union.

In December 1991 the United Nations General Assembly adopted resolution 46/182 on the strengthening of the coordination of humanitarian emergency assistance of the United Nations. The new United Nations Department of Humanitarian Affairs and an Inter-Agency Standing Committee were established to coordinate more closely the work of the organizations of the United Nations system, under the leadership of the Secretary-General and the Under-Secretary-General for Humanitarian Affairs. In response to the widely felt need for closer coordination and more rational distribution of emergency responsibilities among the organizations, WHO in 1992 restructured its emergency services and created a Division of Emergency and Humanitarian Action consisting of relief units with a clear geographical focus and adding an emergency information unit.

Recently, WHO has engaged in a comprehensive review of its global operations for humanitarian relief in order to adapt its structure and procedures to rapidly changing requirements. The object is to enable WHO to assure its leading role in the planning and management of emergency interventions where health is concerned by providing increased support to its Member States and other partners in system-wide emergency response.

2. OBJECTIVE AND SCOPE OF WHO'S INVOLVEMENT IN EMERGENCY AND HUMANITARIAN ACTION

WHO's emergency management activities will help Member States to coordinate, implement and monitor health policies, infrastructure development and relief operations so that they meet the threats of wide-scale emergencies to health, such as epidemics, drought, famine, cyclones, floods, earthquakes, chemical pollution, civil unrest and armed conflict.

WHO's objective is to strengthen national capabilities for emergency preparedness through close collaboration with Member States, and by ensuring maximum congruence of emergency relief, rehabilitation and long-term development efforts, so as to promote increased self-reliance in countries affected by emergencies. Thus WHO intends to make its contribution to implementation of the guiding principles set out in United Nations General Assembly resolution 46/182, according to which special attention should be

[1] Resolutions WHA46.6 on Emergency and humanitarian relief operations (10 May 1993); WHA46.39 on Health and medical services in times of armed conflict (14 May 1993); WHA47.28 on Collaboration within the United Nations system and with other intergovernmental organizations: health assistance to specific countries (12 May 1994); and WHA47.29 on Rwanda (12 May 1994).

[2] United Nations General Assembly resolution 44/236.

[3] Resolution WHA42.16.

given to disaster prevention and preparedness by the governments concerned, as well as by the international community.

WHO's objectives in emergency relief are to provide, where appropriate, initial relief assistance in the humanitarian health field in the aftermath of disasters, to ensure that health relief efforts are efficient, appropriate and effective, and that they are carried out in a coordinated manner; and subsequently to support and rehabilitate health care systems, emphasizing the primary health care approach and the need to provide special groups with essential health services. A primary aspect of WHO's relief efforts will be to ensure that, as far as possible, the initial medical relief structures are incorporated in the permanent infrastructure, in accordance with the principle that emergency assistance should be provided in ways that will be supportive of recovery and long-term development, as stated in United Nations General Assembly resolution 46/182.

3. WHO'S APPROACH IN EMERGENCY AND HUMANITARIAN ACTION

WHO will use a combination of technical advisory services to achieve its objectives as the main public health adviser to other partners with a view to concerted intervention by all relief agencies; direct intervention; and delegation of certain activities to other organizations of the United Nations system or nongovernmental organizations as required, involving the existing United Nations coordination bodies and governmental structures in the delivery of humanitarian assistance.

WHO will continually review and update the technology for humanitarian assistance, drawing upon the vast scientific and technical resources of over 100 technical programmes at WHO headquarters and in six regional offices, and over 1100 scientific and technical institutions linked to WHO as collaborating centres, eight of which are directly concerned with emergency and humanitarian action, in which WHO Representatives and regional offices, including field staff, have a key role to play. New emergency procedures will facilitate more rapid decision-making by WHO's executive management and, in general, a faster response in all emergency situations.

The aim of WHO's emergency activities is above all to encourage self-reliance and national development in Member States by increasing their capacity to manage emergencies. Mindful of the principle expressed in United Nations General Assembly resolution 46/182 that there is a clear relation between emergency assistance, rehabilitation and development, WHO's relief efforts will be integrated into long-term plans for health and social development, and will rely on expertise in countries as much as possible. WHO will also encourage countries to include measures for disaster preparedness, prevention and mitigation into their mid- and long-term development plans, in close collaboration with the DHA secretariat for the International Decade for Natural Disaster Reduction, of which WHO is a key partner. In order to further this process and to establish focal points for expertise in this area, WHO is also planning to increase the use, for emergency activities, of its worldwide network of collaborating centres and to strengthen its WHO Representatives' offices through intensified training and other appropriate measures.

Within the framework of interagency coordination under DHA, WHO intends to focus its efforts mainly on areas in which it possesses particular expertise or other advantages, and to collaborate with other organizations of the United Nations system working in related areas, in order to avoid duplication of effort and to maximize the effectiveness of operations. Special collaboration will be sought with the International Committee of the Red Cross and the International Federation of Red Cross and Red Crescent Societies, particularly in developing advocacy for emergency humanitarian work. Expansion of WHO's collaboration with nongovernmental organizations in the field of medical emergencies is deemed to be particularly important in view of their strong presence in this area and their proven strength in the implementation of field projects.

ANNEX 2

Maternal and child health and family planning: quality of care[1]

Reproductive health: WHO's role in the global strategy

Report by the Director-General

[A48/10 - 24 April 1995]

CONTENTS

I. POLICY BASIS

1. The Health Assembly recognized the public health importance and social and economic consequences of different aspects of reproductive health from as early as 1965 (resolution WHA18.49), and WHO policy is guided by a series of resolutions of the Health Assembly, the Executive Board and regional committees[2] which provides a context for reproductive health as a central component of general health and thus a fundamental right and an issue for public discussion, information and action. WHO has a responsibility to

[1] See resolution WHA48.10.

[2] Related subjects of regional resolutions include: accelerating the improvement of maternal and child health (Africa, 1990); regional plan of action for the reduction of maternal mortality (the Americas, 1990); integrated approach to maternal and child care in the context of primary health care (South-East Asia, 1986); women, health and development (Europe, 1988); maternal and infant mortality: socioeconomic implications and urgent need for control (Eastern Mediterranean, 1988); and adolescent health (Western Pacific, 1988).

provide vision and leadership in the development of approaches to reproductive health. This paper sets out the framework for a global reproductive health strategy and for WHO's related role.

2. Within WHO the programmes directly concerned with reproductive health are, under the Division of Family Health, those on maternal health and safe motherhood, family planning and population, women, health and development, adolescent health and development, and child health and development; the Special Programme for Research, Development and Research Training in Human Reproduction; and the Global Programme on AIDS, which includes the programme on sexually transmitted diseases. Programmes which deal with breast-feeding and nutrition, the environment, cancer, violence, and the elderly are also concerned.

3. Reproductive health is a crucial part of general health and is central to human development. It affects everybody; it involves intimate and highly valued aspects of life. Not only is it a reflection of health in childhood and adolescence, it also sets the stage for health beyond the reproductive years for both women and men and has pronounced effects from one generation to another. Furthermore, it affects other health conditions and aspects. The definition of reproductive health,[1] based on WHO's working definition, adopted in the Programme of Action of the International Conference on Population and Development (ICPD), and endorsed by the United Nations General Assembly in its resolution 49/128, serves as the basis for action by Member States and for support by organizations of the United Nations system.

4. The attainment of reproductive health for all will require an approach that puts people first, rather than problems or interventions. This means greater involvement of people in their own health care; the application of knowledge derived from many disciplines; a multisectoral and intersectoral approach; and an understanding of reproductive health needs in the context of an individual's life span and specific cultural, economic and physical environment. Families - natural bridges between individuals and society - as basic productive and reproductive units are essential to the reproductive health of society as a whole.

5. Reproductive health eludes many people because their knowledge about human sexuality is inadequate and related health information and services are inappropriate, of poor quality or inaccessible; high-risk sexual behaviour is prevalent and the choices many women and girls have in this domain are limited. Adolescents are particularly vulnerable because of their lack of information and access to relevant services. The particular aspects of reproductive health affecting older women and men are often given inadequate attention. Reproductive health needs of people during armed conflicts or mass population displacements are rarely taken into consideration.

6. Advocacy and action for reproductive health are hampered by the absence of reliable information, yet even the information available indicates needs and aspects of considerable scope and magnitude. In order to make more information available on reproductive health, WHO has collected data and maintains databases on a number of indicators for reproductive health such as maternal mortality, morbidity, coverage of maternity care, anaemia during pregnancy, unsafe abortion, low birth weight, neonatal and perinatal mortality, infertility, sexually transmitted diseases and HIV/AIDS (see table below).

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[1] "**Reproductive health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, **reproductive health care** is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes **sexual health**, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases ..." (Programme of Action in ICPD document A/CONF.171/13, paragraph 7.2).

7. Reproductive health has different components and its attainment requires a variety of actions. It calls for continual research; culling and dissemination of information; use of sound data for advocacy to strengthen policies and programmes that promote reproductive health; revision of training; streamlining of services and involvement of users in their planning and management; and monitoring and evaluation to measure the effectiveness of new approaches. The increased participation of nongovernmental organizations, particularly women's health groups, has brought to the fore the women's viewpoint that was often missing in the past.

REPRODUCTIVE HEALTH:
ESTIMATED NUMBER OF PEOPLE AFFECTED

Category	Millions (world)
Couples with unmet family planning needs[1]	120
Infertile couples[1]	60-80
Maternal deaths[2]	0.5
Severe maternal morbidity[2]	20
Perinatal mortality[2] (about 1983)	7
Infants with low weight at birth[2]	25
Infant deaths[2]	9
Unsafe abortions[2]	20
HIV infections by the year 2000[1]	30-40
AIDS cases by the year 2000[1]	12-18
Curable sexually transmitted diseases (new cases)[2]	250
Female genital mutilation[1]	85-114

[1] Total number.
[2] Annual number.

II. THE CHALLENGE OF REPRODUCTIVE HEALTH NEEDS

8. In the broader context of people's lives many factors affect reproductive health, and its attainment is not conditional on interventions by the health sector alone. Such factors include economic circumstances, education, employment, living conditions and family environment, social relationships and relations between the sexes, and the traditional and legal structures within which people live. Sexual and reproductive behaviour is governed by complex biological, cultural and psychosocial factors, and by relations between the sexes generally. Nonetheless, most aspects of reproductive health cannot be significantly improved in the absence of health services and medical knowledge and skills. The attainment of reproductive health requires equity between the sexes, accessible and acceptable-quality services and technology, and the participation of other sectors.

9. As a concept reproductive health means more than the absence of diseases or other health problems. Rather, it must be understood in the context of relationships: fulfilment and risk; the opportunity to have a desired child or the arrival of an unwanted one - occasions that define human growth and development or, by contrast, exploitation and degradation. Reproductive health has positive dimensions - physical and psychosocial comfort and closeness, and social maturation - and negative ones - disease, abuse, exploitation, unwanted pregnancy, sexually transmitted diseases including HIV/AIDS, and death.

10. The status of girls and women in society, and how they are treated or mistreated, is a crucial determinant of their reproductive health. Educational opportunities for girls and women greatly affect their status and the control they have over their own lives and their health and fertility; female education is also an important contributor to child survival and development. The empowerment of women is therefore an essential element for health.

11. A public health approach to reproductive health within the context of primary health care is important if the concept is to be translated into a reality. Such an approach responds to people's needs and involves them in programme formulation, implementation, monitoring and evaluation so that a strong feeling of ownership is established. It seeks sustainable programmes and actions that have the greatest impact for the most people at an affordable price. The guiding principles are those of human rights, ethics, equity, quality of care, participation, partnership, integration, optimal use of resources and sustainability. Partnerships and sharing of responsibilities between government, nongovernmental organizations and the private sector are important in stimulating new ideas and approaches and ensure both service coverage and quality of care.

12. Although there is general consensus on the need to work towards the development of a comprehensive approach to reproductive health, in practice programme development will require prioritization and selection of activities and interventions on the basis of locally conducted analysis and consultation. Programmes directed to particular components of reproductive health exist in one form or another in most countries but tend to be fragmented. The rationale for an integrated approach is strengthened by evidence from the social, behavioural and managerial sciences suggesting that such an approach improves the accessibility, quality and utilization of services, is more responsive to the needs of individuals and families, is more cost-efficient, and can meet the needs of groups not adequately reached by existing structures or services.

III. TOWARDS A GLOBAL STRATEGY FOR REPRODUCTIVE HEALTH

13. A global reproductive health strategy should foster the development and implementation of regional and national policies, strategies and plans of action and should support countries as appropriate in preparing and implementing them, focusing on three major interrelated areas, namely:

- advocacy for the concept of, and for political commitment to, reproductive health, for an "enabling" environment, for wide participation and for increased resources for reproductive health programmes;

- research and action to support promotion and protection of reproductive health, prevention of specific reproductive health problems, and care and rehabilitation for all when needed; and

- attention to the special reproductive health needs and concerns of women, to underserved groups such as adolescents, to the roles and responsibilities of men, and to such population groups as refugees and displaced people.

14. **Advocacy.** A shared understanding of reproductive health will have to be developed through national and local consensus-building in order to lay the foundation for dialogue and programme development. The purpose of advocacy is to draw a community's attention to the challenges of reproductive health and to point decision-makers towards nationally relevant solutions. It involves reaching out to many people in many positions, translating the concepts and content of reproductive health into readily understood information appropriately communicated to different interest groups. Such information will have to be adapted to requirements and disseminated through public, political and professional forums at local, national and international levels.

15. One key objective of advocacy is to create a supportive and enabling cultural, social and political environment for reproductive health. The determination of the necessary changes, the means to realize them and the priorities for action must involve communities and all concerned groups, particularly women.

16. Advocacy will be needed in the area of policy and legislation within the context of national laws and in accordance with internationally recognized conventions. Legal and judicial factors influence reproductive health in many direct and indirect ways, for example through laws and regulations relating to: the minimum age for marriage and the age of consent; the minimum age for school-leaving and employment; education about sexuality and reproductive health; availability of and access to information and services for family planning, prevention of unsafe abortion and management of abortion complications, diagnosis and treatment of sexually transmitted diseases and maternity care, including essential obstetric care, especially for underserved groups.

17. **Research and action.** The promotion of reproductive health entails fostering the health and development of individuals throughout their lives, ensuring adequate nutrition and encouraging healthy lifestyles and relationships based on equity between the sexes. Although the health sector may provide a strong technical and policy foundation for promoting reproductive health, the effectiveness of such promotion depends on many sources, including educational, cultural, religious and communications sectors and institutions. For the prevention of specific reproductive health problems, information, education, guidance, counselling and services need to be available and accessible to help individuals develop mutually responsible and satisfying relationships, delay sexual relations until they are physically and psychologically mature, prevent unwanted pregnancy and make appropriate contraceptive choices; to reduce unsafe abortion; to promote safe pregnancy and delivery; and to prevent, treat and control sexually transmitted diseases.

18. Appropriate care is needed, for physiological events such as pregnancy and delivery, for guidance in the use of contraceptive technologies, and for the management of diseases and conditions such as reproductive tract infections and cancers. Rehabilitation is needed for people whose reproductive health has been compromised through illness or injury. All services should recognize that clients (and their partners) using any one service may need attention in other areas of reproductive health as well.

19. There is no universal formula for countries in planning and implementing programmes to reach the objective of reproductive health for all. Nevertheless, there are guiding principles which apply everywhere. Programme development should be guided by the overall principles of equity - particularly between the sexes - and respect for human rights and by operational principles comprising: national determination of country strategies and priorities; involvement of multiple perspectives in defining the priorities for reproductive health; participatory consultation in planning and in programme development and evaluation; and multisectoral action. Although policies and programmes have been developed for many of the component parts of reproductive health, designing approaches that link them effectively represents a new challenge. Taking the needs and viewpoints of different groups - policy-makers, service providers, research scientists, community groups, women, men, young people - as the starting point and comparing them with what is currently available in terms of interventions will permit the identification of gaps and inadequacies and the development of new programmes for filling and rectifying them.

20. Planning and implementing programmes in countries requires global and local advocacy supported by research. The acceptance of the broad framework for reproductive health is a necessary first step. The planning and organization of services needs an assessment exercise and national consultations on priorities and approaches. Implementation requires action at different levels including: legislation, regulations and other policy actions; the adaptation of norms and standards; human resource development, including the reformulation of curricula and methods of basic and in-service training; development of management information systems that focus on the performance of the programme and on quality of care; and the mobilization of material, human and financial resources.

21. The development and implementation of reproductive health policies and programmes will require an incremental as well as a participatory approach, based on an evaluation of what is currently in place and identification of gaps and inadequacies, and on strengthening of links between programmes in order to respond better to concern for reproductive health. Transforming the way information and services are delivered now so as to fit the broader context of reproductive health will necessitate a series of incremental

steps, adapting current structures as appropriate and feasible, building on previous stages. This process must encompass biomedical, cultural and social considerations.

22. An integrated approach does not necessarily mean that every service delivery point will have to deal with every reproductive health issue; that may be neither feasible nor appropriate. What it means is making use of every opportunity to prevent specific problems, especially for those at risk, providing care, treatment and rehabilitation for those who are or have been ill or injured and, above all, endeavouring to reduce the numbers of people who need care and rehabilitation by strengthening health promotion. Action to reduce many interrelated reproductive health problems should be effectively coordinated and carried out in a cost-efficient and humane way. Since health promotion goes well beyond the reach of the health sector, a great degree of cooperation across sectors and disciplines will be required. Cooperation will be needed at global and country levels, within the international and multinational system, between governments and nongovernmental organizations, with the professional and scientific community, the private sector, and voluntary bodies; above all else, there must be continual involvement of people.

23. A pragmatic approach will be required, starting with what exists, establishing common ground, determining gaps and inadequacies, describing actual or potential links and the steps that can be taken in the immediate and longer term to improve quality and move closer to the concept of reproductive health. This process will permit the identification of obstacles to availability, appropriateness and quality of existing information and services, and help develop strategies to overcome the obstacles through recognition of the interdependency of reproductive health interventions. Linkages are also needed across sectors so that reproductive health care can be closely associated with other services in the social sector. The principle should be that where a capacity exists no opportunity should be missed for meeting other reproductive health needs.

24. Although flexibility will be needed in priority-setting at national level, at global level epidemiological and other data and the expressed needs of various constituencies indicate that reproductive health programmes must give priority to: family planning; prevention of maternal and neonatal deaths and disabilities; and prevention and management of sexually transmitted diseases. As programmes become more comprehensive they should incorporate primary health care approaches to such conditions as reproductive tract infections and cancers, harmful practices, gender-based sexual violence, infertility and conditions due to malnutrition, including anaemia. Services must be accessible and acceptable and include information, education, counselling, care and rehabilitation.

25. WHO has identified clusters of well-delineated, cost-effective interventions that are likely to be important everywhere. One example is the "mother-baby package", which incorporates aspects of family planning and sexually transmitted disease management within the general context of maternity care and defines the minimum programmes and services needed to eliminate the burden of maternal and perinatal ill-health. Other such clusters include special methods for promoting adolescent reproductive health, including multisectoral planning, behavioural research, counselling and training in interpersonal skills, and client-centred service evaluation, and assessment of reproductive health needs.

26. Sexually transmitted disease control services need to be integrated or closely linked at primary health care level. Basic elements include information and education, prevention of infection, syndromic diagnosis and treatment, case finding for treatable sexually transmitted diseases, partner referral, intensified interventions for high-risk populations, and patient referral services.

27. Family planning services should not only provide information, education and universal access to a full range of safe and reliable methods but should also be closely linked to, or integrated with, other reproductive health services. Family planning programmes should focus on enabling people to make informed choices about the timing, number and spacing of their children, and on empowering women to manage their fertility while emphasizing men's joint responsibility in healthy sexuality and reproductive health.

28. Information and services should be improved to respond to the unmet need for family planning. Unsafe abortion is a major public health problem and a clear indication of unmet needs. Some 20 million unsafe abortions occur each year and result in a heavy burden of deaths and disabilities for women. WHO maintains that abortion should not be promoted as a method of family planning. The health consequences of unsafe abortion should be recognized and managed, and counselling and care provided for complications. Where abortion is legal it should be safe. All women should have access to high-quality and affordable counselling and services, including post-abortion family planning.

29. Other elements should be linked to reproductive health programmes and services as soon as feasible. These include, for example, treatment of reproductive tract infections, and information, education, screening and management services for cervical cancers. In the long term other priority areas should be added, such as management of infertility, screening and management of breast cancer and help with problems arising beyond reproductive age which may have their origins in earlier reproductive or sexual events. Reproductive health programmes should actively discourage practices that disadvantage girls; these include discrimination in food allocation or health care, and also female genital mutilation, child marriage and other harmful practices.

30. Efforts should focus on meeting the needs of defined target groups, including families, men as well as women, young people, and refugees and displaced people. Families should be able to provide for their members' basic needs for health, nutrition, shelter, physical and emotional caring, and personal development. Strengthening the capability of families, particularly for intra-familial communication and sharing of responsibilities, will create an environment conducive to full and healthy development of children and adolescents and to equity between the sexes, and will provide children with a foundation for good reproductive health.

31. The "empowerment" of women is a fundamental prerequisite for their reproductive health. This means action to give them increased access to resources, education and employment and the protection and promotion of their human rights and fundamental freedoms, so that they are enabled to make choices free from coercion or discrimination. Women will necessarily remain at the focus of reproductive health activities, but greater efforts should be made to facilitate their involvement in programme development so that they become participants rather than objects of interventions. At the same time, all programmes and services should pay particular attention to the roles and responsibilities of men in reproductive health. Men must be urged and helped to take responsibility for their sexual and reproductive behaviour and their social and family roles. Reproductive health will not be significantly improved in the absence of equity between the sexes and mutually caring relationships between partners.

32. The sexual and reproductive health needs of young people must be a central feature of any reproductive health programme. Policies and programmes must be formulated that facilitate the access of adolescents to information and to appropriate services. The objective is to help young people establish relationships based on mutual respect and trust, avoid premature sexual relations, and have access to information and services which enable them to protect themselves when they are sexually active.

33. Reproductive health is compromised when the security of the individual is endangered, especially in mass population displacements due to natural or man-made disasters. Programmes must be developed to respond to the special reproductive health needs of refugees and displaced people and in general of people during wars and armed conflicts.

34. There should be continual evaluation of reproductive health programmes at both national and international levels. This will involve assessing the accessibility, degree of utilization and quality of reproductive health services; appraising the degree of linkage between different components and with other areas in or outside the health sector; and monitoring the worldwide efforts and evaluating their impact in terms of the attainment of reproductive health for all.

IV. THE ROLE AND RESPONSIBILITIES OF WHO IN THE GLOBAL STRATEGY

35. WHO's primary responsibility is to support countries in the implementation of their national health programmes. Its mandate in reproductive health includes both normative functions and technical cooperation. Through the former the Organization takes a lead role in defining policies, identifying research priorities and giving technical guidance, including setting norms and standards. WHO's technical cooperation with countries involves collaboration with governments and other bodies in putting these policies and standards into practice, building up national capacity and working to ensure effective programmes. The two roles are closely related and mutually reinforcing; both involve the Organization in advocacy, policy and technical guidance, research and training, and monitoring and evaluation. An iterative process of normative work, and support for its application in the field, permit the continuous evolution of policies in the light of experience and changing country needs.

36. WHO's role in the global strategy will focus on four broad interrelated areas:

(i) international and national advocacy for the concept of reproductive health and for the policies and programmes promoted by WHO;

(ii) research aimed at assessing needs, at adapting and applying existing knowledge, and at developing new approaches and interventions, together with coordination of global efforts in these areas;

(iii) normative functions including the development of policies, strategic approaches, norms, standards and guidelines; and,

(iv) technical support to Member States and others in formulating, implementing and evaluating comprehensive national reproductive health policies and programmes.

37. (i) **Advocacy.** In its advocacy role the Organization will promote understanding of the universality of reproductive health needs throughout the life span and their centrality to health and human development. WHO's advocacy will be addressed to Member States, international and national agencies and institutions, and nongovernmental organizations within the health sector and in related sectors - education, social welfare, and the judicial, legislative, economic and financial spheres. WHO will give technical support to international and national agencies and organizations in establishing multidisciplinary and multisectoral task forces to bring together representatives of people with an interest in reproductive health.

38. (ii) **Research.** WHO's advocacy for reproductive health is closely linked to its role in monitoring, coordinating and conducting research. As the main agent for health research within the United Nations system, WHO will continue to conduct, support, promote and evaluate research in reproductive health and coordinate the global research efforts in this field. Closely linked to these objectives is the Organization's commitment to collaborating in the strengthening of research capabilities to enable developing countries to tackle their national priorities in reproductive health research.

39. Key steps in WHO's research collaboration with Member States will include:

- assessment of reproductive health status in order to identify existing needs, in particular those that require research, and determine priorities among them;

- adaptation and application of existing knowledge and current technology and interventions to the identified priority needs; and

- evaluation of the impact of changes introduced into services on the reproductive health and well-being of people.

40. In addition, from its close interaction with Member States and thorough knowledge of their populations' reproductive health needs, WHO will continue to identify areas where a regional or global research effort is needed to strengthen knowledge on key aspects of reproductive health, to develop new technology, interventions and methodology, and to address topics with complex implications such as ethics, sexual behaviour or abortion.

41. In the clinical research that it will conduct and support the Organization will ensure that:

- the views and standpoints of concerned groups (current and potential users of services, service providers, policy-makers, etc.) are adequately reflected at all stages of the research process;
- the research is conducted in conformity with the highest possible ethical standards;
- the research results are widely and effectively disseminated, especially to policy-makers, so that programmes evolve in response to the research findings; and
- the findings contribute, whenever applicable, to the discharge of the Organization's other responsibilities in the global reproductive health strategy, in particular the normative and advocacy functions.

42. National research priorities in reproductive health - which will be the primary factor in deciding the content and balance of WHO's research agenda - are likely to vary and cannot be determined accurately in the absence of systematic baseline evaluations of reproductive health status. However, significant research needs will be in the areas of fertility regulation, safe motherhood, and the prevention and management of sexually transmitted diseases. Thus, for example, global research efforts will be required for the continuing evaluation of the efficacy and long-term safety of existing methods of fertility regulation and the development and assessment of new and improved ones, with special attention to those for men, those that are user-controlled, and those that also exert preventive action against sexually transmitted diseases, including HIV/AIDS. Other priorities will include research on effective interventions to promote safer sexual behaviour and prevent HIV infection and other sexually transmitted diseases, and on more effective clinical management of those diseases. Operational research will explore how best to link services and exploit every opportunity in order to achieve the widest possible coverage of reproductive health needs in an accessible, acceptable, efficient and cost-effective manner, especially for underserved groups; it will also explore mechanisms to ensure involvement and participation of users, particularly women and young people, in programme design, implementation and evaluation. Support with specific activities, including assessment of reproductive health needs and interventions such as those comprising the "mother-baby package", will also be given high priority. WHO will make the maximum possible use of its well-established global network of collaborating agencies and institutions and the cooperation of national and international nongovernmental organizations with an interest in reproductive health.

43. (iii) **Normative functions.** WHO's normative role accommodates a broad range of activities which are linked both with its research functions and technical cooperation in reproductive health. In fulfilment of both these roles WHO will continue to develop technical, managerial and policy guidelines on various aspects of reproductive health. Within the sequence of programme development steps WHO has a crucial part to play in developing guidelines for national assessment of reproductive health needs and the methodologies for converting such assessments into prioritized, operational plans for implementation. Guidelines and methodologies will be adapted in the light of experience in country situations and the results of operational research. Priority for further research and development will be given to production of guidelines for framing of policies, implementation of reproductive health programmes, and formulation of appropriate legislation. Other priorities include research and development for the normalization of interventions and services; and questions of equitable provision, affordability and availability of information and services for reproductive health.

44. WHO will work with other competent agencies and bodies to formulate indicators for measuring the reproductive health status and behaviour of populations as well as the effectiveness of programmes and interventions. Particular attention will be paid to the development of innovative methodology for assessing reproductive health, including both qualitative and quantitative indicators.

45. The training and reorientation needs of all levels of workers in reproductive health will be accorded high priority in WHO's normative work in order to develop their capacity for adaptation and their ability to handle matters such as human sexuality in ways that reflect sensitivity to local cultural settings. Optimizing human resources for reproductive health will require the acquisition of interpersonal communication skills as well as attitudinal changes among health workers to improve the quality of care. Education programmes for all personnel, medical or non-medical, must therefore focus on imparting a range of problem-solving skills and instilling appropriate attitudes. WHO will actively advocate and technically support initiatives to exploit the potential of those with midwifery skills for providing many of the elements of reproductive health care. Understanding of normal reproductive function and of the social and psychological factors needed to prevent conditions leading to maternal and neonatal mortality is an essential element of midwifery practice and should receive increased attention in midwifery training together with management, communication and evaluation skills.

46. WHO's promotion of and support for training will also include the areas of monitoring and evaluation, research, and programme management aimed at ensuring equity of access to health care, quality of care, patient satisfaction, cost containment, and rational allocation of resources, with due regard to environmental determinants, ethical considerations, and technology assessment.

47. (iv) **Technical cooperation.** WHO will promote and facilitate the transfer of knowledge and expertise to Member States and others working to improve reproductive health. Particular attention will be paid to strengthening national capacity for implementation and monitoring and to sustainability of programmes. Although much of its support will concentrate on long-term policy and on programme development, monitoring and evaluation, WHO will also continue to collaborate in the shorter term with governments, nongovernmental organizations and other partners engaged in technical cooperation.

48. At country level WHO is one of many partners, each of which has its own specific responsibilities in terms of providing technical and financial support, collaboration in programme implementation, training and coordination. WHO's advantage stems not only from its continuous interaction with Member States, but also from its expertise in specific areas of reproductive health to be found throughout the Organization, its close links with other organizations of the United Nations system, the worldwide network of experts, collaborating centres and institutions, and its links with nongovernmental organizations and scientific, professional and health advocacy associations and groups.

49. Within WHO, country and regional offices and global programmes play a mutually complementary role in the Organization's strategy in reproductive health. The Organization will evaluate its own activities with regard to the components of reproductive health and the various programmes addressing them and will work to increase linkages between areas and across activities. A high-level Coordinating Committee on Reproductive Health at headquarters will secure maximum collaboration and complementarity and help to ensure that WHO activities in countries are properly coordinated and integrated. Current collaborative work will be continued, strengthened and expanded through joint task forces and working groups linking research and development activities to the adaptation and transfer of reproductive health technologies to support programme action in countries. These groups will build upon the work of existing ones, including the task force on research on the introduction and transfer of technology for fertility regulation, the task force on maternal health research, and joint working groups on "gender and women's perspectives" in reproductive health research and programme development, on strengthening of national and regional networks, on adolescent reproductive health, on female genital mutilation and on reproductive health needs among refugees.

50. The Organization's Global Policy Council and Management Development Committee will promote a technically sound and realistic approach by ensuring that all WHO programmes involved with different

aspects of reproductive health work closely together with regions and countries in order to develop a unified WHO response to the overall reproductive health problems faced by developing and industrialized countries alike. They will ensure the coordination of global and regional reproductive health policies and programmes. Close liaison with the Joint United Nations Programme on AIDS will be maintained.

V. MOBILIZING GLOBAL AND NATIONAL ALLIANCES

51. WHO has engaged upon a consultative process, and convened in March 1995 a meeting on the development and delivery of reproductive health which brought together participants from countries in the various regions, nongovernmental organizations, youth organizations and foundations, and other agencies, together with women's health advocates, to discuss the global strategy for reproductive health and the role and responsibilities of WHO. The conclusions of the meeting are reflected in this report to the Health Assembly and will be incorporated into a forthcoming document on the role of WHO in reproductive health.

52. WHO will implement its role in the global reproductive health strategy in partnership with other bodies, especially within the United Nations system and in the context of the principles and objectives of the ICPD Programme of Action relevant resolutions of the Organization's governing bodies, and resolution 49/128 of the United Nations General Assembly. UNFPA plays an important role in supporting and promoting reproductive health programmes in countries; the Technical Support Services/Country Support Teams which it funds serve as mechanisms for ensuring interagency collaboration and a multidisciplinary approach. UNICEF supports country-level activities concerned with various aspects of women's, young people's and children's health. UNESCO plays a crucial role in education, particularly for girls. The particular needs of refugees are the concern of UNHCR. The support of UNDP to people-centred sustainable development, emphasizing equity between the sexes and promotion of science and technology for development, and its role in coordination of the United Nations system at country level are essential to supporting national reproductive health programmes.

53. With partner agencies and nongovernmental organizations, WHO will promote a more strongly unified and consistent approach to reproductive health. The effectiveness with which it supports countries is greatly enhanced by its partnership with UNFPA. At global level, maintenance of momentum throughout developmental work on policy formulation and programme implementation will be ensured through a range of mechanisms such as the United Nations interagency task force for follow-up to ICPD, which is being coordinated by UNFPA.

54. The development and implementation of strategies for reproductive health will require the coordinated and consistent support of many agencies, sectors and groups at global and national levels. These include both government and nongovernmental organizations in the health field and related sectors such as education, social welfare, labour, justice and religious affairs; priority productive sectors, public or private, dependent on human resources; professional and scientific associations and other voluntary organizations; and the mass media. Coordination of this broad-based multidisciplinary, multisectoral response should be led by the governments, in collaboration with the international organizations and with the assistance of donor agencies.

55. A global strategy will be useful only to the extent that it is used as a basis for action. The challenge facing governments, the international community and concerned nongovernmental organizations and individuals is to give reproductive health policies and programmes their immediate support and sustained political commitment. National action plans should subscribe to the principles of common ownership, community involvement, and incorporation of diverse perspectives and partnerships that will be the hallmarks of the cooperative global strategy for reproductive health.

VI. MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

56. [This paragraph invited the Health Assembly, after reviewing WHO's role in a global strategy for reproductive health and taking into account the Director-General's report on collaboration within the United Nations system: the International Conference on Population and Development (document A48/35), and United Nations General Assembly resolution 49/128, to consider a draft resolution. Resolution WHA48.10 was adopted with amendments, at the twelfth plenary meeting.]

ANNEX 3

Communicable disease prevention and control: new, emerging, and re-emerging infectious diseases[1]

Report by the Director-General

[A48/15 - 22 February 1995]

I. BACKGROUND

1. In recent years, several Health Assembly resolutions have focused on the growing importance of infectious diseases. These include resolutions WHA44.8 and WHA46.36 on tuberculosis, WHA45.35 on human immunodeficiency virus, WHA46.31 on dengue prevention and control, WHA46.32 on malaria, and WHA46.6 on emergency and humanitarian relief, which mentions natural emergencies due to epidemics. These and other infectious diseases have come to comprise a group now described as "new, emerging, and re-emerging infectious diseases". Interest was raised by the current pandemic of HIV/AIDS, but has its origin in the fundamental realization that microorganisms continually mutate, that demographic conditions and social standards change, and that the global environment is being modified. Increasing movement of animals and animal products, changing land use and the population of previously uninhabited areas have placed people at risk of diseases not commonly encountered in the past. Antimicrobial resistance continues to reduce the effectiveness of drugs, increasing health costs and causing needless human suffering and death.

2. During the past decade, numerous new, emerging and re-emerging infectious diseases were recognized. In addition to HIV/AIDS and tuberculosis, examples include:

- cholera, both classic strains and new varieties (the tragedy of its toll among Rwandan refugees in **Africa** dramatically illustrates how devastating this disease can be);
- foodborne outbreaks of severe bloody diarrhoea and kidney failure in several countries of the **Americas and Europe** due to *Escherichia coli* 0157:H7;
- plague, including pneumonic plague in **India**, threatening other countries in **South-East Asia**;
- hantavirus pulmonary syndrome, a completely new disease first recognized in the south-western states of the United States of America in 1993, and now known to occur in several locations in the **Americas**;
- dengue, and its severe complication, dengue haemorrhagic fever, now infecting thousands of children each year in tropical parts of **South-East Asia** and the **Western Pacific**, and increasingly common in the warm regions of the **Americas**;
- the reappearance of Rift Valley fever virus, causing potentially devastating outbreaks in humans and domestic animals in **Egypt**, and threatening adjacent countries in the **Eastern Mediterranean**.

[1] See resolution WHA48.13.

3. Emerging infections are not restricted, however, to dramatic epidemics of new or resurgent diseases, as common bacterial pathogens regularly develop resistance to antimicrobial agents, thereby creating new challenges in disease treatment. Many strains of gonococci are multidrug-resistant, as are strains of staphylococci and pneumococci. Such resistance is a dangerous and costly problem throughout the world, but especially in developing countries where routine susceptibility testing may not be commonly practised and new antibiotics may not be readily available.

4. New, emerging, and re-emerging diseases are not limited to any region of the world, nor are they restricted to developing or developed countries. Rather, they represent a global threat that will require a coordinated, global response.

II. WHY ARE NEW INFECTIOUS DISEASES EMERGING, AND OTHERS ONCE THOUGHT TO BE CONQUERED RE-EMERGING?

5. It is difficult to point to a single cause for new, emerging, and re-emerging diseases. Several factors are involved, for example:

- changes in lifestyle, including overcrowding in cities, where population growth has exceeded supplies of clean water and adequate housing, forcing millions of people to continue an existence under unhygienic conditions;
- dramatic increases in international travel, by which it becomes possible for a person to be infected in one country, fall ill elsewhere, maybe a far distant city, and start an epidemic there;
- the deterioration of traditional public health activities, such as laboratories for surveillance and diagnosis which might otherwise quickly recognize emerging disease problems;
- changes in handling and processing of food, which may have originated thousands of miles away and/or have been prepared from parts of many different individual animals;
- the arrival of people in remote parts of the world never before inhabited, where they may become exposed to potential human pathogens transmitted among the local fauna;
- the continual evolution of pathogenic microorganisms as their mechanism for survival.

6. As a consequence of these and other factors, the world has witnessed a dramatic increase in new, emerging, and re-emerging infectious diseases. Clearly, most of the factors affecting disease emergence are not likely to change in the near future, and it should be expected that such diseases will continue to appear. The best defence is to recognize them as quickly as possible, understand their basic epidemiology and biology, and be prepared to respond promptly with rational and effective interventions.

III. WHAT SHOULD BE DONE?

7. Specific steps can be taken to ensure that a global plan is established to combat emerging infectious diseases. After consultation with international experts,[1] four specific goals are proposed to serve as a foundation for such a global plan:

- **strengthening of global surveillance of infectious diseases** - this includes making certain that national surveillance networks are in place, that they are associated with diagnostic laboratories

[1] See unpublished WHO document CDS/BVI/94.2.

capable of identifying common pathogens, and that information is rapidly exchanged nationally, regionally and internationally; to this end, greater use of WHO collaborating centres is encouraged;

- **establishment of national and international infrastructure to recognize, report and respond to new disease threats** - specific examples of tasks are: strengthening of national, regional and international laboratory capabilities to include measures to ensure that international reference centres are available and prepared to assist in difficult diagnoses; encouraging the provision of training opportunities and technology transfer among collaborating and reference centres; and streamlining communications among collaborating centres and health resources;

- **further development of applied research** - such an initiative might focus on practical problems of public health such as diagnosis, epidemiology and prevention of infectious diseases that are increasing or threaten to do so; specific tasks could include support for development of inexpensive diagnostic tests suitable for global use, encouragement for establishment and maintenance of quality assurance programmes, and evaluation of standards for basic public health action focused on disease prevention;

- **strengthening of international capacity for infectious disease prevention and control** - specific guidelines for prevention and control of newly emerging or re-emerging diseases (zoonotic, parasitic, viral, bacterial, foodborne and others) should be prepared, evaluated, distributed and implemented; recommendations should be implemented to reduce the effects of antimicrobial resistance to a minimum, and methods of communication and dissemination of information should be improved to ensure that guidelines reach the appropriate target groups.

IV. MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

8. [This paragraph invited the Health Assembly to consider the resolution recommended by the Executive Board in its resolution EB95.R12. Resolution WHA48.13 was adopted, with amendments, at the twelfth plenary meeting.]

ANNEX 4

Real Estate Fund[1]

Report by the Director-General

[A48/29 - 22 March 1995]

I. STATUS OF CURRENT PROJECTS UNDERTAKEN PRIOR TO 31 MAY 1995

1. Regional Office for Africa

1.1 The second phase of the project for the replacement of the drinking-water pipes on the Djoué estate of the Regional Office for Africa has been further delayed owing to local circumstances, and is now expected to be completed in 1995. The cost should remain within the previously estimated amount of US$ 135 000.[2]

2. Regional Office for the Americas/Pan American Sanitary Bureau

2.1 The renovation of the concrete façade of the Council Chamber of the Regional Office has been completed at a cost to the Real Estate Fund of US$ 224 000.[3]

2.2 The roof covering of the Council Chamber has also been completed. The cost to the Real Estate Fund was the previously estimated amount of US$ 20 000.[3]

2.3 A lease agreement has been signed for the site where the Caribbean Programme Coordination office is to be constructed. The floor plans of the building are being reviewed and the contribution to the project by the Real Estate Fund is expected to remain within the estimated amount of US$ 325 000.[4]

2.4 A site has been selected for the construction of the PAHO/WHO Representative's Office in Mexico. The cost to the Real Estate Fund should not exceed the previously estimated amount of US$ 250 000.[4]

3. Regional Office for South-East Asia

3.1 One of the two lifts in the Regional Office for South-East Asia has been replaced. The second will be completed during the course of 1995. The costs are not expected to exceed the initial estimate of US$ 71 000.[5]

3.2 Approval from the local government authorities for the addition of one floor to the Regional Office building has still not been obtained as a result of certain new regulations. Negotiations are in progress and

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[1] See resolution WHA48.22.

[2] Document EB91/1993/REC/1, Annex 2, p. 35.

[3] Document EB89/1992/REC/1, Annex 3, p. 45.

[4] Document WHA47/1994/REC/1, Annex 5, p. 144.

[5] Document EB89/1992/REC/1, Annex 3, p. 46.

it is expected that construction can be started and completed in 1995. The costs of the project will remain within the previously estimated amount of US$ 145 000.[1]

3.3 The contract for the replacement of the air-conditioning plant in the Regional Office has been awarded. Certain improvements recommended by a consulting engineer, as well as price increases since the initial estimate, will result in a cost for this project about 20% above the initially estimated amount of US$ 250 000.[2]

4. Regional Office for Europe

4.1 The contract for the improvement of security arrangements in the Regional Office for Europe has been awarded. Preliminary work has commenced and it is expected that the work will be completed within the previously estimated amount of US$ 150 000.[3]

5. Regional Office for the Eastern Mediterranean

5.1 Following the agreement with the local authorities to construct jointly a building to be shared by the Ministry of Culture and the WHO Regional Office in Alexandria, the procedure for a design competition has been initiated. After selection of the design, bids for construction will be called. It is only after this stage that a precise estimate of the cost of construction will be available. All costs will be jointly shared, on a pro rata basis, between the Ministry of Culture and WHO. It is expected that WHO's participation in fees for architects and consulting engineers up to the completion of the bidding procedure will be approximately US$ 300 000. The Health Assembly will be kept informed of developments.

5.2 In the interim, the previous project, approved by resolution WHA43.6, has been deleted from requirements under the Real Estate Fund. The present project, once finalized, will be subject to consideration and approval by a future Health Assembly.

6. Headquarters

6.1 Bids have been invited for the necessary work to reinforce the structure of the tunnel over which runs the access road to the entrance of the main building. It is planned that the work will commence in June 1995 and should be completed by the end of the year. Costs are expected to remain within the initially estimated amount of SFr. 1 500 000.[4]

II. ESTIMATED REQUIREMENTS FOR THE PERIOD 1 JUNE 1995 TO 31 MAY 1996

7. Regional Office for Africa

7.1 The electrical wiring in the print shop of the Regional Office for Africa dates back to the original construction and is no longer capable of taking the load constituted by the increased use of heavy-duty modern equipment. Since the old wiring is becoming unsafe it is proposed to replace it, at an estimated cost of US$ 100 000.

7.2 The main passenger lift in the Regional Office for Africa was renovated in 1988 but has never functioned satisfactorily. It has been out of service since April 1994 as repairs have been ineffective. It is now proposed to replace it at an estimated cost of US$ 130 000.

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[1] Document EB89/1992/REC/1, Annex 3, p. 46.

[2] Document EB91/1993/REC/1, Annex 2, p. 36.

[3] Document EB91/1993/REC/1, Annex 2, p. 35.

[4] Document WHA47/1994/REC/1, Annex 5, p. 143.

7.3 With the increase in size of the computer room and the print shop in the Regional Office for Africa, the air-conditioning unit servicing them has become inadequate. There have been numerous breakdowns since 1993, causing serious disruption of work and production. It is intended to replace the present unit with one better adapted to requirements. The estimated cost for this project is US$ 120 000.

8. Regional Office for South-East Asia

8.1 The internal structure of the Regional Office building, completed in 1960, is no longer suited to present requirements and does not meet current local safety standards. The worn-out electrical wiring and water-pipes need to be replaced, as do all the light fixtures. The wall partitions need to be modified to increase flexibility in the use of space. The window fixtures should be renovated to prevent temperature loss and pollution. In addition, the conference hall requires complete renovation. It is estimated that the combined cost of the renovation and restructuring will be US$ 400 000.

9. Headquarters

Local area network

9.1 The transmission of information has taken on the same vital significance in a modern office building as that of other utilities such as electricity, telephone and water. The information infrastructure has therefore become an essential feature of the building infrastructure.

9.2 The present WHO headquarters local area network (LAN) was installed at the end of 1985, in order to solve the problem of interconnection of the existing computing equipment (but the *ad hoc* cabling resulted in the congestion of the ducts in the buildings); to promote the integration of the computing services - administrative and scientific data-processing (on the mainframe computer), word-processing (on the Wang minicomputers) and personal computing (on microcomputers); and to share resources (software, hardware and communication facilities). The economic justification was a five-year projection according to which the number of computing devices to be interconnected would grow from 155 in 1985 to a little over 300 by the end of 1989.

9.3 Meanwhile information technology has grown beyond all predictions. It has penetrated virtually every sector of activity of the Organization, so that the related infrastructure has become of strategic importance for the Organization's essential activities and mission. The number of microcomputers connected to the LAN has increased much more rapidly than originally foreseen; in 1989 there were nearly 600 personal computers (PCs) connected to the LAN - double the number predicted - and at the end of 1994 there were over 1400. It should be noted that the computing capacity of today's microcomputers is a hundredfold what it was in 1985.

9.4 This growth has significant consequences for the present headquarters LAN. A projection based on its utilization over the past several years indicates that it will reach saturation point by the middle of 1995; it will no longer be possible to introduce new applications requiring substantial communications capacity. This in turn would exclude introduction and implementation of the WHO management information system. Other planned activities will also not be possible with the limitations of the present system: expansion of electronic mail, introduction of documents management, use of electronic forms, workflow automation and reduction of the size of current mainframe applications.

9.5 Lastly, the supplier of the present LAN has announced that, from mid-1996, it will not be possible to obtain spare parts or to maintain the current system.

9.6 A study was therefore undertaken in early 1994 to analyse the situation and propose solutions. It confirmed that the present system was close to saturation and that the technology used (broadband) was being phased out by the industry. It further established that, in view of its proprietary or supplier-dependent nature, the hardware components for and maintenance of the present LAN were far more expensive than is warranted

by current market conditions. The study therefore concluded that it was not a viable information support infrastructure in the medium and long term and should be replaced.

9.7 A consulting firm was commissioned in October 1994 to undertake a thorough feasibility study for replacement of the LAN. Taking into consideration WHO's current and planned network activities the firm was asked to specify the technical characteristics of the new network infrastructure, encompassing the cabling system, the active network components and the network management system, and to establish a cost estimate.

9.8 The proposed solution recommended by the firm will:

- allow WHO to meet current and expected communication requirements, in particular those of the management information system;
- remain suitable for at least 10 years;
- be based on international standards and, to the extent feasible, on nonproprietary components;
- accommodate the integration of all communication services - voice, data and video material - and be equipped with universal connectors;
- cover all workplaces, current and potential, with sufficient spare capacity for growth;
- allow central and automated management, thus keeping staffing requirements to a minimum;
- preinvest in a voice-carrying capacity that will replace, in the near future, the present telephone cable which is nonstandard, old and expensive to maintain.

9.9 The estimated cost of this project which, if approved, would have to be completed by the middle of 1996, is US$ 6 765 000 at present rates of exchange.

Adaptation of the sub-basement

9.10 The sub-basement of the WHO headquarters main building was initially designed and built to house workshops and other mechanical installations. One part of the area contained WHO's mainframe computer.

9.11 Subsequently, this area was enlarged and used to install the International Computing Centre (ICC), into which the WHO mainframe computer was absorbed. Over the years ICC increased in size and added several installations in a further expanded area. ICC recently moved out of WHO premises, vacating 600 m^2 of space.

9.12 In addition to a chronic shortage of office space, WHO headquarters has never had purpose-built areas for training and related activities. The Director-General therefore proposes to use this opportunity to convert the vacated space into a combination of offices, training areas and computer servicing facilities. One part of the area will also be used to accommodate the equipment for the new LAN referred to above.

9.13 A major renovation of the area will be required. The façade of the corresponding part of the building will have to be modified and flooring and lighting will have to be adapted so that the area can be used for offices. False ceilings will have to be put in for wiring and ventilation ducts. Partitions will have to be erected to separate offices and other areas. Appropriate heating and ventilation will have to be installed.

9.14 Once completed, the project is expected to yield approximately 300 m^2 of office space and 300 m^2 of training areas, computer and communication facilities. The estimated cost of the renovation is US$ 1 780 000 at present rates of exchange.

10. In conclusion, considering that a LAN is today an integral part of any modern office building, its financing in totality from the Real Estate Fund is fully justified. None the less, the Director-General had proposed to the Executive Board at its ninety-fifth session that, bearing in mind the low level of estimated available casual income at the time of preparation of the related documentation (approximately US$ 9 million), only part of the costs should be met from the Real Estate Fund, the balance being assessed against other resources.[1] However, the final situation reveals that the available casual income (approximately US$ 18 million at 31 December 1994) is far above what was expected in October 1994. Consequently, the Director-General believes it is fully appropriate to charge the Real Estate Fund with the totality of the cost for replacement of the LAN. Had it been possible to determine sufficiently in advance of the ninety-fifth session of the Executive Board that a much higher level of casual income would eventually become available, the Director-General would have made the same recommendation to the Executive Board as he is making to the Health Assembly.

III. SUMMARY

11. On the basis of the foregoing considerations, the estimated requirements of the Real Estate Fund for the period 1 June 1995 to 31 May 1996 are as follows:

	US $
- Replacement of electrical wiring in the print shop of the Regional Office for Africa	100 000
- Replacement of the main passenger lift at the Regional Office for Africa	130 000
- Replacement of the air-conditioning system for the computer room and print shop of the Regional Office for Africa	120 000
- Renovation and restructuring of the internal structure of the Regional Office for South-East Asia	400 000
- Replacement of headquarters local area network (LAN)	6 765 000
- Renovation of sub-basement at headquarters	1 780 000
Total estimated requirements	9 295 000
Unencumbered balance of the Real Estate Fund, including accrued interest, as at 31 December 1994 (see Appendix) rounded off at	1 604 000
Shortfall which it is proposed to cover by appropriation by the Health Assembly	7 691 000

IV. MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

12. [This paragraph invited the Health Assembly to consider the resolution recommended in resolution EB95.R18, the text of which had been revised to take into account changes in the method of financing described in paragraph 10 above. The recommended resolution was adopted at the twelfth plenary meeting as resolution WHA48.22.]

[1] Document EB95/41 Rev.1.

REAL ESTATE FUND

SITUATION AS AT 31 DECEMBER 1994

(expressed in US dollars)

		1 January 1970 - 31 December 1991	1992-1993	1994	Total (from inception)
1.	**BALANCE AT 1 JANUARY**	-	5 922 950	3 160 172	-
2.	**INCOME**				
	Balance of Revolving Fund for Real Estate Operations (resolution WHA23.14)	68 990	-	-	68 990
	Casual income appropriated (resolutions WHA23.15, WHA24.23, WHA25.38, WHA28.26, WHA29.28, WHA33.15, WHA34.12, WHA35.12, WHA36.17, WHA37.19, WHA39.5, WHA42.10, WHA43.6, WHA44.29)	22 914 186	-	-	22 914 186
	resolution WHA46.22	-	145 000	-	145 000
	resolution WHA47.25	-	-	1 721 250	1 721 250
	Transfer from Part II of the Working Capital Fund (resolution WHA23.15)	1 128 414	-	-	1 128 414
	Rents collected	6 530 557	775 431	304 586	7 610 574
	Interest	5 337 645	254 290	138 420	5 730 355
	Other	1 567	-	-	1 567
	Total income	35 981 359	1 174 721	2 164 256	39 320 336
	Total funds available	35 981 359	7 097 671	5 324 428	-
3.	**OBLIGATIONS AND EXPECTED OBLIGATIONS** (see Attachment to this Appendix)	30 058 409	3 937 499	3 720 168	37 716 076
4.	**BALANCE AT 31 DECEMBER**	5 922 950	3 160 172	1 604 260	1 604 260

Attachment

REAL ESTATE FUND
OBLIGATIONS AND EXPECTED OBLIGATIONS FROM INCEPTION (1 JANUARY 1970) TO 31 DECEMBER 1994

(expressed in US dollars)

	Purpose	Relevant authorization (resolution/ decision)	Obligations				
			1 Jan 1970-31 Dec 1991	1992-1993	1994 Obligated	1994 Earmarked	Total
1.	**Maintenance, repairs and alterations to houses for staff**	WHA23.14, para. 3(i)					
	Regional Office for Africa		4 168 841	518 716	213 991	381 007	5 282 555
	Regional Office for the Eastern Mediterranean		161 419	19 636	20 000	-	201 055
			4 330 260	538 352	233 991	381 007	5 483 610
2.	**Major repairs, and repairs to the Organization's existing buildings**	WHA23.14, para. 3(ii)					
	Headquarters:						
	Current repairs		903 101	-	-	-	903 101
	Restoration of the structural safety of the eighth floor of the main building	WHA35.12 & WHA36.17	363 193	-	-	-	363 193
	Renovation of the headquarters roofing and the technical installations built thereon	WHA39.5	335 757	-	-	-	335 757
	Remodelling of the headquarters eighth floor	WHA39.5	1 550 363	-	-	-	1 550 363
	Replacement of the telephone exchange	WHA42.10	2 071 272	102 863	30 475	14 548	2 219 158
	Replacement of the Freon gas in the air-conditioning system	WHA47.25	-	-	-	231 000	231 000
	Strengthening of the supporting structure below the access road to the headquarters building	WHA47.25	-	-	140 098	908 902	1 049 000
	Regional Office for Africa		1 716 220	-	-	-	1 716 220
	Regional Office for the Americas		167 470	215 250	110 250	-	492 970
	Regional Office for South-East Asia		242 311	255 217	237 885	113 867	849 280
	Regional Office for Europe		964 479	572 442	36 472	181 251	1 754 644
	Regional Office for the Eastern Mediterranean		157 816	-	-	-	157 816
	Regional Office for the Western Pacific		892 922	-	-	-	892 922
			9 364 904	1 145 772	555 180	1 449 568	12 515 424
3.	**Acquisition of land, construction/extension of buildings**	WHA23.14 para. 3(iii)					
	Headquarters						
	Main building:						
	Transfer to Headquarters Building Fund for part settlement of litigation with Compagnie française d'Entreprise	WHA23.18	655 140	-	-	-	655 140
	Acquisition of land	WHA23.17	1 000 095	-	-	-	1 000 095
	Second prefabricated building	WHA24.22	689 791	-	-	-	689 791
	Third prefabricated building	WHA28.26	1 799 575	-	-	-	1 799 575
	Architectural studies for proposed extension of main building	WHA24.22 & WHA25.38	243 832	-	-	-	243 832
	Alterations to "V" building	WHA33.15	102 658	-	-	-	102 658
	Additional car park	WHA33.15	104 564	-	-	-	104 564
	Construction of a building to house the kitchen and restaurant	WHA36.17	2 728 844	-	-	-	2 728 844

Purpose	Relevant authorization (resolution/ decision)	Obligations				
		1 Jan 1970-31 Dec 1991	1992-1993	1994 Obligated	1994 Earmarked	Total
Regional Office for Africa						
Construction of additional staff housing	WHA23.16	936 937	-	-	-	936 937
First extension of Regional Office building	WHA23.16	751 585	-	-	-	751 585
Second extension of Regional Office building	WHA28.26	930 588	-	-	-	930 588
Acquisition of land for additional staff housing	WHA24.24	13 517	-	-	-	13 517
Conversion of staff housing	WHA34.12	292 955	-	-	-	292 955
Construction of small office building and staff housing in Malabo, Equatorial Guinea	WHA34.12	599 287	-	-	-	599 287
Third extension of Regional Office building	WHA37.19	863 552	-	-	-	863 552
Purchase of five staff houses in Namibia	WHA43.6	353 740	611	-	-	354 351
Replacement of the telephone exchange	WHA44.29	-	1 001 197	291 947	(17 744)	1 275 400
Regional Office for the Americas						
Construction of Zone Office, Brasilia (WHO's contribution)	WHA25.39	100 000	-	-	-	100 000
Construction of a building for the Caribbean Food and Nutrition Institute (WHO's contribution)	WHA35.12	300 000	-	-	-	300 000
Construction of an office for the Caribbean Programme Coordination, Barbados	WHA47.25	-	-	-	325 000	325 000
Construction of an office for the PAHO/WHO Representative in Mexico	WHA47.25	-	-	-	250 000	250 000
Regional Office for South-East Asia						
Extension of Regional Office building	WHA24.25	137 331	-	-	-	137 331
Fire-fighting equipment and emergency generator	WHA28.26	63 172	-	-	-	63 172
Installation of new telephone exchange	Dec.EB63(8)	120 557	-	-	-	120 557
Extension of Regional Office building, including new air-conditioning plant and electrical substation	WHA34.12	673 497	-	-	-	673 497
Additional stand-by generator	WHA35.12	84 791	-	-	-	84 791
Addition of one floor at the Regional Office building	WHA45.9	-	1 596	4 630	138 774	145 000
Regional Office for Europe						
Renovation of additional premises:	WHA27.15 &					
39 Strandpromenaden	WHA29.28	93 213	-	-	-	93 213
33 Strandpromenaden	Dec.EB63(8)	91 546	-	-	-	91 546
Installation of new telephone exchange	WHA29.28	190 000	-	-	-	190 000
Preliminary architectural study for extension of Regional Office building	WHA34.12	63 707	-	-	-	63 707
Lift and toilet facilities for disabled persons in the Regional Office	WHA34.12	38 102	-	-	-	38 102
Regional Office for the Eastern Mediterranean						
Extension of Regional Office building	WHA25.40	39 634	-	-	-	39 634
Additional extension of Regional Office building	WHA38.9	190 000	-	-	-	190 000
Architectural study for the extension of Regional Office building	WHA41.13	10 000	-	-	-	10 000
Construction of an annex at the Regional Office	WHA43.6	50 241	549 572	101 913	-	701 726
Regional Office for the Western Pacific						
Installation of fire detection and control equipment	WHA27.16	25 097	-	-	-	25 097
Extension of Regional Office building	WHA29.28	537 437	-	-	-	537 437
Additional extension of Regional Office building	WHA33.15	1 090 141	-	-	-	1 090 141
Construction of an annex at the Regional Office	WHA43.6	398 119	700 399	5 902	-	1 104 420
Total acquisition of land, construction/extension of buildings		16 363 245	2 253 375	404 392	696 030	19 717 042
TOTAL OBLIGATIONS AND EXPECTED OBLIGATIONS		30 058 409	3 937 499	1 193 563	2 526 605	37 716 076

ANNEX 5

Joint United Nations Programme on AIDS[1]

1. Report by the Director-General

[A48/34 - 13 April 1995]

I. INTRODUCTION

1. On 14 May 1993 the Health Assembly adopted resolution WHA46.37, requesting the Director-General to study the "feasibility and practicability" of establishing a joint and cosponsored United Nations programme on HIV/AIDS, in close consultation with the executive heads of UNICEF, UNDP, UNFPA, UNESCO and the World Bank. A report on the requested study was submitted to the Executive Board, which at its ninety-third session in January 1994 adopted resolution EB93.R5 recommending the development and eventual establishment of a joint and cosponsored United Nations programme on HIV/AIDS, to be administered by WHO, in accordance with the consensus option described in the Director-General's report on the study.[2] Subsequently, and as requested in resolution EB93.R5, the respective governing bodies of UNICEF, UNDP, UNFPA and UNESCO at their 1994 sessions endorsed the establishment of such a programme and committed these agencies to continuing their participation in the negotiation process. The World Bank also formally indicated its agreement to being a sponsor of the programme.

2. In accordance with resolution EB93.R5, the Director-General reported to the Health Assembly in May 1994 on action taken to comply with the resolution and also submitted a paper to the July 1994 session of the United Nations Economic and Social Council, which adopted resolution 1994/24 endorsing the establishment of the programme as outlined in an annex to the resolution (see Appendix).

II. COMMITTEE OF COSPONSORING ORGANIZATIONS

3. In accordance with Economic and Social Council resolution 1994/24 a Committee of Cosponsoring Organizations (CCO) comprising the heads of the six cosponsors was constituted, with interim responsibility for overseeing the transition process leading to full implementation of the programme by 1 January 1996, including establishment of a transition team to assist in the process. Paragraph 9 of the resolution requested the six cosponsors, through CCO, to produce by January 1995, for the consideration of the Economic and Social Council and other concerned parties, "a comprehensive proposal specifying the programme's mission ... and the terms and conditions of co-ownership, and detailing the programme's organizational, programmatic, staffing, administrative and financial elements, including proposed budgetary allocations".

4. CCO, at its first meeting (New York, 22 September 1994), agreed that the six cosponsors would assign staff to form a transition team as soon as possible, with WHO providing accommodation and administrative support. It also decided on a wide-ranging consultative process for the nomination of a director of the programme who, once designated by the Secretary-General, would take responsibility for the transition

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[1] See resolution WHA48.30.

[2] Document EB93/1994/REC/1, Annex 3, Part I.

process, including the work of the transition team. In accordance with Economic and Social Council resolution 1994/24, it was decided that the chairmanship of CCO would rotate among the cosponsors every six months; WHO was selected to assume the chairmanship during the first term, with UNDP serving during the second term from April 1995.

5. The transition team was constituted with at least one representative of each of the cosponsors and began work in Geneva on 25 October 1994. Its main task was to prepare, for CCO, the comprehensive proposal mentioned in paragraph 3 above.

6. CCO, at its second meeting (New York, 12 December 1994), unanimously recommended Dr Peter Piot as director of the programme. The Secretary-General appointed Dr Piot as Executive Director for a period of two years starting on 1 January 1995.

7. On 23 January 1995 a report on the joint and cosponsored United Nations programme on HIV/AIDS was submitted by CCO to the Economic and Social Council as requested by its resolution 1994/24. The report was discussed by the Council on 31 January 1995 in an informal consultation and then on 10 February 1995 during its organizational session. The Executive Director presented the report on both occasions and answered questions from the delegates. As requested during the informal consultation, a proposed modification of the chapter on governance and management of the programme was formulated by the President of the Council and sent to CCO for consideration. In accordance with paragraph 11 of resolution 1994/24, the Council was to make recommendations on the report submitted by CCO.

8. CCO, at its third meeting (Vienna, 27 February 1995), agreed on a number of proposals submitted by the Executive Director concerning an outline of a work plan and budget for 1995; a broad consultative process for the preparation of a strategic plan; and an initial staffing plan for establishing and filling key posts in the programme as soon as possible. CCO also endorsed the proposal to name the new programme the Joint United Nations Programme on AIDS (UNAIDS).

III. PROGRAMME DEVELOPMENT

9. The Executive Director of UNAIDS has appointed a small team to assist him in further planning and developing the Programme during 1995 in order to make it fully operational by 1 January 1996. At the third CCO meeting each cosponsoring organization was requested to second at least one professional staff member to UNAIDS for 1995. Thus far, WHO has assigned a total of 17 professional and general service staff to UNAIDS, and UNFPA has seconded one professional staff member. Australia has also seconded one professional to the Programme and another donor country has indicated its desire to do so.

10. A provisional work plan and interim budget for 1995 were drawn up; US$ 1 million was made available to UNAIDS from WHO's Global Programme on AIDS, and other verbal commitments for financial resources during this transitional period for a number of start-up activities were received from specific donor countries, in particular Sweden. Priorities have been determined for the work in coming months, including the preparation of a strategic plan for the Programme. An initial consultation of the six cosponsors was held in Geneva on 14 and 15 March 1995, and five regional consultative meetings involving a broad range of partners will be organized from mid-April to early June 1995. Another priority is the further development of UNAIDS country-level operations, including the strengthening or initiation of the "theme group" mechanism in selected countries. The administrative arrangements for the Programme, including the administrative support to be provided by WHO, constitute another area under development.

11. As requested in paragraph 11 of its resolution 1994/24, the Economic and Social Council held informal consultations to discuss the specific composition of the governing body of UNAIDS, provisionally called the Programme Coordinating Board. It is expected that the Board will be established by the end of April 1995 and that its first meeting may be held in early June in order, *inter alia*, to review and approve the proposed programme budget for UNAIDS for the 1996-1997 biennium.

12. In order to establish UNAIDS formally as from 1 January 1996, the six cosponsors will sign, during 1995, a legal instrument, most likely a Memorandum of Understanding.

IV. MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

13. The Health Assembly is invited to note the report. A further report on progress made towards full implementation of the Joint United Nations Programme on AIDS by 1 January 1996 will be submitted through the Executive Board to the Forty-ninth World Health Assembly in May 1996.

2. Addendum to the report by the Director-General

[A48/34 Add.1 - 9 May 1995]

1. Reference is made to resolutions WHA46.37, EB93.R5 and EB95.R13 on the establishment of a joint and cosponsored United Nations programme on HIV/AIDS. In accordance with resolution EB93.R5, the Director-General reported to the Forty-seventh World Health Assembly in May 1994 on action taken to comply with resolution EB93.R5 and also submitted a paper to the United Nations Economic and Social Council at its session in July 1994, which adopted resolution 1994/24 endorsing the establishment of such a programme, as outlined in an annex to the resolution.

2. The Council subsequently discussed a report by CCO on the joint programme (see Part 1, paragraph 7).

3. As requested in operative paragraph 11 of resolution 1994/24, the Council has held several informal consultations since October 1994 among Member States, with the participation of the cosponsoring organizations, to discuss the composition of the Programme Coordinating Board. According to the addendum of the report on governance, the Board is to act as the governing body on all programmatic issues concerning policy, strategy, finance, monitoring and evaluation of the joint programme.

4. The Council, in its organizational session on 5 May 1995, decided that 22 Member States should be represented on the Board in the following regional distribution:

Western European and others group	7 seats
Asia	5 seats
Africa	5 seats
Latin America and the Caribbean	3 seats
Eastern European/Commonwealth of Independent States	2 seats

5. The term of office of Member States would be three years. Both Member States of the United Nations and Observer States would be able to submit their candidacy for election. The initial appointments would be for variable terms (one, two or three years) to permit renewal of roughly one-third of the Board in each subsequent year.

6. So that the Board can review and approve the budget and work plan or strategic plan of the joint programme as soon as possible, it was decided that the Council would elect on 1 June 1995 the initial 22 Member States to be represented on the Board. Further consultation would be required to determine in which body or bodies subsequent elections of Member States would be conducted.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

7. Three of the six agencies cosponsoring the joint programme (WHO, UNESCO and the World Bank) are specialized agencies and thus have a different governance structure from the funds and programmes of the United Nations which report to the Economic and Social Council. The concern has been expressed that the Health Assembly should also play a role in the selection of members of the Programme Coordinating Board so that its interests and matters of concern can be reflected on it, as would be those of the governing bodies of the other cosponsors.

8. The Director-General believes it is essential, as global AIDS activities are transferred from a WHO programme to a joint United Nations programme, that public health experience and expertise are retained, both in the programme's work and in its governance.

9. The Health Assembly may wish to request that Member States elected to the Programme Coordinating Board should consider the importance of maintaining public health experience and expertise when selecting their representatives.

Appendix

TEXT OF RESOLUTION 1994/24 OF THE ECONOMIC AND SOCIAL COUNCIL

1994/24. Joint and co-sponsored United Nations programme on human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)

The Economic and Social Council,

Recalling its resolution 1993/51 on the coordination of United Nations activities related to HIV/AIDS,

Taking note of the decisions of the United Nations Development Programme, the United Nations Children's Fund, the United Nations Population Fund, the World Health Organization, the United Nations Educational, Scientific and Cultural Organization and the World Bank to undertake a joint and co-sponsored United Nations programme on HIV/AIDS, on the basis of co-ownership, collaborative planning and execution, and an equitable sharing of responsibility,

Noting that the World Health Organization is to be responsible for the administration in support of the programme, including during the transition period,

Emphasizing that the global HIV/AIDS epidemic affects every country of the world and that its magnitude and impact are greatest in developing countries,

Emphasizing also the urgent need to mobilize fully all United Nations system organizations and other development partners in the global response to HIV/AIDS, in a coordinated manner and according to the comparative advantages of each organization,

1. Endorses the establishment of a joint and co-sponsored United Nations programme on HIV/AIDS, as outlined in the annex to the present resolution, subject to further review by April 1995 of progress made towards its implementation;

2. Calls for the full implementation of the programme by January 1996, and requests that a report confirming its implementation be submitted to the Economic and Social Council at its organizational session for 1996;

3. Notes that further details of the programme are being developed by the Inter-Agency Working Group that has been established by the six co-sponsors;

4. Invites the six co-sponsors to take immediate steps to transform the Inter-Agency Working Group into a formally constituted Committee of Co-sponsoring Organizations, comprising the heads of those organizations or their specifically designated representatives, which would function under a rotational chairmanship, establish a transition team and assume interim responsibility, inter alia, for overseeing the transition process leading to the full implementation of the programme;

5. Also invites the six co-sponsors, through the Committee, to initiate action to fill the position of director of the joint and co-sponsored programme as soon as possible, through an open, wide-ranging search process, including consultation with Governments and other concerned parties, and to submit their nominee to the Secretary-General, who will make the appointment;

6. Urges the six co-sponsors, through the Committee, to initiate, as soon as possible, programme activities at the country level, as well as any other programme elements on which there is already full consensus;

7. Stresses that priority should be given to the programme's activities at the country level, where the response to the urgent needs and problems posed by HIV/AIDS should be focused, and underlines the importance of the programme's country-level operations' functioning within the framework of national plans and priorities and a strengthened resident coordinator system, in accordance with General Assembly resolution 47/199;

8. Also stresses that during the transition process, the ongoing HIV/AIDS activities of each of the six co-sponsors should be maintained and/or enhanced, bearing in mind the need for these activities to fit within national AIDS programmes and the general framework of the joint and co-sponsored programme;

9. Requests the six co-sponsors, through the Committee, to produce the following by January 1995, for the consideration of the Economic and Social Council and other concerned parties: a comprehensive proposal specifying the programme's mission statement and the terms and conditions of co-ownership, and detailing the programme's organizational, programmatic, staffing, administrative and financial elements, including proposed budgetary allocations, and to attach to this proposal an annex containing the proposed legal document that the six co-sponsors will sign to establish the programme formally;

10. Encourages the active involvement of the Task Force on HIV/AIDS Coordination during the programme's detailed development phase, through the direct provision of assistance to the Committee, in accordance with the Committee's requirements;

11. Requests the President of the Economic and Social Council to organize, in cooperation with the Committee of Co-sponsoring Organizations, informal open-ended consultations to be held as soon as possible for the purpose of deciding on the specific composition of the programme coordinating board that will govern the programme, interacting periodically with the Committee during the transition period to facilitate progress towards programme implementation, and reviewing the detailed programme proposal after it is received from the Committee, with a view to making appropriate recommendations on the proposal not later than April 1995.

44th plenary meeting
26 July 1994

Annex to Res. 1994/24

PROGRAMME OUTLINE

1. The co-sponsored United Nations programme on HIV/AIDS represents an internationally coordinated response to the HIV/AIDS pandemic. The programme comprises the following United Nations system organizations: the United Nations Development Programme, the United Nations Children's Fund, the United Nations Population Fund, the World Health Organization, the United Nations Educational, Scientific and Cultural Organization and the World Bank. The programme has been formally endorsed by the Executive Boards of the World Health Organization (resolution EB93.R5) and the United Nations Educational, Scientific and Cultural Organization (resolution 144EX-5.1.5); the other four co-sponsors have also committed themselves to full participation.

2. The fundamental characteristics that define the programme are set out below.

I. OBJECTIVES

3. The objectives of the programme are to:

(a) Provide global leadership in response to the epidemic;

(b) Achieve and promote global consensus on policy and programmatic approaches;

(c) Strengthen the capacity of the United Nations system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level;

(d) Strengthen the capacity of national Governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level;

(e) Promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions;

(f) Advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.

4. In fulfilling these objectives, the programme will collaborate with national Governments, intergovernmental organizations, non-governmental organizations, groups of people living with HIV/AIDS, and United Nations system organizations.

II. CO-SPONSORSHIP

5. The HIV/AIDS epidemic is a global concern. Inter-agency cooperation is vital for ensuring the mobilization of resources and the effective implementation of a coordinated programme of activities throughout the United Nations system.

6. The programme will draw upon the experience and strengths of the six co-sponsors to develop its strategies and policies, which will be incorporated in turn into their programmes and activities. The co-sponsors will share responsibility for the development of the programme, contribute equally to its strategic direction and receive from it policy and technical guidance relating to the implementation of their HIV/AIDS activities. In this way, the programme will also serve to harmonize the HIV/AIDS activities of the co-sponsors.

Annex to Res. 1994/24

7. The programme will be managed by a director, who will focus on the programme's overall strategy, technical guidance, research and development, and the global budget. The co-sponsors will contribute to the resource needs of the programme at levels to be determined. The World Health Organization will be responsible for the administration in support of the programme.

8. Other United Nations system organizations concerned with the HIV/AIDS epidemic may be encouraged to join the programme as co-sponsors in the future.

III. FUNCTIONAL RESPONSIBILITIES

9. The programme will build on the capacities and comparative advantages of the co-sponsors. At the global level, the programme will provide support in policy formulation, strategic planning, technical guidance, research and development, advocacy and external relations. This will include normative activities relating to HIV/AIDS in areas such as social and economic planning, population, culture, education, community development and social mobilization, sexual and reproductive health, and women and adolescents.

10. At the country level, the programme will provide support to the resident coordinator system. Co-sponsors will incorporate the normative work undertaken at the global level on policy, strategy and technical matters into their HIV/AIDS activities, consistent with national plans and priorities. An important function of the programme will be to strengthen national capacities to plan, coordinate, implement and monitor the overall response to HIV/AIDS. The participation in the programme of six organizations of the United Nations system will ensure the provision of technical and financial assistance to national activities in a coordinated multisectoral manner. This will strengthen intersectoral coordination of HIV/AIDS activities and will facilitate further incorporation of these activities in national programme and planning processes.

11. While the programme will not have a uniform regional structure, it will support intercountry or regional activities that may be required in response to the epidemic, utilizing regional mechanisms of the co-sponsors where appropriate.

IV. FLOW OF PROGRAMME FUNDS

12. Funds for programme activities at the global level will be obtained through appropriate common global means. Contributions to the programme will be channelled in accordance with the global budget and work plan.

13. Funding for country-level activities will be obtained primarily through the existing fund-raising mechanisms of the co-sponsors. These funds will be channelled through the disbursement mechanisms and procedures of each organization.

V. FIELD-LEVEL COORDINATION

14. It is recognized that national Governments have the ultimate responsibility for the coordination of HIV/AIDS issues at the country level. To this end, the arrangements of the programme for coordinating HIV/AIDS activities will complement and support national development planning.

15. The coordination of field-level activities will be undertaken through the United Nations resident coordinator system within the framework of General Assembly resolutions 44/211 and 47/199. This will involve a theme group on HIV/AIDS established by the resident coordinator and comprising representatives of the six co-sponsors and other United Nations system organizations. The chairperson of the theme group

will be selected by consensus from among the United Nations system representatives. It is intended that the theme group will help the United Nations system integrate more effectively its efforts with national coordination mechanisms. To support the coordination process, in a number of countries the programme will recruit a country staff member, who will assist the chairperson of the theme group in carrying out his or her functions.

VI. ORGANIZATIONAL STRUCTURE

16. A programme director will be appointed by the Secretary-General upon the recommendation of the co-sponsors. This will follow a search process undertaken by the co-sponsors which will include consultation with Governments and other interested parties. The director will report directly to the programme coordinating board, which will serve as the governance structure for the programme. Annual reports prepared by the director will be submitted to the board and will also be made available to the governing body of each of the co-sponsors.

17. The composition of the programme coordinating board will be determined on the basis of open-ended consultations, as outlined in operative paragraph 11 of the present resolution. In exercising its governance role, the board will have ultimate responsibility for all policy and budgetary matters. It will also review and decide upon the planning and execution of the programme. Its detailed responsibilities and meeting schedule will be specified in a document containing its terms of reference, which is currently being prepared.

18. The programme will also have a committee of co-sponsoring organizations, which will serve as a standing committee of the board. It will comprise one representative from each of the co-sponsors. The committee will meet regularly and will facilitate the input of the co-sponsors into the strategy, policies and operations of the programme.

19. Through consultation with interested non-governmental organizations, a mechanism will be established to ensure their meaningful participation in the programme, so that they can provide information, perspectives and advice to the board, based on their experience and involvement with HIV/AIDS issues.

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS[1]

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[1] Bilingual list, as issued in document A48/DIV/3 Rev.1 on 8 May 1995, with the incorporation of corrections subsequently received.

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(Chief Delegate from 1 to 2 and from 4 to 12 May 1995)
Mr J. ESKOLA, Director-General, Department for Promotion and Prevention, Ministry of Social Affairs and Health

Alternates
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Professor J. HUTTUNEN, Director-General, National Public Health Institute
Mrs L. OLLILA, Senior Counsellor for International Affairs, Ministry of Social Affairs and Health
Dr T. MELKAS, Senior Medical Officer, Department for Promotion and Prevention, Ministry of Social Affairs and Health
Mr H. HÄMÄLÄ, Counsellor, Ministry for Foreign Affairs
Mr J. SORMUNEN, First Secretary, Permanent Mission, Geneva

Advisers
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Mrs A. MILEN, Director, Health and Development Cooperation Group (Hedec), National Research and Development Centre for Welfare and Health
Mr B. LANGVIK, Director, Association of Finnish Local Authorities
Ms M. ANTTILA, Director, The Union of Health Professionals, (Tehy)
Ms M.-L. SALO, Public Information Officer, Ministry of Social Affairs and Health

FRANCE

Chief Delegate
Mme S. VEIL, Ministre d'Etat, Ministre des Affaires sociales, de la Santé et de la Ville
(2 mai)

Delegates
M. M. de BONNECORSE
Ambassadeur, Représentant permanent, Genève
Professeur J.-F. GIRARD, Directeur général de la Santé, Ministère des Affaires sociales, de la Santé et de la Ville

Alternates
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M. J.-L. DURAND-DROUHIN, Chef de la Division des Relations internationales, Ministère des Affaires sociales, de la Santé et de la Ville

M. A. SORTAIS, Représentant permanent adjoint, Genève
M. P. CHARLAT, Conseiller, Mission permanente, Genève
M. J.-M. BRUNO, Sous-Directeur de la Santé et du Développement social, Ministère de la Coopération
Professeur M. MANCIAUX, Université de Nancy
Dr B. MONTAVILLE, Direction générale des Relations culturelles, scientifiques et techniques, Ministère des Affaires étrangères
Dr Maguy JEANFRANCOIS, Division des Relations internationales, Ministère des Affaires sociales, de la Santé et de la Ville
Dr J.-G. MOREAU, Division des Relations internationales, Ministère des Affaires sociales, de la Santé et de la Ville
M. B. LABORDERIE, Sous-Direction de la Santé et du Développement social, Ministère de la Coopération
Dr J.-M. LAURE, Sous-Direction de la Santé et du Développement social, Ministère de la Coopération
Mme L. INDRIANJAFY, Attachée, Mission permanente, Genève

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Mme R. DENIAU, Chargée des Relations internationales, Agence du Médicament
Dr P. SOCCOJA, Mission des Affaires internationales, Direction générale de la Santé, Division SIDA

GABON

Chief Delegate
Dr S. MBA BEKALE, Ministre de la Santé publique et de la Population

Delegates
Dr T. ENGONGAH-BEKA, Conseiller, Relations extérieures, Ministère de la Santé publique et de la Population
Mme P. MOUNGUENGUI, Conseiller financier

Alternates
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M. F. BENGONE BAYI, Conseiller à la Planification, Ministère de la Santé publique et de la Population

GAMBIA

Chief Delegate
Mrs C. CEESAY-MARENAH, Minister of Health, Social Welfare and Women's Affairs

Delegates
Mr L. SAMATEH, Permanent Secretary, Ministry of Health, Social Welfare and Women's Affairs
Dr M. GEORGE, Director of Health Services

GEORGIA

Chief Delegate
Dr A. DJORBENADZE, Minister of Health

Delegates
Dr T. KVESITADZE, Chief of Medical Staff Department, Ministry of Health
Dr T. KERESELIDZE, Liaison Officer

GERMANY

Chief Delegate
Mr H. VOIGTLÄNDER, Director, Federal Ministry for Health

Delegates
Dr W. DAUM, First Counsellor, Permanent Mission, Geneva
Mr M. DEBRUS, Head of Division, Federal Ministry for Health

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Dr M. BRUMMER, Ministry for Labour and Social Affairs, Family, Women and Health, Free State of Bavaria
Count G. von WESTFALEN, Head of Division, Budgetary Matters of International and Supranational Organizations, and the United Nations, Federal Ministry of Finance
Dr C. WETZ, Counsellor, Permanent Mission, Geneva
Dr M. REUSS, Second Secretary, Permanent Mission, Geneva
Dr R. KORTE, Head, Health, Population, Nutrition Division, German Agency for Technical Cooperation (GTZ), Eschborn
Mrs I. KLAIS, Counsellor

GHANA

Chief Delegate
Mr S. G. OBIMPEH, Minister of Health

Deputy Chief Delegate
Mr B. G. GODWYLL, Ambassador, Permanent Representative, Geneva

Delegate
Dr N. A. ADAMAFIO, Director of Health Services, Ministry of Health

Alternates
Dr A. ASAMOA-BAAH, Director of Planning, Ministry of Health
Mr F. BENNEH, Minister Counsellor, Permanent Mission, Geneva

GREECE

Chief Delegate
M. C. POLITOPOULOS, Secrétaire général, Ministère de la Santé, de la Prévoyance et de la Sécurité sociale

Deputy Chief Delegate
M. G. P. HELMIS, Ambassadeur, Représentant permanent, Genève

Delegate
M. J. N. BOUCAOURIS, Ministre plénipotentiaire, Représentant permanent adjoint, Genève

Alternates
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M. D. YANTAIS, Premier Conseiller, Mission permanente, Genève
M. T. THEODOROU, Premier Secrétaire d'Ambassade, Mission permanente, Genève

GUATEMALA

Chief Delegate
Dr G. HERNÁNDEZ POLANCO, Ministre de la Santé publique et de l'Assistance sociale

Delegates
M. F. URRUELA PRADO, Ambassadeur, Représentant permanent, Genève
M. J. SMITH, Représentant de la Fédération centraméricaine des Laboratoires pharmaceutiques

Alternate
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Adviser
M. G. SMITH, Conseiller

GUINEA

Chief Delegate
Dr K. DRAME, Ministre de la Santé

Delegates
Dr C. LOUA, Conseiller technique chargé de la Coopération
Dr M. L. TOURE, Directeur national de la Santé

GUINEA-BISSAU

Chief Delegate
Dr Eugénia S. ARAUJO, Ministre de la Santé publique

Delegates
Dr A. P. DA SILVA, Directeur général, Planification et Coopération internationale
Dr C. GOMES, Directeur du Centre de la Santé mentale

HAITI

Chief Delegate
M. J. MOLIERE, Ministre de la Santé publique et de la Population

Delegates
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M. J. P. ANTONIO, Ambassadeur, Représentant permanent, Genève

HONDURAS

Chief Delegate
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Delegates
M. A. LÓPEZ LUNA, Ambassadeur, Représentant permanent, Genève
Dr A. A. MELARA VEGA, Directeur général de l'Environnement, Ministère de la Santé publique

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Mme G. BU FIGUEROA, Conseiller, Mission permanente, Genève

HUNGARY

Chief Delegate
Dr G. SZABÓ, Minister of Welfare
(Chief Delegate from 1 to 3 May 1995)

Deputy Chief Delegate
Dr M. KÖKÉNY, Secretary of State, Ministry of Welfare
(Chief Delegate from 4 to 12 May 1995)

Delegate
Dr G. BOYTHA, Ambassador, Permanent Representative, Geneva

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Dr Erzsébet PODMANICZKY, Head, Department for International Relations, Ministry of Welfare
Dr Piroska VARGA, Deputy Head, Department of Health Policy, Ministry of Welfare
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Dr Marianna SZATMÁRI, Senior Ministerial Counsellor, Liaison Officer

ICELAND

Chief Delegate
Dr G. MAGNUSSEN, Deputy Secretary General, Ministry of Health and Social Security

Deputy Chief Delegate
Ms D. PÁLSDÓTTIR, Director, Ministry of Health and Social Security

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Mr O. ÓLAFSSON, Director-General of Health

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Ms L. ÓLAFSDÓTTIR, Deputy Permanent Representative, Geneva
Mr G. B. HELGASON, First Secretary, Permanent Mission, Geneva

INDIA

Chief Delegate
Dr C. SILVERA, Minister of State for Health and Family Welfare

Delegates
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Mr S. CHANDRA, Ambassador, Permanent Representative, Geneva

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Mr M. SINGH, Counsellor, Permanent Mission, Geneva
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Mr T. S. TIRUMURTI, First Secretary, Permanent Mission, Geneva
Mr R. K. MISRA, Ministry of Health and Family Welfare
Mr A. S. GILL, Third Secretary, Permanent Mission, Geneva

INDONESIA

Chief Delegate

Professor SUJUDI, Minister of Health

Delegates

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Ms D. H. MOEHARIO, First Secretary, Permanent Mission, Geneva
Mr S. S. KADARISMAN, Third Secretary, Permanent Mission, Geneva
Ms R. TAHAR, Third Secretary, Permanent Mission, Geneva
Ms A. L. LUHULIMA, Directorate for International Organizations, Department of Foreign Affairs
Mr DORODJATUN, President Director of Biofarma

IRAN (ISLAMIC REPUBLIC OF)

Chief Delegate

Dr A. MARANDI, Minister of Health and Medical Education

Delegates

Mr S. NASSERI, Ambassador, Permanent Representative, Geneva
Dr I. AKBARI, Adviser to the Minister of Health and Medical Education

Alternates

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Dr M. H. NICKNAM, Director-General, Public Relations and International Affairs Department, Ministry of Health and Medical Education
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Mr A. TOUTOUNCHIAN, Expert, International Economics and Specialized Affairs Department, Ministry of Foreign Affairs

IRAQ

Chief Delegate

Dr O. M. MUBARAK, Minister of Health

Delegates

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Mr K. AL-KHERO, First Secretary, Permanent Mission, Geneva

IRELAND

Chief Delegate

Mr M. NOONAN, Minister for Health

Delegates

Mr J. SWIFT, Ambassador, Permanent Representative, Geneva
Mr J. HURLEY, Secretary (Public Service Management and Development), Department of Finance

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Mr J. CREGAN, Assistant Principal Officer, Department of Health
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Ms M. KENNY, Personal Assistant to the Minister for Health
Ms C. BERGIN, Permanent Mission, Geneva

ISRAEL

Chief Delegate

Dr E. SNEH, Minister of Health

Delegates
Dr Y. LAMDAN, Ambassador, Permanent Representative, Geneva
(Chief Delegate from 4 to 12 May 1995)
Mrs P. HERZOG, Senior Adviser, Ministry of Health

Alternates
Dr M. OREN, Director-General, Ministry of Health
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Mrs S. FRANKEL, Counsellor, Permanent Mission, Geneva
Mr Y. AVRAHAMI, Adviser to the Minister of Health
Dr D. LEVANON, Deputy Minister, Counsellor, Ministry of Health
Dr Y. SEVER, Director of General Medicine Division, Ministry of Health
Miss Y. BEN-CHAY, Spokeswoman of the Minister of Health
Mr S. NAVEH, Second Secretary, Permanent Mission, Geneva

ITALY

Chief Delegate
Professeur P. GUZZANTI, Ministre de la Santé

Deputy Chief Delegate
M. G. BALDOCCI, Ambassadeur, Représentant permanent, Genève

Delegate
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Alternates
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Professeur E. VICARI, Directeur général, Istituto Superiore di Sanità
Professeur A. MANTOVANI, Istituto Superiore di Sanità
Dr G. MAJORI, Directeur, Département de Parasitologie, Istituto Superiore di Sanità
Professeur L. GIANNICO, Commissaire extraordinaire, Croix-Rouge italienne
Dr F. TAVERNITI, Chef du Bureau de Presse, Ministère de la Santé
M. G. L. MASCIA, Premier Conseiller, Mission permanente, Genève
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Dr R. MASIRONI, Ministère de la Santé

JAMAICA

Chief Delegate
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Delegates
Mr R. PIERCE, Ambassador, Permanent Representative, Geneva
Mr G. BRIGGS, Permanent Secretary, Ministry of Health

Alternates
Dr B. WINT, Chief Medical Officer, Ministry of Health
Miss V. BETTON, Minister-Counsellor, Permanent Mission, Geneva
Miss J. STEWART, First Secretary, Permanent Mission, Geneva

JAPAN

Chief Delegate
Mr S. IDE, Minister for Health and Welfare

Delegate
Mr M. ENDO, Ambassador Extraordinary and Plenipotentiary, Permanent Representative, Geneva

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Dr M. ITO, Counsellor for Science and Technology, Minister's Secretariat, Ministry of Health and Welfare
Mr H. SAKAI, Director, International Affairs Division, Minister's Secretariat, Ministry of Health and Welfare
Mr T. KOEZUKA, Counsellor, Permanent Mission, Geneva
Mr T. HIRAI, Director, Research and Development Division, Pharmaceutical Affairs Bureau, Ministry of Health and Welfare
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Mr H. BETSUI, Deputy Director, International Affairs Division, Minister's Secretariat, Ministry of Health and Welfare
Mr G. ICHIKAWA, Political Secretary to the Minister of Health and Welfare
Mr Y. TAKAI, Administrative Secretary to the Minister for Health and Welfare

Mr S. TAIRA, Director-General, Medical Cooperation Department, Japan International Cooperation Agency
Mr N. KUROSAKI, Planning Division, Medical Cooperation Department, Japan International Cooperation Agency

JORDAN

Chief Delegate
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Delegates
Dr H. OWEIS, Secretary-General, Ministry of Health (Chief Delegate from 7 May 1995)
Mr M. KASIM, Chief, International Health Department

Alternates
Dr J. AL-SHARMAN, Director of Health, Kura District
Dr K. EL-KHAYATT, Department of Planning and Project Management
Mr A. F. SHARAF, Ambassador, Permanent Representative, Geneva
Mr I. AWAWDEH, Second Secretary, Permanent Mission, Geneva

KAZAKHSTAN

Delegates
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Dr Jibek KARAGULOVA, Head, WHO Collaborating Centre for Primary Health Care

KENYA

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Mr A. CHEPSIROR, Second Secretary, Permanent Mission, Geneva

KIRIBATI

Delegate
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Dr T. TAITAI, Secretary for Health and Family Planning

KUWAIT

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Dr A. R. A. AL-AWADI, President of the Islamic Organization for Medical Sciences

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Mr W. Y. AL-WAGAYYAN, Director of Minister's Office
Dr M. I. A. AL-SALAH, Head of Communicable Diseases Section
Mr R. S. M. G. AL-AZEMI, Central Registry Superintendent, Department of Legal Affairs and Investigation
Mrs L. Z. R. ABOASHA, Legal Researcher

KYRGYZSTAN

Chief Delegate
Mr V. M. GLINENKO, Deputy Minister of Health

Delegate
Mr A. S. IMANBAEV, Head of WHO Centre for Central Asian Countries

LAO PEOPLE'S DEMOCRATIC REPUBLIC

Chief Delegate
Professeur Vannareth RAJPHO, Ministre de la Santé

Delegate
Dr S.-O. KINGSADA, Directeur général adjoint de la Santé

LATVIA

Chief Delegate
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Mr I. REZEBERGS, Ministry of Welfare, Vice-State Secretary

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LEBANON

Chief Delegate
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Deputy Chief Delegate
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Delegate
Dr W. AMMAR, Directeur général du Ministère de la Santé publique

Alternates
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Professeur F. BOUSTANI, ancien Président de l'Ordre des Médecins
M. G. MOALLEM, Premier Secrétaire, Mission permanente, Genève

Dr Lina OUEIDAT, Directeur du Programme de la Banque mondiale, Ministère de la Santé publique
M. H. CHAAR, Fonctionnaire administratif

LESOTHO

Chief Delegate
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Delegates
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Dr N. MAPETLA, Director of Health Services, Ministry of Health

Alternates
Mr B. MAJARA, Chief Nutritionist, Ministry of Health
Ms M. TIHELI, Chief Nursing Officer, Ministry of Health

LIBERIA

Delegate
Mr H. D. WILLIAMSON, Chargé d'affaires a.i., Permanent Mission, Geneva

LIBYAN ARAB JAMAHIRIYA

Chief Delegate
Dr A. B. A. AL-MAHMOUDI, Secretary, People's General Committee on Health and Social Security

Delegates
Dr A. M. ABDULHADI, Primary Health Care Consultant, Secretariat of the People's General Committee on Health and Social Security
Dr A. S. JAIDY, Director of Health, Foreign Affairs and International Organizations Department

Alternates
Mr H. I. TAMER, Under-Secretary, People's General Committee on Health and Social Security
Dr B. ALLAGHI, Director, National Committee on AIDS
Dr A. AL-MAGHADDAMI, Director, National Committee on Maternal and Child Care
Dr A. A. KRIN, Secretary, Management Committee, Medical Services Department
Mr S. A. AL-HAJ, Committee Office, People's General Committee on Health and Social Security
Mr M. R. AL-DOKALI, People's Office for Foreign Relations and International Cooperation
Mr M. DROUJI, Minister-Plenipotentiary, Chargé d'affaires a.i., Permanent Mission, Geneva
Dr Mabrouka LEGNAIN, Counsellor (Health Affairs), Permanent Mission, Geneva

LITHUANIA

Chief Delegate
Mr A. VINKUS, Minister of Health

Delegates
Mr N. PRIELAIDA, Ambassador, Permanent Representative, Geneva
Mr R. PETKEVIČIUS, Adviser to the Minister of Health on External Relations

Alternate
Mr K. A. ŠČEPONAVIČIUS, Director of the Health Reforms Management Bureau

LUXEMBOURG

Chief Delegate
M. J. LAHURE, Ministre de la Santé
(Chief Delegate on 2 May 1995)

Deputy Chief Delegate
Dr Danielle HANSEN-KOENIG, Directeur général de la Santé, Ministère de la Santé
(Chief Delegate on 1 May and from 3 to 12 May 1995)

Delegate
Mme A. SCHLEDER-LEUCK, Conseiller de Direction première classe, Ministère de la Santé (Deputy Chief Delegate on 1 May and from 3 to 12 May 1995)

Alternates
M. P. PETERS, Ambassadeur, Représentant permanent, Genève
M. P. DUHR, Conseiller, Représentant permanent adjoint, Genève
M. A. WEBER, Attaché, Mission permanente, Genève

MADAGASCAR

Chief Delegate
Professeur D. S. ANDRIAMBAO, Ministre de la Santé

Deputy Chief Delegate
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Delegate
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Alternates
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M. K. ALLAOUIDINE, Attaché, Mission permanente, Genève

MALAWI

Chief Delegate
Dr N. G. A. MTAFU, Minister of Health and Population

Deputy Chief Delegate
Dr W. B. MUKIWA, Secretary for Health and Population

Delegate
Dr W. O. O. SANGALA, Chief of Health Services

Alternates
Mrs J. MAKOZA, Controller of Nursing Services
Mr A. F. KALIMA, Under-Secretary
Mrs M. E. CHAPONDA, Public Health Physician

MALAYSIA

Chief Delegate
Dato' ISMAIL MANSOR, Secretary-General, Ministry of Health

Deputy Chief Delegate
Dr ABU BAKAR Dato' SULEIMAN, Director-General of Health, Ministry of Health

Delegate
Mr HARON HJ SIRAJ, Ambassador, Permanent Representative, Geneva

Alternates
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Dr SURINDER SINGH, Deputy Director of Health, Sabah, Ministry of Health
Mr ABDULLAH FAIZ ZAIN, First Secretary, Permanent Mission, Geneva

MALDIVES

Chief Delegate
Mr A. ABDULLAH, Minister of Health and Welfare

Deputy Chief Delegate
Dr A. WAHEED, Director-General, Health Services, Ministry of Health and Welfare

Delegate
Mr A. SALIH, Assistant Director, Human Resource Development, Ministry of Health and Welfare

MALI

Chief Delegate
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Delegates
Professeur M. A. MAIGA, Conseiller technique, Ministère de la Santé, de la Solidarité et des Personnes âgées
Dr L. KONATE, Directeur national de la Santé

MALTA

Chief Delegate
Dr L. DEGUARA, Parliamentary Secretary for Health

Deputy Chief Delegate
Mr M. BARTOLO, Ambassador, Permanent Representative, Geneva

Delegate
Dr A. VASSALLO, Chief Government Medical Officer

Alternates
Dr P. ABELA-HYZLER, Consultant Adviser, Department of Health
Mr M. VALENTINO, First Secretary, Permanent Mission, Geneva
Mr A. BONNICI, Third Secretary, Permanent Mission, Geneva

MAURITANIA

Chief Delegate
M. M. OULD AMAR, Ministre de la Santé et des Affaires sociales

Delegates
Dr M. S. OULD ZEINE, Conseiller technique du Ministre de la Santé et des Affaires sociales
Dr I. KANE, Directeur de la Protection sanitaire, Ministère de la Santé et des Affaires sociales

MAURITIUS

Chief Delegate
Mr J. R. FINETTE, Minister of Health

Delegates
Mr J. M. DEDANS, Ambassador, Permanent Representative, Geneva
Dr A. K. PURRAN, Chief Medical Officer

Alternate
Mr P. E. CURÉ, Minister-Counsellor, Permanent Mission, Geneva

MEXICO

Chief Delegate
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Delegates
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Dr F. CHÁVEZ PEÓN, Directeur du Développement et de la Gestion internationale, Secrétariat à la Santé

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M. E. ROMERO ESQUIVEL, Deuxième Secrétaire, Mission permanente, Genève
M. L. JOUBLANC, Représentant permanent adjoint, Genève

MICRONESIA (FEDERATED STATES OF)

Delegate
Dr E. K. PRETRICK, Secretary (Minister), Department of Health Services

MONACO

Chief Delegate
Mme C. GASTAUD, Directeur de l'Action sanitaire et sociale

Delegate
Dr Anne NEGRE, Médecin de santé publique, Direction de l'Action sanitaire et sociale

MONGOLIA

Chief Delegate
Dr P. NYMADAWA, Minister of Health
(Chief Delegate from 8 to 12 May 1995)

Deputy Chief Delegate
Mr S. YUMJAV, Ambassador, Permanent Representative, Geneva
(Chief Delegate from 1 to 7 May 1995)

Delegate
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MOROCCO

Chief Delegate
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Delegates
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Dr A. ZAHI, Secrétaire général, Ministère de la Santé publique

Alternates
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Dr A. DRISSI, Directeur de la Population, Ministère de la Santé publique
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