



WORLD HEALTH ORGANIZATION

FORTY-FIRST WORLD HEALTH ASSEMBLY

GENEVA, 2-13 MAY 1988

**RESOLUTIONS AND DECISIONS
ANNEXES**

GENEVA

1988

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACC	- Administrative Committee on Coordination	OAU	- Organization of African Unity
ACHR	- Advisory Committee on Health Research	OECD	- Organisation for Economic Co-operation and Development
AGFUND	- Arab Gulf Programme for United Nations Development Organizations	PAHO	- Pan American Health Organization
ASEAN	- Association of South-East Asian Nations	PASB	- Pan American Sanitary Bureau
CIDA	- Canadian International Development Agency	SIDA	- Swedish International Development Authority
CIOMS	- Council for International Organizations of Medical Sciences	UNCTAD	- United Nations Conference on Trade and Development
DANIDA	- Danish International Development Agency	UNDP	- United Nations Development Programme
ECA	- Economic Commission for Africa	UNDR0	- Office of the United Nations Disaster Relief Coordinator
ECE	- Economic Commission for Europe	UNEP	- United Nations Environment Programme
ECLAC	- Economic Commission for Latin America and the Caribbean	UNESCO	- United Nations Educational, Scientific and Cultural Organization
ESCAP	- Economic and Social Commission for Asia and the Pacific	UNFDAC	- United Nations Fund for Drug Abuse Control
ESCWA	- Economic and Social Commission for Western Asia	UNFPA	- United Nations Population Fund
FAO	- Food and Agriculture Organization of the United Nations	UNHCR	- Office of the United Nations High Commissioner for Refugees
IAEA	- International Atomic Energy Agency	UNICEF	- United Nations Children's Fund
IARC	- International Agency for Research on Cancer	UNIDO	- United Nations Industrial Development Organization
ICAO	- International Civil Aviation Organization	UNITAR	- United Nations Institute for Training and Research
IFAD	- International Fund for Agricultural Development	UNRWA	- United Nations Relief and Works Agency for Palestine Refugees in the Near East
ILO	- International Labour Organisation (Office)	UNSCEAR	- United Nations Scientific Committee on the Effects of Atomic Radiation
IMO	- International Maritime Organization	USAID	- United States Agency for International Development
ITU	- International Telecommunication Union	WFP	- World Food Programme
NORAD	- Norwegian Agency for International Development	WIPO	- World Intellectual Property Organization
		WMO	- World Meteorological Organization

The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation "country or area" appears in the headings of tables, it covers countries, territories, cities or areas.

PREFACE

The Forty-first World Health Assembly was held at the Palais des Nations, Geneva, from 2 to 13 May 1988, in accordance with the decision of the Executive Board at its eightieth session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

Resolutions and decisions,¹ and list of participants -
document WHA41/1988/REC/1

Verbatim records of plenary meetings, and committee reports -
document WHA41/1988/REC/2

Summary records of committees -
document WHA41/1988/REC/3

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, and are grouped in the table of contents under the appropriate subject headings. This is to ensure continuity with the Handbook, Volumes I, II and III (first edition) of which contain most of the resolutions adopted by the Health Assembly and the Executive Board between 1948 and 1986. 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 (first edition) of the Handbook (page XIII).

CONTENTS

	<u>Page</u>
Preface	iii
Agenda	ix
List of documents	xii

RESOLUTIONS AND DECISIONS

PROGRAMME

Strategies for health for all

WHA41.26	Leadership development for health for all	22
WHA41.27	The role of epidemiology in attaining health for all	25

Technical cooperation

WHA41.21	Health and medical assistance to Lebanon	17
WHA41.23	Liberation struggle in southern Africa: assistance to the front-line States, Lesotho and Swaziland	19
WHA41.30	Implementation of technical cooperation among non-aligned and developing countries	29
WHA41.32	Difficult health situation experienced by the people of Panama	30

WHO's general programme development and management

Decision 8	Report of the Director-General on the work of WHO in 1986-1987	36
------------	--	----

Organization of health systems based on primary health care

WHA41.34	Strengthening primary health care	31
----------	---	----

General health protection and promotion

WHA41.25	Tobacco or health	22
----------	-------------------------	----

Protection and promotion of the health of specific population groups

WHA41.9	Special Programme of Research, Development and Research Training in Human Reproduction	6
WHA41.11	Infant and young child nutrition	9

Promotion of environmental health

WHA41.29	Radionuclides in food: WHO guidelines for derived intervention levels	28
Decision 9	Conventions concerning nuclear accidents	36

Diagnostic, therapeutic and rehabilitative technology

WHA41.16	Rational use of drugs	13
WHA41.17	Ethical criteria for medicinal drug promotion	14
WHA41.18	WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce	15
WHA41.19	Traditional medicine and medicinal plants	15

Disease prevention and control

WHA41.24	Avoidance of discrimination in relation to HIV-infected people and people with AIDS	20
WHA41.28	Global eradication of poliomyelitis by the year 2000	26

Supplies and equipment

WHA41.31	The embargo of medical supplies and its effects on health care	30
----------	--	----

PROGRAMME BUDGET

Consideration and approval

WHA41.10	Revised appropriation resolution for the financial period 1988-1989	7
----------	---	---

GOVERNING BODIES

World Health Assembly

WHA41.4	Amendments to the Rules of Procedure of the World Health Assembly	2
Decision 1	Composition of the Committee on Credentials	34
Decision 2	Composition of the Committee on Nominations	34
Decision 3	Election of officers of the Forty-first World Health Assembly .	34
Decision 4	Election of officers of the main committees	34
Decision 5	Establishment of the General Committee	35
Decision 6	Adoption of the agenda	35
Decision 7	Verification of credentials	35
Decision 14	Selection of the country in which the Forty-second World Health Assembly will be held	37

Executive Board

Decision 10	Election of Members entitled to designate a person to serve on the Executive Board	36
Decision 13	Reports of the Executive Board on its eightieth and eighty-first sessions	37

FINANCIAL AND ADMINISTRATIVE MATTERS

Financial matters

WHA41.5	Financial report and audited financial statements for the period 1 January 1986 - 31 December 1987, and report of the External Auditor to the Health Assembly	2
WHA41.6	Status of collection of assessed contributions and status of advances to the Working Capital Fund	3
WHA41.7	Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution: statement of principles	3
WHA41.12	Incentive scheme to promote timely payment of assessed contributions by Members	10
WHA41.13	Real Estate Fund	11
WHA41.20	Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution	16

Staff matters

WHA41.1	Appointment of the Director-General	1
WHA41.2	Contract of the Director-General	1
WHA41.3	Expression of appreciation to Dr Halfdan T. Mahler	1
WHA41.14	Salaries and allowances for ungraded posts and the Director-General	12
Decision 11	Annual report of the United Nations Joint Staff Pension Board for 1986	37
Decision 12	Appointment of representatives to the WHO Staff Pension Committee	37

EXTERNAL COORDINATION FOR HEALTH AND SOCIAL DEVELOPMENT

United Nations system

WHA41.8	Health conditions of the Arab population in the occupied Arab territories, including Palestine	4
WHA41.15	Report of the World Commission on Environment and Development .	12
WHA41.22	Health assistance to refugees and displaced persons in Cyprus .	19
WHA41.33	Health assistance to the people of Afghanistan	31

ANNEXES

1.	Contract of the Director-General	41
2.	Programme budget reduction for 1988-1989 proposed by the Director-General	43
3.	Ethical criteria for medicinal drug promotion	46
4.	WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce	53
5.	Tobacco or health	57
6.	Declaration of Talloires	71
7.	Alma-Ata reaffirmed at Riga	74
8.	Conventions concerning nuclear accidents:	
	Convention on early notification of a nuclear accident	76
	Convention on assistance in the case of a nuclear accident or radiological emergency	82

MEMBERSHIP OF THE HEALTH ASSEMBLY

List of delegates and other participants	91
Representatives of the Executive Board	134
Officers of the Health Assembly and membership of its committees	135
<u>Index to resolutions and decisions</u>	137

AGENDA¹

PLENARY MEETINGS

1. Opening of the session
2. Appointment of the Committee on Credentials
3. Election of the Committee on Nominations
4. Election of the President and the five Vice-Presidents
5. Election of the Chairman of Committee A
6. Election of the Chairman of Committee B
7. Establishment of the General Committee
8. Adoption of the agenda and allocation of items to the main committees
9. [deleted]
10. Review and approval of the reports of the Executive Board on its eightieth and eighty-first sessions
11. Review of the report of the Director-General on the work of WHO in 1986-1987
12. Fortieth anniversary of the World Health Organization and tenth anniversary of the Declaration of Alma-Ata
13. Election of Members entitled to designate a person to serve on the Executive Board
14. Director-General
 - 14.1 Appointment
 - 14.2 Approval of contract
15. Awards
 - 15.1 Presentation of the Léon Bernard Foundation Prize
 - 15.2 Presentation of the Dr A. T. Shousha Foundation Prize
 - 15.3 Presentation of the Sasakawa Health Prize
16. Approval of reports of main committees
17. Closure of the Forty-first World Health Assembly

¹ The agenda was adopted at the third plenary meeting.

COMMITTEE A

18. Election of Vice-Chairmen and Rapporteur
19. Making optimal use of WHO resources (report by the Executive Board)
20. Infant and young child nutrition (progress and evaluation report; and status of implementation of the International Code of Marketing of Breast-milk Substitutes)
21. Special Programme of Research, Development and Research Training in Human Reproduction (progress report)
22. Tobacco or health (progress report)
23. Rational use of drugs (review of implementation of WHO's revised drug strategy) (report by the Director-General)
24. Global strategy for the prevention and control of AIDS (report by the Director-General)
25. Radionuclides in food: WHO guidelines for derived intervention levels¹

Supplementary agenda item 1: Revised appropriation resolution for the financial period 1988-1989

COMMITTEE B

26. Election of Vice-Chairmen and Rapporteur
27. Review of the financial position of the Organization
 - 27.1 Financial report on the accounts of WHO for the financial period 1986-1987, report of the External Auditor, and comments thereon of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Health Assembly
 - 27.2 Status of collection of assessed contributions and status of advances to the Working Capital Fund
 - 27.3 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution
 - 27.4 Incentive scheme to promote timely payment of assessed contributions by Members
 - 27.5 Use of additional casual income to help finance the approved programme budget for 1988-1989
 - 27.6 Programme budget reduction for 1988-1989 proposed by the Director-General
28. [deleted]
29. [deleted]
30. [deleted]

¹ Item referred to Committee B.

AGENDA

31. Real Estate Fund
32. Salaries and allowances for ungraded posts and the Director-General
33. Health conditions of the Arab population in the occupied Arab territories, including Palestine
34. Collaboration within the United Nations system
 - 34.1 General matters
 - 34.2 Health and medical assistance to Lebanon
 - 34.3 Health assistance to refugees and displaced persons in Cyprus
 - 34.4 Liberation struggle in southern Africa: assistance to the front-line States, Lesotho and Swaziland
35. United Nations Joint Staff Pension Fund
 - 35.1 Annual report of the United Nations Joint Staff Pension Board for 1986
 - 35.2 Appointment of representatives to the WHO Staff Pension Committee

LIST OF DOCUMENTS

Health Assembly documents¹

- A41/1 Rev.1 Agenda²
- A41/2 Review and approval of the reports of the Executive Board on its eightieth and eighty-first sessions
- A41/3 Contract of the Director-General³
- A41/4 Tobacco or health (Report by the Director-General)⁴
- A41/5 Global strategy for the prevention and control of AIDS (Report by the Director-General)
- A41/6 Financial report and audited financial statements for the financial period 1 January 1986 - 31 December 1987 and report of the External Auditor to the World Health Assembly
- A41/7 Status of collection of assessed contributions and status of advances to the Working Capital Fund (Report by the Director-General)
- A41/8 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution (Second report of the Committee of the Executive Board to Consider Certain Financial Matters Prior to the Forty-first World Health Assembly)
- A41/9 Health conditions of the Arab population in the occupied Arab territories, including Palestine (Report of the Special Committee of Experts)
- A41/10 Collaboration within the United Nations system: general matters (Report by the Director-General)
- A41/10 Add.1 Collaboration within the United Nations system: general matters. International collaboration for child survival and development⁵
- A41/11 Collaboration within the United Nations system: general matters. Conventions concerning nuclear accidents⁶
- A41/12 Rev.1 Collaboration within the United Nations system: health and medical assistance to Lebanon (Report by the Director-General)

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

² See p. ix.

³ See Annex 1.

⁴ See Annex 5.

⁵ See Annex 6.

⁶ See Annex 8.

- A41/13 Collaboration within the United Nations system: health assistance to refugees and displaced persons in Cyprus (Report by the Director-General)
- A41/14 Collaboration within the United Nations system: liberation struggle in southern Africa - assistance to the front-line States, Lesotho and Swaziland, and to Namibia and national liberation movements in South Africa (Report by the Director-General)
- A41/15 United Nations Joint Staff Pension Fund (Annual report of the United Nations Joint Staff Pension Board for 1986)
- A41/16 United Nations Joint Staff Pension Fund (Appointment of representatives to the WHO Staff Pension Committee)
- A41/17 and Corr.1 Rational use of drugs: review of implementation of WHO's drug revised strategy (Report by the Director-General)¹
- A41/18 Incentive scheme to promote timely payment of assessed contributions by Members (Report by the Director-General)
- A41/19 Alma-Ata reaffirmed at Riga (Statement issued by a meeting in Riga, USSR)²
- A41/20 Health conditions of the Arab population in the occupied Arab territories, including Palestine: WHO collaborating centres in primary health care research in the occupied Arab territories (Progress report by the Director-General)
- A41/21 Financial report and audited financial statements for the financial period 1 January 1986 - 31 December 1987 and report of the External Auditor to the World Health Assembly (First report of the Committee of the Executive Board to Consider Certain Financial Matters Prior to the Forty-first World Health Assembly)
- A41/22 Committee on Nominations: first report
- A41/23 Committee on Nominations: second report
- A41/24 Committee on Nominations: third report
- A41/25 Programme budget reduction for 1988-1989 proposed by the Director-General (Third report of the Committee of the Executive Board to Consider Certain Financial Matters Prior to the Forty-first World Health Assembly)³
- A41/26 Committee on Credentials: first report
- A41/27 Report of Committee B to Committee A
- A41/28 Election of Members entitled to designate a person to serve on the Executive Board
- A41/29 First report of Committee B
- A41/30 First report of Committee A

¹ See Annex 4.

² See Annex 7.

³ See Annex 2.

A41/31 Second report of Committee B

A41/32 Committee on Credentials: second report

A41/33 Second report of Committee A

A41/34 Third report of Committee B

A41/35 Third report of Committee A

A41/36 Fourth report of Committee B

A41/37 Fourth report of Committee A

Information documents¹

A41/INF.DOC./1 Collaboration within the United Nations system: general matters. Operational activities for development of the United Nations system (Note by the Director-General)

A41/INF.DOC./2 Review of the report of the Director-General on the work of WHO in 1986-1987. Progress in elimination of dracunculiasis (Report by the Director-General)

A41/INF.DOC./3 Health conditions of the Arab population in the occupied Arab territories, including Palestine (Report of an Assessment Mission)

A41/INF.DOC./4 Health conditions of the Arab population in the occupied Arab territories, including Palestine (Report by the Ministry of Health of Israel)

A41/INF.DOC./5 Health conditions of the Arab population in the occupied Arab territories, including Palestine (Annual report of the Director of Health UNRWA)

A41/INF.DOC./6 Tobacco or health (Report of the Advisory Group on a WHO Global Action Plan on Tobacco or Health)²

A41/INF.DOC./7 Health conditions of the Arab population in the occupied Arab territories, including Palestine (Report submitted by the Permanent Observer of the Palestine Liberation Organization to the United Nations Office at Geneva)³

A41/INF.DOC./8 Rational use of drugs: traditional medicine and medicinal plants (Chiang Mai Declaration)

A41/INF.DOC./9 Contributions of Members and Associate Members to the amended programme budget for the financial period 1988-1989

¹ Issued in English and French.

² See Annex 5.

³ Issued also in Arabic.

RESOLUTIONS

WHA41.1 Appointment of the Director-General

The Forty-first World Health Assembly,

On the nomination of the Executive Board;

APPOINTS Dr Hiroshi Nakajima as Director-General of the World Health Organization.

Hbk Res., Vol. II (1985), 6.2.10

(Fifth plenary meeting, 4 May 1988)

WHA41.2 Contract of the Director-General

The Forty-first World Health Assembly,

I

Pursuant to Article 31 of the Constitution and Rule 109 of the Rules of Procedure of the World Health Assembly;

APPROVES the contract¹ establishing the terms and conditions of appointment, salary and other emoluments for the post of Director-General;

II

Pursuant to Rule 112 of the Rules of Procedure of the World Health Assembly;

AUTHORIZES the President of the Forty-first World Health Assembly to sign this contract in the name of the Organization.

Hbk Res., Vol. II (1985), 6.2.10

(Fifth plenary meeting, 4 May 1988)

WHA41.3 Expression of appreciation to Dr Halfdan T. Mahler

The Forty-first World Health Assembly,

Expressing its profound gratitude to Dr Halfdan T. Mahler for his outstanding services to health and development the world over throughout his long career in the World Health Organization, and in particular as its Director-General from 1973 to 1988;

Paying tribute in particular to his personal qualities of integrity, sincerity and leadership, his wide knowledge of all aspects of health, and his deep emotional and moral commitment to WHO and everything it stands for;

¹ See Annex 1.

Appreciating his staunch stand for the health of people everywhere, both for its humane value and for its contribution to social and economic development, and deeply moved by his empathy regarding the underprivileged, particularly the people of the developing countries;

Sharing his moral conscience concerning the gap between those who have the means of promoting and maintaining their health and ensuring appropriate health care when necessary and those who do not have such means, and emphasizing his unceasing efforts throughout his life to close that gap and to inspire others to equal efforts;

Considering that under his inspired leadership the World Health Organization has fulfilled more strongly than ever its constitutional role of directing and coordinating authority on international health work;

DECLARES Dr Halfdan T. Mahler Director-General Emeritus of the World Health Organization as from the date of his retirement.

Hbk Res., Vol. II (1985), 6.2.10

(Fifth plenary meeting, 4 May 1988)

WHA41.4 Amendments to the Rules of Procedure of the World Health Assembly

The Forty-first World Health Assembly,

Considering resolution WPR/RC38.R8 of the Regional Committee for the Western Pacific and decision EB81(16);

ADOPTS the following amendments to the Rules of Procedure of the World Health Assembly:

Rule 24

Replace the word "twenty-four" by "twenty-five" in the first and second paragraphs.

Rule 31

Replace the word "twenty-four" by "twenty-five" in the first sentence of the first paragraph.

Hbk Res., Vol. II (1985), 3.1.2

(Thirteenth plenary meeting, 9 May 1988)

WHA41.5 Financial report and audited financial statements for the financial period 1 January 1986 - 31 December 1987, and report of the External Auditor to the Health Assembly

The Forty-first World Health Assembly,

Having examined the financial report and audited financial statements for the financial period 1 January 1986 - 31 December 1987 and the report of the External Auditor to the Health Assembly;¹

¹ Document A41/6.

Having noted the report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Forty-first World Health Assembly;¹

ACCEPTS the Director-General's financial report and audited financial statements for the financial period 1 January 1986 - 31 December 1987 and the report of the External Auditor to the Health Assembly.

Hbk Res., Vol. III (1st ed.), 6.1.10.3

(Fourteenth plenary meeting, 11 May 1988 -
Committee B, first report)

WHA41.6 Status of collection of assessed contributions and status of advances to the Working Capital Fund

The Forty-first World Health Assembly,

Noting with concern that as at 31 December 1987:

(a) the rate of collection in 1987 of current year contributions in respect of the effective working budget amounted to 78.47%, being the second-lowest rate since the year 1950;

(b) only 88 Members had paid their current year contributions to the effective working budget in full, and 50 Members had made no payment towards their current year contributions;

1. EXPRESSES concern at the alarming deterioration in the payment of contributions, which has had a deleterious effect on programme implementation and the financial situation during the current financial period;
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. URGES Members that systematically make a practice of late payment of contributions to take whatever steps may be necessary to ensure earlier payment;
4. REQUESTS the Director-General to draw the contents of this resolution to the attention of all Members.

Hbk Res., Vol. III (1st ed.), 6.1.2.4

(Fourteenth plenary meeting, 11 May 1988 -
Committee B, first report)

WHA41.7 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution: statement of principles

The Forty-first World Health Assembly,

Recalling previous resolutions of the Health Assembly concerning Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution and, in particular, resolutions WHA8.13, WHA16.20 (part II) and WHA37.7 (paragraph 4);

¹ Document A41/21.

ADOPTS the following statement of the principles that should be followed henceforth:

APPLICATION OF ARTICLE 7 OF THE CONSTITUTION
IN THE CASE OF FAILURE TO MEET FINANCIAL OBLIGATIONS

1. Towards the end of the year preceding each Health Assembly, the Director-General will invite Members that will, unless corrective action is taken, be in arrears to an extent which would justify invoking Article 7 of the Constitution pursuant to resolution WHA8.13, to submit to the Executive Board a statement of their intentions as to the payment of arrears so that the Health Assembly, when it considers whether or not the right of vote of those Members is to be suspended, can make its decision on the basis of the statements of the Members and the recommendations of the Executive Board.
2. Unless there are exceptional circumstances justifying a different measure, the Health Assembly will adopt a decision, by a two-thirds majority pursuant to Rule 72 of the Rules of Procedure of the World Health Assembly, under which the voting rights of a Member in arrears to the extent referred to in paragraph 1 above will be suspended as from the opening day of the following Health Assembly if at that time the Member is still in arrears to the extent referred to. If the Member is no longer in arrears to the said extent, the decision will lapse and the suspension will not take effect. Any suspension will be without prejudice to the right to request restoration pursuant to Article 7 of the Constitution.

Hbk Res., Vol. III (1st ed.), 6.1.2.4

(Fourteenth plenary meeting, 11 May 1988 -
Committee B, first report)

WHA41.8 Health conditions of the Arab population in the occupied Arab territories, including Palestine

The Forty-first 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;

Aware of its responsibility for ensuring proper health conditions for all peoples who suffer from exceptional situations, including foreign occupation and especially settler colonialism;

Affirming the principle that acquisition of territories by force is inadmissible and that any occupation of territories by force and the practice of repression and violence against the civilian population as well as acts of deportation and expulsion have serious repercussions on the health and psychosocial conditions of the people under occupation, including mental and physical health;

Expressing its deepest concern at the obstacles created by Israel to the provision of basic health services and the establishment and strengthening of health centres and hospitals in the occupied Arab territories, including Palestine and the Golan;

Considering that the States parties to the Geneva Convention of 12 August 1949 pledged themselves, under Article One thereof, not only to respect the Convention but also to ensure that it was respected under all circumstances;

Recalling the resolutions of the United Nations General Assembly concerning the inalienable right of the Palestinian people to self-determination;

Recognizing the reasons behind the present uprising of the Palestinian people and affirming its support for the Arab population in the occupied Arab territories so that it might enjoy freedom, health and security;

Affirming the right of Arab refugees and deportees to return to their land and property from which they were deported;

Recalling previous resolutions of the Health Assembly on the health conditions of the Arab population in the occupied Arab territories, including Palestine;

Expressing profound concern and disquiet at practices and measures resorted to by Israel in the occupied Arab territories at present;

Taking into consideration the report of the Special Committee of Experts on health conditions of the Arab population in the occupied Arab territories, including Palestine;¹

Taking into consideration also the progress report of the Director-General on WHO collaborating centres in primary health care research in the occupied Arab territories;²

1. REAFFIRMS the right of the Palestinian people to have their own institutions that provide them with the health and social services required;
2. EXPRESSES ITS DEEPEST CONCERN at the deterioration of the health conditions of the population of the occupied Arab territories, including Palestine and the Golan;
3. AFFIRMS that the Israeli occupation is contradictory to the basic requirements for the development of an adequate health system to meet the needs of the population of the occupied Arab territories;
4. CONDEMNS Israel for its inhuman practices against the Arab population in the occupied Arab territories and particularly against the Palestinian people in their present uprising, as reflected in the infliction of physical and psychological injury;
5. DEMANDS that Israel comply with the Geneva Conventions of 1949 with respect to the Arab population under occupation;
6. CONDEMNS Israel for refusing to allow the Special Committee of Experts to visit the occupied Arab territories, including Palestine and the Golan, and demands that the Committee be allowed to perform its function of reviewing the health conditions of the inhabitants and submitting reports thereon to the Health Assembly;
7. THANKS the Special Committee of Experts for its report and requests that the Committee continue performing its duties, and submit its report on the health conditions of the Arab inhabitants of the occupied Arab territories, including Palestine and the Golan, to the Forty-second World Health Assembly, with particular reference to the physical and psychological effects of the inhuman practices of the Israeli authorities against the Palestinian people in their uprising against occupation;
8. DEMANDS that Israel allow the entry of medical and relief supplies for the Arab inhabitants of the occupied Arab territories, including Palestine and the Golan, and allow all institutions, societies and organizations, whether local or international, to develop and promote health care services for inhabitants of the occupied Arab territories, including Palestine and the Golan;

¹ Document A41/9.

² Document A41/20.

9. THANKS the Director-General for his efforts to implement Health Assembly resolutions and requests him:

- (1) to take the necessary measures to enable the Special Committee of Experts to visit the occupied Arab territories and present its report to the Forty-second World Health Assembly;
- (2) to collaborate and coordinate further with the Arab States concerned and with the Palestine Liberation Organization regarding the provision of the necessary assistance to the inhabitants of the occupied Arab territories, including Palestine;
- (3) to provide further assistance to the centres that train cadres working in the health field so that they may train more Palestinian workers in that field, in order to develop primary health care services in the occupied Arab territories;
- (4) to continue the development of, and further support to, the health centres that are under the direct supervision of WHO in the occupied Arab territories, and to strengthen their services;
- (5) to provide financial and moral support to all local, Arab and international institutions, societies and organizations that seek to establish hospitals and health units in the occupied Arab territories;
- (6) to present a report to the Forty-second World Health Assembly on the implementation of this resolution and measures that could be taken by the Health Assembly if Israel should persist in its refusal to implement Health Assembly resolutions concerning the health conditions of the Arab population of the occupied Arab territories, including Palestine;

10. THANKS all regional and international agencies and institutions for their assistance, in particular the United Nations Relief and Works Agency for Palestine Refugees in the Near East, and urges all Member States to support further those institutions.

Hbk Res., Vol. III (1st ed.), 7.1.4.4

(Fourteenth plenary meeting, 11 May 1988 -
Committee B, first report)

WHA41.9 Special Programme of Research, Development and Research Training in Human Reproduction

The Forty-first World Health Assembly,

Having considered the Director-General's progress report on the Special Programme of Research, Development and Research Training in Human Reproduction;¹

1. ENDORSES the policy guidelines outlined by the Director-General, with particular attention to the role of the Programme in:

- (1) the continued assessment of existing technologies and the acceleration of the development of new technologies in fertility regulation;
- (2) the building-up of national self-reliance in research on all aspects of human reproduction in developing countries to meet their specific needs in primary health care;

¹ Document EB81/1988/REC/1, Annex 3.

- (3) promoting scientific and technical cooperation between developed and developing countries, and between developing countries;
 - (4) coordination of the global research effort in the field of reproductive health;
 - (5) promoting ethical practices in the field of human reproduction research to protect the health and rights of individuals in different social and cultural settings;
2. REAFFIRMS the close relationship between family planning, health and development, and the need to integrate family planning activities with those of maternal and child health;
 3. EMPHASIZES the importance of ensuring the rapid and widespread application of the results of research supported by the Programme in countries' national health strategies and programmes;
 4. APPROVES the co-sponsorship of the Programme by the World Bank, the United Nations Development Programme and the United Nations Population Fund, as outlined in the report of the Director-General;
 5. URGES Member States to contribute, or to increase their contributions, to the Programme in order to accelerate the achievement of its objectives at the approved level.

Hbk Res., Vol. II (1985), 1.12.2

(Fourteenth plenary meeting, 11 May 1988 -
Committee A, first report)

WHA41.10 Revised appropriation resolution for the financial period 1988-1989

The Forty-first World Health Assembly,

Noting the proposal of the Director-General and the recommendation of the Executive Board that an additional amount of US\$ 13 961 000 of casual income available as at 31 December 1986 should be appropriated to help finance the 1988-1989 programme budget;¹

Noting also the proposal of the Director-General that the level of the effective working budget for the financial period 1988-1989 should be reduced by US\$ 25 000 000;²

DECIDES to amend the appropriation resolution for the financial period 1988-1989 (resolution WHA40.37) to read as follows:

RESOLVES to appropriate for the financial period 1988-1989 an amount of US\$ 679 590 300 as follows:

¹ See document EB81/1988/REC/1, resolution EB81.R13 and Annex 9.

² See Annex 2.

A.		Amount
Appropriation Section	Purpose of appropriation	US\$
1.	Direction, coordination and management ..	74 433 700
2.	Health system infrastructure	192 970 000
3.	Health science and technology: health promotion and care	110 239 600
4.	Health science and technology: disease prevention and control	86 223 900
5.	Programme support	145 112 800
Effective working budget		608 980 000
6.	Transfer to Tax Equalization Fund	59 000 000
7.	Undistributed reserve	11 610 300
Total		679 590 300

B. Amounts not exceeding the appropriations voted under paragraph A shall be available for the payment of obligations incurred during the financial period 1 January 1988 - 31 December 1989 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 1988-1989 to sections 1-6.

C. 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 1 exclusive of the provision made for the Director-General's and Regional Directors' Development Programme (US\$ 10 163 000). 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 1988-1989. Any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.5.

D. 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	4 000 000
(ii) casual income in the amount of	38 961 000
	42 961 000

thus resulting in assessments on Members of US\$ 636 629 300. Notwithstanding the provisions of Financial Regulation 5.3, the first annual instalment of the assessed contributions due from Members shall be US\$ 325 438 350 and the second annual instalment of the assessed contributions due from Members shall be US\$ 311 190 950. In establishing the amounts of contributions to be paid by individual Members, their assessments shall be reduced further by the amount standing to their credit in the Tax Equalization Fund, except that the credits of those Members that require staff members of WHO to pay taxes on their WHO emoluments shall be reduced by the estimated amounts of such tax reimbursements to be made by the Organization.

Hbk Res., Vol. III (1st ed.), 2.3

(Fourteenth plenary meeting, 11 May 1988 -
Committee A, first report)

WHA41.11 Infant and young child nutrition

The Forty-first World Health Assembly,

Having considered the report by the Director-General on infant and young child nutrition;¹

Recalling resolutions WHA33.32, WHA34.22 and WHA39.28 on infant and young child feeding and nutrition, and resolutions WHA37.18 and WHA39.31 on the prevention and control of vitamin A deficiency and xerophthalmia, and of iodine deficiency disorders;

Concerned at continuing decreasing breast-feeding trends in many countries, and committed to the identification and elimination of obstacles to breast-feeding;

Aware that appropriate infant and young child nutrition could benefit from further broad national, community and family interventions;

1. COMMENDS governments, women's organizations, professional associations, consumer and other nongovernmental groups, and the food industry for their efforts to promote appropriate infant and young child nutrition, and encourages them, in cooperation with WHO, to support national efforts for coordinated nutrition programmes and practical action at country level to improve the health and nutrition of women and children;

2. URGES Member States:

(1) to develop or enhance national nutrition programmes, including multisectoral approaches, with the objective of improving the health and nutritional status of their populations, especially that of infants and young children;

(2) to ensure practices and procedures that are consistent with the aim and principles of the International Code of Marketing of Breast-milk Substitutes, if they have not already done so;

3. REQUESTS the Director-General to continue to collaborate with Member States, through WHO regional offices and in collaboration with other agencies of the United Nations system, especially FAO and UNICEF:

(1) in identifying and assessing the main nutrient and dietary problems, developing national strategies to deal with them, applying these strategies, and monitoring and evaluating their effectiveness;

¹ Document EB81/1988/REC/1, Annex 10.

- (2) in establishing effective nutritional status surveillance systems in order to ensure that all the main variables which collectively determine nutritional status are properly addressed;
- (3) in compiling, analysing, managing and applying information that they have gathered on the nutritional status of their populations;
- (4) in monitoring, together with other maternal and child health indicators, changes in the prevalence and duration of full and supplemented breast-feeding with a view to improving breast-feeding rates;
- (5) in developing recommendations regarding diet, including timely complementary feeding and appropriate weaning practices, which are appropriate to national circumstances;
- (6) in providing legal and technical assistance, upon request from Member States, in the drafting and/or the implementation of national codes of marketing of breast-milk substitutes, or other similar instruments;
- (7) in designing and implementing collaborative studies to assess the impact of measures taken to promote breast-feeding and child nutrition in Member States.

Hbk Res., Vol. III (1st ed.), 1.12.1

(Fourteenth plenary meeting, 11 May 1988 -
Committee A, first report)

WHA41.12 Incentive scheme to promote timely payment of assessed contributions by Members

The Forty-first World Health Assembly,

Noting that in accordance with Financial Regulation 5.6 annual instalments of contributions are considered as due and payable in full as of the first day of the year to which they relate;

Recalling the past efforts of the Health Assembly, the Executive Board and the Director-General to ensure timely payment of contributions;

Noting the serious deterioration in the rate of payment of contributions in recent years;

Having been informed of the Joint Inspection Unit's recommendation to the effect that the governments which have met all their financial obligations concerning the payment of contributions should benefit from any surpluses to be credited to them, proportionate to the scale of contributions and in accordance with the timing of their payment during the previous budgetary period;

Agreeing that some incentive should be provided to Members to encourage them to advance the date of payment of their contributions;

Considering that the proposals made by the Director-General and endorsed by the Executive Board¹ for an incentive scheme to promote timely payment of assessed contributions by Members are appropriate in the context of WHO's financial mechanisms;

¹ See document EB81/1988/REC/1, resolution EB81.R12 and Annex 8.

1. DECIDES that an incentive scheme to promote timely payment of assessed contributions by Members to the Organization's regular budget as proposed by the Director-General and the Executive Board shall be effective as from the programme budget for 1992-1993, to be approved in 1991, based upon the record of Members' payments of assessed contributions in the years 1989 and 1990 and the record of the casual income earned in those two years and subjected to the scheme;
2. DECIDES FURTHER that, pursuant to this incentive scheme and to the extent that casual income is appropriated to help finance the budget, the component of such casual income consisting of interest earned shall be apportioned among Members in the form of credits against their gross assessments in accordance with an S-curve formula which takes into account not only the scale of assessments but also the dates and amounts of the payments of assessed contributions made by Members in respect of and during each year of the two-year period prior to the year in which a programme budget is adopted;
3. CONFIRMS that, as in the past, casual income exclusive of interest earned, which is appropriated to help finance the regular budget, will continue to be apportioned to Members in accordance with the WHO scale of assessments;
4. DECIDES to amend the text of Financial Regulation 5.3 to read as follows:
 - 5.3 The Health Assembly shall adopt a total budget level and scale of assessments for the following financial period. The assessed contributions of Members based on the scale of assessments shall be divided, after applying credits due to Members in accordance with any financial incentive scheme that may be adopted by the Health Assembly, into two equal annual instalments, the first of which shall relate to the first year and the second of which shall relate to the second year of the financial period. In the first year of the financial period, the Health Assembly may decide to amend the scale of assessments to be applied to the second year of the financial period.

Hbk Res., Vol. III (1st ed.), 6.1.2.4

(Fourteenth plenary meeting, 11 May 1988 -
Committee B, second report)

WHA41.13 Real Estate Fund

The Forty-first World Health Assembly,

Having considered resolution EB81.R3 and 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 1988 to 31 May 1989;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, and paragraphs 27 and 28 of the addendum to that report,² at the estimated cost of US\$ 386 250;

¹ Document EB81/1988/REC/1, Annex 2, part 1.

² Document EB81/1988/REC/1, Annex 2, part 2.

2. AGREES in principle that the Regional Director for the Eastern Mediterranean pursue negotiations with the Egyptian authorities concerning the extension of the Regional Office building in Alexandria.

Hbk Res., Vol. III (1st ed.), 6.1.7

(Fourteenth plenary meeting, 11 May 1988 -
Committee B, second report)

WHA41.14 Salaries and allowances for ungraded posts and the Director-General

The Forty-first 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

1. ESTABLISHES the salary for the posts of Assistant Directors-General and Regional Directors at US\$ 95 100 per annum before staff assessment, resulting in a modified net salary of US\$ 59 203 (dependency rate) or US\$ 53 891 (single rate);
2. ESTABLISHES the salary for the post of Deputy Director-General at US\$ 106 769 per annum before staff assessment, resulting in a modified net salary of US\$ 65 320 (dependency rate) or US\$ 58 892 (single rate);
3. ESTABLISHES the salary for the Director-General at US\$ 131 981 per annum before staff assessment, resulting in a modified net salary of US\$ 78 430 (dependency rate) or US\$ 69 178 (single rate);
4. DECIDES that these adjustments in remuneration shall be effective from 1 April 1988.

Hbk Res., Vol. III (1st ed.), 6.2.4.3

(Fourteenth plenary meeting, 11 May 1988 -
Committee B, second report)

WHA41.15 Report of the World Commission on Environment and Development

The Forty-first World Health Assembly,

Welcoming the report of the World Commission on Environment and Development, entitled Our common future, and calling particular attention to its conclusions and recommendations as they relate to the mandate of WHO;

Noting United Nations General Assembly resolution 42/187 of 11 December 1987, transmitting to all governments and to the governing bodies of the organs, organizations and programmes of the United Nations system the report of the World Commission on Environment and Development, and inviting them to take account of the analysis and recommendations contained in the report in determining their policies and programmes;

Noting further that, in the same resolution, the General Assembly called upon the governing bodies of the organs, organizations and programmes of the United Nations system to review their policies, programmes, budgets and activities aimed at contributing to sustainable development;

¹ See document EB81/1988/REC/1, resolution EB81.R2 and Annex 1.

1. REQUESTS the Director-General, the Executive Board and its Programme Committee, in preparing the programme budget for the biennium 1990-1991, to take into account the recommendations in the report of the World Commission on Environment and Development in all relevant programme areas, in order to contribute to sustainable development;
2. FURTHER REQUESTS the Director-General to submit to the eighty-third session of the Executive Board a progress report on WHO's contribution to the international efforts towards sustainable development as a contribution to the report to be submitted to the forty-fourth session of the United Nations General Assembly in accordance with operative paragraph 18 of General Assembly resolution 42/187.

Hbk Res., Vol. III (1st ed.), 7.1.3

(Fourteenth plenary meeting, 11 May 1988 -
Committee B, second report)

WHA41.16 Rational use of drugs

The Forty-first World Health Assembly,

Recalling resolutions WHA37.33 and WHA39.27 on the rational use of drugs;

Having reviewed the report of the Executive Board on the implementation of WHO's revised drug strategy, aimed at ensuring the rational use of drugs;¹

1. NOTES with satisfaction that, in spite of severe financial constraints, the revised drug strategy is being carried out almost in its entirety, the implementation of the remaining components having been delayed solely due to lack of resources;
2. CONGRATULATES all parties concerned that have fulfilled their responsibilities in compliance with resolution WHA39.27, and encourages them to continue to do so;
3. INVITES bilateral agencies, multilateral agencies inside and outside the United Nations system, and voluntary organizations, to support developing countries in setting up and carrying out programmes aimed at ensuring the rational use of drugs, particularly essential drugs programmes, and thanks those that are already doing so;
4. REQUESTS governments and pharmaceutical manufacturers to cooperate in the detection and prevention of the increasing incidence of the export or smuggling of falsely labelled, spurious, counterfeited or substandard pharmaceutical preparations;
5. REQUESTS the Director-General:
 - (1) to implement the remaining components of the revised drug strategy, seeking extrabudgetary resources in addition to those in the regular budget to this end;
 - (2) to include in his biennial reports to the Health Assembly information on the implementation of the revised drug strategy, and to provide reports thereon to the Executive Board from time to time, as necessary;
 - (3) to initiate programmes for the prevention and detection of the export, import and smuggling of falsely labelled, spurious, counterfeited or substandard pharmaceutical preparations, and to cooperate with the Secretary-General of the United Nations in cases when the provisions of the international drug treaties are violated.

Hbk Res., Vol. III (1st ed.), 1.15.2

(Fifteenth plenary meeting, 13 May 1988 -
Committee A, second report)

¹ See document EB81/1988/REC/1, resolution EB81.R9 and Annex 6.

WHA41.17 Ethical criteria for medicinal drug promotion

The Forty-first World Health Assembly,

Recalling resolutions WHA21.41 and WHA39.27;

Having considered the report of the Executive Board concerning the ethical criteria for medicinal drug promotion based on a draft prepared by an international group of experts;¹

Convinced that observance of ethical criteria for medicinal drug promotion by all parties concerned will contribute to a more rational use of drugs;

1. THANKS the international group of experts for its work;
2. ENDORSES the ethical criteria for medicinal drug promotion that are annexed to this resolution,² on the understanding that they constitute general principles that could be adapted by governments to countries' circumstances as appropriate to their political, economic, cultural, social, educational, scientific and technical situation, their national laws and regulations, disease profile, therapeutic traditions, and the level of development of their health system, and that they do not constitute legal obligations;
3. URGES Member States:
 - (1) to take account of these ethical criteria in developing their own appropriate measures to ensure that medicinal drug promotion supports the aim of improving health care through the rational use of drugs;
 - (2) to monitor and enforce, where appropriate, the implementation of the measures they have developed;
4. APPEALS to pharmaceutical manufacturers and distributors, the promotion industry, health personnel involved in the prescription, dispensing, supply and distribution of drugs, universities and other teaching institutions, professional associations, patient and consumer groups, the professional and general media (including publishers and editors of medical journals and related publications), and the public:
 - (1) to use these criteria as appropriate to their spheres of competence, activity and responsibility;
 - (2) to adopt measures based on these criteria as appropriate, and monitor and enforce their standards;
5. REQUESTS the Director-General:
 - (1) to ensure the wide dissemination of these criteria in all official languages;
 - (2) to follow the practice of these criteria and to report to the Executive Board from time to time as appropriate.

¹ See document EB81/1988/REC/1, resolution EB81.R10 and Annexes 6 and 7.

² See Annex 3.

WHA41.18 WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce

The Forty-first World Health Assembly,

Taking note of previous resolutions on the question;

Having examined the Director-General's report on the rational use of drugs, and in particular the proposed amendments to the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce;

Noting the fact that, in any case of obvious doubt, any Member State may request the Organization for assistance in finding an independent collaborating centre to carry out batch tests for the purposes of quality control;

1. ADOPTS the revised text of the expanded WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce;¹
2. INVITES Member States which are not yet participating in the Scheme to do so;
3. RECOMMENDS to Member States that they implement as far as possible all the provisions of the expanded WHO Certification Scheme;
4. REQUESTS the Director-General to report, in his report on WHO's revised drug strategy to a future Health Assembly, on the progress accomplished in the implementation of the expanded WHO Certification Scheme.

Hbk Res., Vol. II (1985), 1.15.3

(Fifteenth plenary meeting, 13 May 1988 -
Committee A, second report)

WHA41.19 Traditional medicine and medicinal plants

The Forty-first World Health Assembly,

Recalling the resolutions of the Health Assembly concerning traditional medicine in general (WHA40.33) and medicinal plants in particular (WHA31.33);

Realizing that, as a consequence of the loss of plant diversity around the world, many of the plants that provide traditional and modern drugs are threatened with extinction;

Commending the Director-General for having taken the initiative of convening an International Consultation on the Conservation of Medicinal Plants, in association with the International Union for the Conservation of Nature and Natural Resources and the World Wildlife Fund;

Noting that the Consultation resulted in the adoption of the Chiang Mai Declaration reaffirming commitment to the collective goal of health for all by the year 2000 through the primary health care approach, and to the principles of conservation and sustainable development outlined in the World Conservation Strategy;

Endorsing the call for international cooperation and coordination to establish programmes for the conservation of medicinal plants, to ensure that adequate quantities are available for future generations;

¹ See Annex 4.

1. URGES Member States:

- (1) to examine the situation with regard to their indigenous medicinal plants;
- (2) to take effective measures to ensure their conservation and encourage their sustainable utilization;

2. REQUESTS the Director-General:

- (1) to promote intercountry meetings for the dissemination of knowledge and the exchange of experience on the subject;
- (2) to collaborate with Member States in the design and implementation of programmes for the conservation and sustainable utilization of medicinal plants;
- (3) to report on the progress achieved to a subsequent Health Assembly.

Hbk Res., Vol. II (1985), 1.15.4

(Fifteenth plenary meeting, 13 May 1988 -
Committee A, second report)

WHA41.20 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution

The Forty-first World Health Assembly,

Having considered the report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Forty-first World Health Assembly on Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution;¹

Having noted that Benin, Chad, Comoros, Dominican Republic, Equatorial Guinea, Grenada, Guatemala, Liberia, Libyan Arab Jamahiriya, Saint Lucia and Sierra Leone were in arrears at the time of the opening of the 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;

Having been informed that, as a result of payments made by Chad and the Libyan Arab Jamahiriya after the opening of the Forty-first World Health Assembly, these two Member States each owe amounts which are less than the amounts due from each of them for the preceding two full years;

Noting that Equatorial Guinea, Grenada, Liberia and Saint Lucia have either communicated with the Director-General prior to the opening of the Forty-first World Health Assembly indicating their intention to settle their arrears or made some payments towards their contributions prior to that date;

Noting further that Benin, Comoros, Dominican Republic, Guatemala and Sierra Leone have neither communicated to the Director-General prior to the opening of the Forty-first World Health Assembly their intention to settle their arrears nor made any payments towards their contributions prior to that date;

1. EXPRESSES serious concern at the number of Members in recent years which have been in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution;

¹ Document A41/8.

2. URGES the Members concerned to regularize their position at the earliest possible date;
3. FURTHER URGES those Members which have not communicated their intention to settle their arrears to do so as a matter of urgency;
4. REQUESTS the Director-General to approach, through the Regional Directors, 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 and after the Members concerned have had an opportunity to explain their situation to the Board, to report to the Forty-second World Health Assembly on the status of payment of contributions;
6. DECIDES:

(1) that if, by the time of the opening of the Forty-second World Health Assembly, Benin, Comoros, Dominican Republic, Guatemala and Sierra Leone 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, unless the Executive Board has previously found that the Member concerned is faced with exceptional difficulties and the Member has made a payment considered by the Board to be reasonable in the circumstances;

(2) that any suspension which takes effect as aforesaid shall continue until the arrears of the Member concerned have been reduced, at the next and subsequent Health Assembly sessions, 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 (1st ed.), 6.1.2.4

(Fifteenth plenary meeting, 13 May 1988 -
Committee B, third report)

WHA41.21 Health and medical assistance to Lebanon

The Forty-first World Health Assembly,

Recalling resolutions WHA29.40, WHA30.27, WHA31.26, WHA32.19, WHA33.23, WHA34.21, WHA35.19, WHA36.23, WHA37.25, WHA38.26, WHA39.12 and WHA40.21 on health and medical assistance to Lebanon;

Taking note of United Nations General Assembly resolutions 33/146 of 20 December 1978, 34/135 of 14 December 1979, 35/85 of 5 December 1980, 36/205 of 16 December 1981, 37/163 of 17 December 1982, 38/220 of 20 December 1983, 39/197 of 17 December 1984, 40/229 of 17 December 1985, 41/196 of 8 December 1986 and 42/199 of 11 December 1987 on international assistance for the reconstruction and development of Lebanon, calling on the specialized agencies, organs and other bodies of the United Nations to expand and intensify programmes of assistance within the framework of the needs of Lebanon;

Having examined the Director-General's report¹ on the action taken by WHO, in cooperation with other international bodies, for emergency health and medical assistance to Lebanon in 1987 and the first quarter of 1988;

Aware that the situation arising from the increase in the numbers of wounded, handicapped and displaced persons and the paralysis of economic activities requires urgent health and medical assistance;

Aware that the increased financial burden upon the State, coinciding with the alarming drop in budgetary revenue, requires assistance to the health services that are the responsibility of the State;

Noting the health and medical assistance provided by the Organization to Lebanon during 1987-1988;

1. EXPRESSES its appreciation to the Director-General for his continuous efforts to mobilize health and medical assistance to Lebanon;
2. EXPRESSES also its appreciation to all the international agencies, organs and bodies of the United Nations, and to all governmental and nongovernmental organizations, for their cooperation with WHO in this regard;
3. CONSIDERS that the growing health and medical problems in Lebanon, which have recently reached a critical level, constitute a source of great concern and necessitate thereby a continuation and substantial expansion of programmes of health and medical assistance to Lebanon;
4. REQUESTS the Director-General to continue and expand substantially the Organization's programmes of health, medical and relief assistance to Lebanon and to allocate for this purpose, as far as possible, funds from the regular budget and other financial resources;
5. CALLS UPON the specialized agencies, organs and bodies of the United Nations, and on all governmental and nongovernmental organizations, to intensify their cooperation with WHO in this field, and in particular to put into operation the recommendations of the report on the reconstruction of the health services of Lebanon;
6. CALLS UPON Member States to increase their technical and financial support for relief operations and the reconstruction of the health services of Lebanon in consultation with the Ministry of Health in Lebanon;
7. CALLS UPON donors, as far as possible, to direct their assistance in cash or in kind to the Ministry of Health, which has responsibility for the hospitals, dispensaries and public health services;
8. REQUESTS the Director-General to report to the Forty-second World Health Assembly on the implementation of this resolution.

¹ Document A41/12 Rev.1.

WHA41.22 Health assistance to refugees and displaced persons in Cyprus

The Forty-first World Health Assembly,

Mindful of the principle that the health of all peoples is fundamental to the attainment of peace and security;

Recalling resolutions WHA28.47, WHA29.44, WHA30.26, WHA31.25, WHA32.18, WHA33.22, WHA34.20, WHA35.18, WHA36.22, WHA37.24, WHA38.25, WHA39.11 and WHA40.22;

Noting all relevant United Nations General Assembly and Security Council resolutions on Cyprus;

Considering that the continuing health problems of the refugees and displaced persons in Cyprus call for further assistance;

1. NOTES with satisfaction the information provided by the Director-General¹ on health assistance to refugees and displaced persons in Cyprus;
2. EXPRESSES its appreciation for all the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus to obtain the funds necessary for the Organization's action to meet the health needs of the population of Cyprus;
3. REQUESTS the Director-General to continue and intensify health assistance to refugees and displaced persons in Cyprus, in addition to any assistance made available within the framework of the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus, and to report to the Forty-second World Health Assembly on such assistance.

Hbk Res., Vol. III (1st ed.), 7.1.4.5

(Fifteenth plenary meeting, 13 May 1988 -
Committee B, third report)

WHA41.23 Liberation struggle in southern Africa: assistance to the front-line States. Lesotho and Swaziland

The Forty-first World Health Assembly,

Considering that the front-line States continue to suffer from the consequences of military, political and economic destabilization by South Africa which hamper their economic and social development;

Considering that the front-line States have to accept enormous sacrifices to rehabilitate and develop their health infrastructure which has suffered as a result of destabilization by South Africa;

Considering also resolutions AFR/RC31/R12 and AFR/RC32/R9 of the Regional Committee for Africa, which call for a special programme for health cooperation with the People's Republic of Angola;

Recalling resolutions WHA39.24 and WHA40.23 adopted at the Thirty-ninth and Fortieth World Health Assemblies respectively;

Bearing in mind that the consequences of these destabilization activities still force the countries concerned to divert large amounts of financial and technical resources from their national health programmes to defence and reconstruction;

¹ Document A41/13.

1. THANKS the Director-General for his report;¹
2. RESOLVES that WHO shall:
 - (1) continue to take appropriate and timely measures to help the front-line States, Lesotho and Swaziland solve the acute health problems of the Namibian and South African refugees;
 - (2) continue to provide countries which are or have been targets of destabilization by South Africa with technical cooperation in the health field, for the rehabilitation of their damaged health infrastructures;
3. CALLS UPON the Member States, according to their capabilities, to continue to provide adequate health assistance to liberation movements recognized by the Organization of African Unity and to the front-line States (Angola, Botswana, Mozambique, United Republic of Tanzania, Zambia and Zimbabwe) and Lesotho and Swaziland;
4. REQUESTS the Director-General:
 - (1) to intensify humanitarian assistance to national liberation movements recognized by the Organization of African Unity;
 - (2) to make use, when necessary, of funds from the Director-General's Development Programme to assist the countries concerned to overcome the problems arising both from the presence of the Namibian and South African refugees and displaced persons and from destabilization activities, as well as for the rehabilitation of their damaged health infrastructures;
 - (3) to report to the Forty-second World Health Assembly on the progress made in the implementation of this resolution.

Hbk Res., Vol. III (1st ed.), 1.2.2.2

(Fifteenth plenary meeting, 13 May 1988 -
Committee B, third report)

WHA41.24 Avoidance of discrimination in relation to HIV-infected people and people with AIDS

The Forty-first World Health Assembly,

Recalling resolution WHA40.26 on the global strategy for the prevention and control of AIDS, Economic and Social Council resolution 1987/75, and United Nations General Assembly resolution 42/8 on the prevention and control of AIDS;

Endorsing the London Declaration on AIDS Prevention unanimously adopted on 28 January 1988 by the World Summit of Ministers of Health on Programmes for AIDS Prevention;

Recognizing that AIDS is a global problem which poses a serious threat to humanity, and that urgent and worldwide action is required to implement WHO's global strategy to combat it;

Acknowledging with deep appreciation the work of WHO, through the Global Programme on AIDS, in directing and coordinating the global strategy;

¹ Document A41/14.

Noting the medical, ethical, legal, socioeconomic, cultural and psychological implications of AIDS prevention and control programmes;

Recognizing the responsibility of Member States to safeguard the health of everyone and to control the spread of HIV infection through their national policies and programmes, taking into account their epidemiological situation, and in conformity with the global strategy;

Bearing in mind the responsibility of individuals not to put themselves or others at risk of infection with HIV;

Strongly convinced that respect for the human rights and dignity of HIV-infected people and people with AIDS, and of members of population groups, is vital to the success of national AIDS prevention and control programmes and of the global strategy;

1. URGES Member States, particularly in devising and carrying out national programmes for the prevention and control of HIV infection and AIDS:

(1) to foster a spirit of understanding and compassion for HIV-infected people and people with AIDS through information, education and social support programmes;

(2) to protect the human rights and dignity of HIV-infected people and people with AIDS, and of members of population groups, and to avoid discriminatory action against and stigmatization of them in the provision of services, employment and travel;

(3) to ensure the confidentiality of HIV testing and to promote the availability of confidential counselling and other support services to HIV-infected people and people with AIDS;

(4) to include in any reports to WHO on national AIDS strategies information on measures being taken to protect the human rights and dignity of HIV-infected people and people with AIDS;

2. CALLS ON all governmental, nongovernmental and international organizations and voluntary bodies engaged in AIDS control programmes to ensure that their programmes take fully into account the health needs of all people as well as the health needs and dignity of HIV-infected people and people with AIDS;

3. REQUESTS the Director-General:

(1) to take all measures necessary to advocate the need to protect the human rights and dignity of HIV-infected people and people with AIDS, and of members of population groups;

(2) to collaborate with all relevant governmental, nongovernmental and international organizations and voluntary bodies in emphasizing the importance to the global strategy for the prevention and control of AIDS of avoiding discrimination against HIV-infected people and people with AIDS;

(3) to stress to Member States and to all others concerned the dangers to the health of everyone of discriminatory action against and stigmatization of HIV-infected people and people with AIDS, and members of population groups, by continuing to provide accurate information on AIDS and guidance on its prevention and control;

(4) to report annually to the Health Assembly through the Executive Board on the implementation of this resolution.

WHA41.25 Tobacco or health

The Forty-first World Health Assembly,

Recalling resolutions WHA31.56, WHA33.35 and WHA39.14, and emphasizing the importance of ensuring that these resolutions are fully implemented;

Having considered the Director-General's report on tobacco or health,¹ the comments by the Executive Board² and the report of the Advisory Group on a WHO Global Action Plan on Tobacco or Health;³

Encouraged by the response to the first world no-smoking day on 7 April 1988;

REQUESTS the Director-General to draw up a plan of action, bearing in mind the recommendations of the Advisory Group and covering in particular:

- (1) the special problems of developing countries which at present depend upon tobacco production as a major source of income;
- (2) targets and intervention plans, including consideration of future no-smoking days, for example annually on World Health Day;
- (3) the administrative and management structure of an action programme on tobacco or health, including its relationship to other programmes of the Organization;
- (4) resource needs;
- (5) sources of finance and other support;

for submission, through the Programme Committee, to the eighty-third session of the Executive Board.

Hbk Res., Vol. III (1st ed.), 1.11.4

(Fifteenth plenary meeting, 13 May 1988 -
Committee A, third report)

WHA41.26 Leadership development for health for all

The Forty-first World Health Assembly,

Recalling resolutions WHA30.43 and WHA34.36 by which the Member States of WHO unanimously adopted a policy and strategy for achieving the goal of health for all by the year 2000;

Noting the progress made at this midpoint between the adoption in 1978 of the Declaration of Alma-Ata on Primary Health Care, which set a new course for action for health, and the year 2000, but also being aware of the need for accelerated progress to achieve the collectively agreed goal of health for all;

Stressing that accelerated progress will require an even greater involvement of people from all walks of life and the mobilization of all potential resources in society in support of primary health care;

¹ See Annex 5.

² Document EB81/1988/REC/2, pp. 36-43.

³ See Appendix 4 to Annex 5.

Recognizing that informed and committed leadership at all levels of society is crucial for harnessing this potential;

Recalling resolution WHA37.31 on the role of universities in the strategies for health for all, resolution WHA38.31 on collaboration with nongovernmental organizations in implementing the strategy, resolution WHA39.7 on the evaluation of the strategy, and resolution WHA39.22 on intersectoral action for health;

1. ENDORSES the Declaration of Personal Commitment¹ and the report of the Technical Discussions held during the Forty-first World Health Assembly, on leadership development for health for all;²
2. AFFIRMS that enlightened and effective leadership is vital to intensify and sustain social and political action for health for all;
3. CALLS ON Member States:
 - (1) to develop leadership for health for all actively by using all educational entry points, and by sensitizing current leadership to the issues involved and generating continually new leadership, in order to accelerate progress towards health for all through primary health care;
 - (2) to make renewed efforts to increase understanding of health for all and primary health care, utilizing effective communication strategies, including sensitizing the leadership of the media to their social responsibility in promoting communication for health;
 - (3) to accelerate decentralization and socioeconomic and structural reforms which favour active involvement of people and encourage the emergence of leadership potential and provide opportunities for setting examples of effective leadership at all levels;
 - (4) to make renewed and innovative efforts to involve people and communities creatively so as to empower them, develop self-reliance and leadership at local level;
 - (5) to expand mutually supportive partnerships with communities, nongovernmental organizations, educational institutions and other community-based organizations to bring their creativity and commitment to bear on the challenge of health for all;
4. CALLS ON the leadership of educational institutions and universities to demonstrate their commitment to achieve health for all through primary health care, by:
 - (1) accelerating changes in the curricula for the training of health and other professionals, including teachers, involved in health action to promote the value system of health for all and enhance the potential of leadership for health for all;
 - (2) modifying academic reward systems and providing career opportunities so as to acknowledge and encourage career academic commitments to primary health care;
 - (3) including in the curricula of institutions throughout the educational system, from primary schools on, subjects related to education for health, social values, attitudinal change and leadership development;

¹ Text annexed to this resolution.

² Document A41/Technical Discussions/7.

5. URGES the leadership of national and international nongovernmental organizations to expand their partnership with governments and educational institutions to accelerate progress towards health for all, and to use their flexibility and creativity in developing leadership potential and capacities at community level, involving particularly women and youth groups;

6. REQUESTS the Director-General:

(1) to publish the Declaration of Personal Commitment and the report of the Technical Discussions on leadership development for health for all, and disseminate them widely to all governments, educational institutions and universities, nongovernmental and voluntary organizations, and other interested groups;

(2) to ensure the continuity and sustainability of the leadership development initiative within WHO, building upon the strong beginnings already realized, and establishing other appropriate mechanisms so that it becomes an integral part of WHO's support for the health-for-all strategy, at all levels;

(3) to support the efforts of Member States, educational institutions and nongovernmental organizations in their endeavours to develop leadership to accelerate social and political action towards health for all through primary health care, and to encourage the use of WHO resources, particularly fellowships, for leadership development;

(4) to establish and foster a technical resource network drawn from educational institutions and health leaders, to provide support to health for all and leadership development;

(5) to promote and encourage leadership potential by documenting and disseminating information on successful and innovative initiatives in primary health care and creating incentives such as awards and recognition for such endeavours, and to provide simplified and relevant documentation for lay people and community leadership;

(6) to evaluate the impact of the leadership development initiative in implementing the Global Strategy for Health for All in conjunction with the second evaluation of the strategy in 1991, and to report thereon to the eighty-ninth session of the Executive Board and the Forty-fifth World Health Assembly in 1992.

Annex

DECLARATION OF PERSONAL COMMITMENT

We, the participants at the Technical Discussions on leadership development for health for all (held in Geneva on 5-7 May 1988, during the Forty-first World Health Assembly), representing people from many walks of life, including governments, nongovernmental organizations, universities, educational institutions, voluntary agencies and United Nations agencies, make the following declaration:

I. We believe that:

- there is a need for greater concern and commitment to achieve the goal of health for all by the year 2000 through primary health care, among political, professional and community leaders;

- building self-reliance and leadership capabilities at local level is the most important ingredient for sustained development and progress in health;

- the development of leadership that can be sustained as a continuing process at all levels is an important strategy to mobilize greater social and political commitment for the total health-for-all movement.

II. We therefore commit ourselves and urge others in leadership and other strategic positions to adopt the following Five-point Personal Agenda for Action:

1. to inform ourselves, our colleagues, fellow-workers, community members and others about the fundamental values, principles and processes to achieve health for all by the year 2000 through primary health care, and to generate a social conscience in people regarding the health conditions and needs of the under-served, socially deprived and vulnerable population groups;
2. to make a serious review of progress towards the specific targets set in our respective countries, to identify where the critical needs and gaps are, and to provide leadership in identifying and implementing corrective actions;
3. to serve as prime movers for change, particularly in areas which fall within our respective roles, and to motivate others to accelerate the changes required in order to achieve the goal of health for all;
4. to develop and promote partnerships and new alliances of support for health, including the professional associations, institutions of higher education, religious leaders, people's organizations, concerned nongovernmental organizations and individuals, philanthropic groups, the private sector and the media;
5. to promote self-reliance and enable others, particularly within the home and at the community level, to take greater responsibility for their own health and the health of their communities, through informing and educating them and developing their leadership potential.

III. We are convinced that additional courageous and innovative strategies and tactics will be needed to ensure that all people of the world will be covered by primary health care. Leadership development is one such strategy which provides new opportunities to inform and communicate, to expand partnerships among people - people who are empowered and motivated - who then take on new responsibilities for their health, the health of their families and of their communities.

Hbk Res., Vol. III (1st ed.), 1.1

(Fifteenth plenary meeting, 13 May 1988 -
Committee A, third report)

WHA41.27 The role of epidemiology in attaining health for all

The Forty-first World Health Assembly,

Noting the importance of epidemiology as a tool for the formulation of rational health policy;

Recognizing the essential role of epidemiology not only in studying the causes and means of prevention of disease, but also in health systems research, information support, technology assessment, and the management and evaluation of health services;

Recalling that the role of epidemiology in the work of WHO has for many years been emphasized by the Health Assembly;

Emphasizing the need of Member States for relevant epidemiological input in preparing and updating their health-for-all strategies, defining related targets, and monitoring and evaluating their attainment;

Noting with concern the discrepancy between the content of training in epidemiology in most schools of medicine, public health and other health sciences, and the needs of Member States;

Encouraged by the interest shown by epidemiologists and their associations, including the International Epidemiological Association, in promoting the broader view of epidemiology encompassing consideration of economic, social, cultural and other factors relevant to contemporary health problems, and in promoting related training;

1. URGES Member States to make greater use of epidemiological data, concepts and methods in preparing, updating, monitoring and evaluating their health-for-all strategies;
2. APPEALS to schools of medicine, public health and other health sciences to ensure training in modern epidemiology that is relevant to countries' needs regarding their health-for-all strategies and, in particular, the needs of developing countries;
3. WELCOMES the involvement of many epidemiologists around the world and their willingness to collaborate with WHO in promoting new trends in epidemiology and related training;
4. REQUESTS the Director-General:
 - (1) to convene as soon as possible a group of experts including adequate representation from developing countries to define the desired nature and scope of epidemiology in support of health-for-all strategies and related training with regard to the expanded role of epidemiology;
 - (2) to report in 1989 to the eighty-third session of the Executive Board and the Forty-second World Health Assembly on the implementation of this resolution, including the conclusions of the above-mentioned group of experts.

Hbk Res., Vol. III (1st ed.), 1.1; 1.6.1 (Fifteenth plenary meeting, 13 May 1988 - Committee B, fourth report)

WHA41.28 Global eradication of poliomyelitis by the year 2000

The Forty-first World Health Assembly,

Appreciating the rapid progress being achieved by the Expanded Programme on Immunization, as evidenced by coverage for a third dose of poliomyelitis or diphtheria/pertussis/tetanus vaccines of over 50% of children under the age of one year in developing countries, as well as by the prevention of the death of more than one million children from measles, neonatal tetanus or pertussis, and the prevention of the crippling of nearly 200 000 children through poliomyelitis annually in these countries;

Confident that these coverage rates will continue to rise rapidly and be sustained, in pursuit of the goal endorsed by the Thirtieth World Health Assembly in 1977 (resolution WHA30.53) - the provision of immunization for all children of the world by 1990 - and will lead to further marked reductions in the incidence of most of the target diseases;

Aware that poliomyelitis is the target disease most amenable to global eradication, and that regional eradication goals by or before the year 2000 have already been set in the Regions of the Americas, Europe and the Western Pacific;

Recognizing that the global eradication of poliomyelitis by the year 2000, a goal cited in the Declaration of Talloires,¹ represents both a fitting challenge to be undertaken now, on the Organization's fortieth anniversary, and an appropriate gift, together with the eradication of smallpox, from the twentieth to the twenty-first century;

Noting:

- (1) that achievement of the goal will depend on the political will of countries and on the investment of adequate human and financial resources;
- (2) that this achievement will be facilitated by the continued strengthening of the Expanded Programme on Immunization within the context of primary health care and by improving current poliomyelitis vaccines and clinical and laboratory surveillance;
- (3) that efforts to eradicate poliomyelitis serve to strengthen other immunization and health services, especially those for women and children;

1. DECLARES the commitment of WHO to the global eradication of poliomyelitis by the year 2000;
2. EMPHASIZES that eradication efforts should be pursued in ways which strengthen the development of the Expanded Programme on Immunization as a whole, fostering its contribution, in turn, to the development of the health infrastructure and of primary health care;
3. INVITES Member States which have covered at least 70% of their target populations with a protective course of poliomyelitis vaccine, and which continue to have cases of poliomyelitis, to formulate plans for the elimination of the indigenous transmission of wild poliomyelitis viruses in ways which strengthen and sustain their national immunization programmes;
4. ENCOURAGES Member States which have not yet attained a 70% coverage rate to accelerate their efforts so as to surpass this level as quickly as possible through means which also improve and sustain the coverage for the other vaccines included within the national immunization programmes;
5. REQUESTS Member States which have confirmed the absence of the indigenous transmission of wild poliomyelitis viruses to sustain their success and to offer their technical expertise, their resources and support to countries still working to achieve this goal;
6. URGES all Member States:
 - (1) to intensify surveillance to ensure prompt identification and investigation of cases of poliomyelitis and control of outbreaks and accurate and timely reporting of cases at national and international levels;
 - (2) to make all possible efforts to permit the rehabilitation of as many as possible of the children who still become disabled by poliomyelitis;
7. THANKS the many partners already collaborating in the Expanded Programme on Immunization (including the United Nations agencies, multilateral and bilateral development agencies, private and voluntary groups and concerned individuals), especially UNICEF for its overall efforts and Rotary International for its "Polio Plus" initiative, and requests them to continue to work together in support of national immunization programmes, including activities aimed at the eradication of poliomyelitis, and to ensure that adequate resources are available to accelerate and sustain these programmes;

¹ See Annex 6.

8. REQUESTS the Director-General:

- (1) to strengthen the technical capacities of WHO in order to be able to respond better to requests from governments for collaboration in:
- (a) strengthening planning, training and supervision within national immunization programmes and undertaking country-specific evaluation to facilitate corrective action towards achieving the goal of eradication in countries with coverage of less than 70%;
 - (b) improving programme monitoring and evaluation at national, regional and global levels;
 - (c) improving national disease surveillance systems to permit the rapid control of outbreaks and the investigation and confirmation of clinical diagnoses of poliomyelitis through serological and virus isolation techniques;
 - (d) strengthening clinical laboratory services;
 - (e) improving the quality control and production of vaccines;
- (2) to pursue efforts to promote the development and application of new vaccines, other new technologies and knowledge which will help to achieve the eradication goal;
- (3) to seek from extrabudgetary contributions the additional resources required to support these activities;
- (4) to submit regular plans and reports of progress concerning the poliomyelitis eradication effort through the Executive Board to the Health Assembly, in the context of the progress being achieved by the Expanded Programme on Immunization.

Hbk Res., Vol. III (1st ed.), 1.16.1

(Fifteenth plenary meeting, 13 May 1988 -
Committee B, fourth report)

WHA41.29 Radionuclides in food: WHO guidelines for derived intervention levels

The Forty-first World Health Assembly,

Having considered the report of the Director-General¹ on the work of WHO on guidelines for derived intervention levels regarding radioactive contamination of food;

Concerned by the potential hazards to health due to contamination of the food supply with radionuclides;

Recognizing the problem that such contamination poses to international trade in food;

Aware that the action undertaken by national authorities to protect the public following the serious nuclear accident in 1986 varied widely and caused considerable public confusion and concern;

Noting that most developing countries lack the means necessary for evaluation and control of radionuclide contamination of their environment and foodstuffs;

¹ Document EB81/1988/REC/1, Annex 11.

1. CALLS UPON Member States to utilize the WHO guidelines for derived intervention levels regarding radionuclides in food¹ when developing their own plans and procedures for the protection of public health following accidental radioactive contamination of food supplies;
2. REQUESTS the Director-General:
 - (1) to continue to cooperate with Member States in the development and strengthening of national capabilities for the protection of public health following radioactive contamination of food supplies, including the development of derived intervention levels regarding radionuclides in food on the basis of the recommendations contained in the WHO guidelines, and the monitoring of food supplies;
 - (2) to provide support through WHO collaborating centres to Member States in case of radiological emergencies and in the preparation of plans and procedures for dealing with such emergencies;
 - (3) to intensify collaboration with other relevant international organizations and agencies, such as IAEA, FAO and UNEP, in establishing capabilities for the rapid exchange of information during emergencies and for radiation monitoring during normal and emergency conditions, and in harmonizing approaches to measure and control radioactive contamination for the protection of public health.

Hbk Res., Vol. III (1st ed.), 1.14.5

(Fifteenth plenary meeting, 13 May 1988 -
Committee B, fourth report)

WHA41.30 Implementation of technical cooperation among non-aligned and other developing countries

The Forty-first World Health Assembly,

Noting with great satisfaction the decisions taken by a group of Member States - the non-aligned and other developing countries - concerning the implementation of technical cooperation among developing countries;

Reiterating that peace and security are essential to health, and therefore condemning all actions that disturb other countries' peace and security;

Stressing the importance of the decisions adopted by the non-aligned and other developing countries regarding the need for countries to attain self-reliance through technical cooperation;

1. CONGRATULATES the non-aligned and other developing countries on their continuing political commitment and vigorous efforts to attain the goal of health for all through technical cooperation;
2. DEPLORES the interference of any country in other countries' self-reliance and their national social, economic and health development efforts;

¹ World Health Organization. Derived intervention levels for radionuclides in food. Geneva, 1988.

3. REQUESTS the Director-General to mobilize support for these and other Member countries in the implementation of their strategies to achieve self-reliance through technical cooperation, and to keep the Health Assembly informed of the progress made.

Hbk Res., Vol. III (1st ed.), 1.1; 1.2.2.1 (Fifteenth plenary meeting, 13 May 1988 - Committee B, fourth report)

WHA41.31 The embargo of medical supplies and its effects on health care

The Forty-first World Health Assembly,

Mindful of the principle contained in the WHO Constitution stating that the health of all peoples is fundamental to the attainment of peace and security;

Reaffirming that the United Nations General Assembly resolution 2625 (XXV) concerning friendly relations and cooperation between countries is fully valid for the solution of the problems facing those countries;

Rejecting any embargo on medical supplies for political reasons;

Recalling the note by the Director-General¹ concerning the effects on people's health of withholding medical supplies and the Executive Board's decision on the subject;

CONFIRMS the principles laid down by the Executive Board's decision EB81(3).

Hbk Res., Vol. II (1985), 1.18; 8.2.2 (Fifteenth plenary meeting, 13 May 1988 - Committee B, fourth report)

WHA41.32 Difficult health situation experienced by the people of Panama

The Forty-first World Health Assembly,

Reaffirming that health is an inalienable right of all peoples;

Concerned at the difficult health situation now being experienced by the people of Panama;

1. URGES all Member States to refrain from taking measures which could be detrimental to the health of the people of Panama;
2. INVITES all Member States to intensify technical cooperation in the field of health, especially among developing countries, with the aim of attaining the goal of health for all by the year 2000.

Hbk Res., Vol. III (1st ed.), 1.2.2.1 (Fifteenth plenary meeting, 13 May 1988 - Committee B, fourth report)

¹ Document EB81/1988/REC/1, Annex 12.

WHA41.33 Health assistance to the people of Afghanistan

The Forty-first World Health Assembly,

Bearing in mind the principle set out in the WHO Constitution that health is fundamental to the attainment of peace and security;

Welcoming the signing of the Agreements on the settlement of the situation relating to Afghanistan in Geneva in April 1988;

Noting the appointment by the United Nations Secretary-General of a Special Coordinator of all activities of the United Nations system in respect of the emergency relief and rehabilitation needs relating to Afghanistan;

Taking into account the numerous health problems of the people of Afghanistan that require an urgent solution;

Being aware that the solution of these problems demands considerable logistic, financial, manpower and other resources;

1. URGES Member States, intergovernmental and nongovernmental international organizations to provide on a continuous basis additional resources to satisfy the basic and most urgent health requirements of the people of Afghanistan in order to assist in the implementation of WHO's health-for-all strategy;
2. REQUESTS the Director-General to cooperate with the United Nations Special Coordinator by providing expanded health assistance to the people of Afghanistan, and making appropriate funds available for this purpose.

Hbk Res., Vol. III (1st ed.), 7.1.4

(Fifteenth plenary meeting, 13 May 1988 -
Committee B, fourth report)

WHA41.34 Strengthening primary health care

The Forty-first World Health Assembly,

Recalling resolution WHA30.43 in which it was decided that the main social target of governments and WHO should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life;

Further recalling resolution WHA32.30 which endorsed the Declaration of Alma-Ata with its emphasis on primary health care and its integrated approach as the key to attaining health for all, and resolution WHA34.36 by which the Health Assembly adopted the Global Strategy for Health for All by the Year 2000;

Mindful of United Nations General Assembly resolution 36/43 which endorsed the Global Strategy, urged all Member States to ensure its implementation as part of their multisectoral development efforts, and requested all appropriate organizations and bodies of the United Nations system to collaborate with WHO in carrying it out;

Having considered the statement issued by a meeting in Riga, Union of Soviet Socialist Republics, in March 1988 to mark the tenth anniversary of the Declaration of Alma-Ata, known as "Alma-Ata reaffirmed at Riga";¹

¹ See Annex 7.

Recognizing that, at this mid-point between the establishment and the attainment of the goal of health for all by the year 2000, much progress has been made by many countries in parallel with the evolution of their social and economic situation, but that there remain a considerable number of countries in which the health situation and the means for improving it remain highly unsatisfactory ten years after Alma-Ata;

Convinced of the importance of district health systems for the optimal organization and provision of primary health care, as an integral part of national health systems and of the global health system and constructed primarily by countries themselves with appropriate support by WHO, as well as of the need for research and development as a vital step in fostering the development of such care;

Recognizing further that the active participation of the people and the communities and their contribution are essential to the attainment of the goal of health for all;

1. ENDORSES the statement "Alma-Ata reaffirmed at Riga", which emphasizes that the Declaration of Alma-Ata remains valid for all countries at all stages of social and economic development and that the application of its principles should therefore be maintained after the year 2000;
2. URGES all Member States:
 - (1) to increase their efforts to attain the goal of health for all by the year 2000 through health systems based on primary health care in line with the global, regional and national strategies to that end, taking into account the statement "Alma-Ata reaffirmed at Riga";
 - (2) to prepare for the continuation of these efforts beyond the year 2000 to ensure the maintenance and progressive improvement of the health of all their people;
3. THANKS all the multilateral and bilateral development agencies, nongovernmental organizations and voluntary and philanthropic bodies that have supported the struggle to attain health for all, and appeals to them to continue and intensify this support;
4. CALLS ON the international community:
 - (1) to continue its support to the efforts of Member States in the development of health systems based on primary health care;
 - (2) to take unprecedented measures to support the least developed countries committed to improving the health of their people in line with the policy of health for all;
 - (3) to support such efforts under the international coordination of WHO;
5. REQUESTS the regional committees:
 - (1) to pay particular attention to the monitoring and evaluation of strategies for health for all, with a view to identifying areas in which particular efforts are required and to taking appropriate action;
 - (2) to report thereon to the Executive Board in conformity with the revised plan of action for implementing the Global Strategy for Health for All;
6. REQUESTS the Director-General:
 - (1) to ensure the widest dissemination of this resolution and the statement "Alma-Ata reaffirmed at Riga";
 - (2) to cooperate with Member States in the implementation of the recommendations made at Riga for accelerating progress towards health for all by the year 2000, paying particular attention to the problems that have hitherto resisted solution;

(3) to intensify the programme of activities of research and development in primary health care, including health services, within the existing organizational framework, with particular emphasis on:

(a) strengthening integrated health approaches and district health systems within the national context;

(b) the development and rational use of science and appropriate technology and their transfer among countries;

(4) to secure resources from within the regular budget of the Organization and the continued mobilization of extrabudgetary resources as additional means for implementation of the above programme;

(5) to ensure that the activities of the programme and those of all other related programmes give particular emphasis to supporting the least developed countries;

(6) to direct all programmes of the Organization to increase their support to countries in strengthening the integrated approach and in research and development in primary health care, with emphasis on strengthening district health systems;

(7) to present to the Executive Board at its eighty-third session proposals for the intensification of activities of research and development in primary health care, including the feasibility of establishing a special programme, and information on international support to the least developed countries;

7. REQUESTS the Executive Board:

(1) to intensify its monitoring and evaluation of the Global Strategy for Health for All, paying particular attention to supporting countries in the strengthening of integrated approaches and to international support to the least developed countries;

(2) to report on this subject to the Health Assembly in conformity with the revised plan of action for implementing the Global Strategy for Health for All.

DECISIONS

(1) Composition of the Committee on Credentials

The Forty-first World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Bahrain; Benin; Brazil; German Democratic Republic; Indonesia; Kenya; Netherlands; Paraguay; Portugal; Samoa; Sudan; and Togo.

(First plenary meeting, 2 May 1988)

(2) Composition of the Committee on Nominations

The Forty-first World Health Assembly elected a Committee on Nominations consisting of delegates of the following 24 Member States: Australia; Bulgaria; Burma; China; Colombia; Comoros; Congo; Cyprus; Ethiopia; France; Guatemala; Guyana; Italy; Liberia; Mexico; Morocco; Mozambique; Qatar; Somalia; Sri Lanka; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United States of America; and Zimbabwe.

(First plenary meeting, 2 May 1988)

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

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

President: Professor D. Ngandu-Kabeya (Zaire)

Vice-Presidents:

Professor M. A. Matin (Bangladesh), Dr C. Hernández Gil (Spain),
Dr P. Papageorgiou (Cyprus), Dr T. Maoate (Cook Islands),
Dr E. Mohs (Costa Rica)

(Second plenary meeting, 2 May 1988)

(4) Election of officers of the main committees

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

COMMITTEE A: Chairman, Professor A. R. Y. Abdul Razak (Kuwait)

COMMITTEE B: Chairman, Dr T. Mork (Norway)

(Second plenary meeting, 2 May 1988)

The main committees subsequently elected the following officers:

COMMITTEE A: Vice-Chairmen, Professor H. Huyoff (German Democratic Republic) and Dr G. Perdomo (Colombia)

Rapporteur, Mr Mya Than (Burma)

COMMITTEE B: Vice-Chairmen, Dr Z. Jakab (Hungary) and Dr M. M. Law (Canada)

Rapporteur, Dr Sung Woo Lee (Republic of Korea)

(First meetings of Committees A and B, 3 May 1988)

(5) Establishment of the General Committee

The Forty-first World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the delegates of the following 16 countries as members of the General Committee: Barbados; Bhutan; China; Cuba; France; Gabon; Ghana; Iraq; Nigeria; Peru; Qatar; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United States of America; Zambia; and Zimbabwe.

(Second plenary meeting, 2 May 1988)

(6) Adoption of the agenda

The Forty-first World Health Assembly adopted the provisional agenda prepared by the Executive Board at its eighty-first session with the addition of one item and one sub-item, and the deletion of four items.

(Third plenary meeting, 3 May 1988)

(7) Verification of credentials

The Forty-first World Health Assembly recognized the validity of the credentials of the following delegations:

Members

Afghanistan; Albania; Algeria; Angola; Antigua and Barbuda; Argentina; Australia; Austria; Bahamas; Bahrain; Bangladesh; Barbados; Belgium; Benin; Bhutan; Bolivia; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burma; Burundi; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Cuba; Cyprus; Czechoslovakia; Democratic Kampuchea; Democratic People's Republic of Korea; Democratic Yemen; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Ethiopia; Finland; France; Gabon; Gambia; German Democratic Republic; Germany, Federal Republic of; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Haiti;¹ Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kenya; Kiribati; Kuwait; Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Morocco; Mozambique; Nepal; Netherlands; New Zealand; Nicaragua; Niger;

¹ Credentials provisionally accepted.

Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Romania; Rwanda; Saint Vincent and the Grenadines; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Seychelles; Sierra Leone; Singapore; Solomon Islands; Somalia; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Uganda; Union of Soviet Socialist Republics; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Venezuela; Viet Nam; Yemen; Yugoslavia; Zaire; Zambia; and Zimbabwe.

Associate Member

Namibia.

(Fifth and fourteenth plenary meetings, 4 and 11 May 1988)

(8) Report of the Director-General on the work of WHO in 1986-1987

The Forty-first World Health Assembly, after reviewing the Director-General's report on the work of the Organization in 1986-1987,¹ noted with satisfaction the manner in which the Organization's programme for this biennium had been implemented.

(Thirteenth plenary meeting, 9 May 1988)

(9) Conventions concerning nuclear accidents

The Forty-first World Health Assembly, having considered the Convention on Early Notification of a Nuclear Accident and the Convention on Assistance in the Case of a Nuclear Accident or Radiological Emergency,² adopted in Vienna on 26 September 1986, requests the Director-General to make the necessary arrangements for the Organization's accession to both Conventions, indicating - in accordance with Article 12.5(c) and Article 14.5(c), respectively - that WHO is competent to act as the directing and coordinating authority in international health work in matters covered by the Conventions, and to provide related assistance upon the request or acceptance of governments, without prejudice to the national competence of each of its Member States.

(Fourteenth plenary meeting, 11 May 1988)

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

The Forty-first 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: Argentina; Austria; Czechoslovakia; India; Iran (Islamic Republic of); Libyan Arab Jamahiriya; Mozambique; Nicaragua; Tonga; and United Kingdom of Great Britain and Northern Ireland.

(Fourteenth plenary meeting, 11 May 1988)

¹ The Work of WHO, 1986-1987: Biennial report of the Director-General. Geneva, World Health Organization, 1988.

² See Annex 8.

³ For report of the General Committee, see document WHA41/1988/REC/2.

(11) Annual report of the United Nations Joint Staff Pension Board for 1986

The Forty-first World Health Assembly noted the status of the operations of the Joint Staff Pension Fund, as indicated by the annual report of the United Nations Joint Staff Pension Board for the year 1986 and as reported by the Director-General.¹

(Fifteenth plenary meeting, 13 May 1988)

(12) Appointment of representatives to the WHO Staff Pension Committee

The Forty-first World Health Assembly appointed Sir John Reid, in a personal capacity, as member of the WHO Staff Pension Committee, and the member of the Executive Board designated by the Government of the Libyan Arab Jamahiriya as alternate member of the Committee, the appointments being for a period of three years.

(Fifteenth plenary meeting, 13 May 1988)

(13) Reports of the Executive Board on its eightieth and eighty-first sessions

The Forty-first World Health Assembly, after reviewing the Executive Board's reports on its eightieth² and eighty-first³ sessions, approved 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. It requested the President to convey the thanks of the Health Assembly in particular to those members of the Board who would be completing their terms of office immediately after the closure of the Assembly.

(Fifteenth plenary meeting, 13 May 1988)

(14) Selection of the country in which the Forty-second World Health Assembly will be held

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

(Fifteenth plenary meeting, 13 May 1988)

¹ Document A41/15.

² Document EB80/1987/REC/1.

³ Documents EB81/1988/REC/1 and EB81/1988/REC/2.

ANNEXES

ANNEX 1

CONTRACT OF THE DIRECTOR-GENERAL¹

THIS CONTRACT is made this tenth day of May One Thousand Nine Hundred and Eighty-eight between the World Health Organization (hereinafter called the Organization) of the one part and Dr Hiroshi Nakajima (hereinafter called the Director-General) of the other part.

WHEREAS

(1) It is provided by Article 31 of the Constitution of the Organization that the Director-General of the Organization shall be appointed by the World Health Assembly (hereinafter called the Health Assembly) on the nomination of the Executive Board (hereinafter called the Board) on such terms as the Health Assembly may decide; and

(2) The Director-General has been duly nominated by the Board and appointed by the Health Assembly at its meeting held on the fourth day of May One Thousand Nine Hundred and Eighty-eight for a period of five years.

NOW THIS CONTRACT WITNESSETH and it is hereby agreed as follows,

I. (1) The Director-General shall serve from the twenty-first day of July One Thousand Nine Hundred and Eighty-eight until the twentieth day of July One Thousand Nine Hundred and Ninety-three, on which date his appointment and this Contract shall terminate.

(2) Subject to the authority of the Board, the Director-General shall exercise the functions of chief technical and administrative officer of the Organization and shall perform such duties as may be specified in the Constitution and in the rules of the Organization and/or as may be assigned to him by the Health Assembly or the Board.

(3) The Director-General shall be subject to the Staff Regulations of the Organization in so far as they may be applicable to him. In particular he shall not hold any other administrative post and shall not receive emoluments from any outside sources in respect of activities relating to the Organization. He shall not engage in business or in any employment or activity which would interfere with his duties in the Organization.

(4) The Director-General, during the term of his appointment, shall enjoy all the privileges and immunities in keeping with his office by virtue of the Constitution of the Organization and any relevant arrangements already in force or to be concluded in the future.

(5) The Director-General may at any time give six months' notice of resignation in writing to the Board, which is authorized to accept his resignation on behalf of the Health Assembly; in which case, upon the expiration of the said period of notice, the Director-General shall cease to hold his appointment and this Contract shall terminate.

¹ See resolution WHA41.2.

(6) The Health Assembly shall have the right, on the proposal of the Board and after hearing the Director-General and subject to at least six months' notice in writing, to terminate this Contract for reasons of exceptional gravity likely to prejudice the interests of the Organization.

II. (1) As from the twenty-first day of July One Thousand Nine Hundred and Eighty-eight the Director-General shall receive from the Organization an annual salary of one hundred and thirty-one thousand nine hundred and eighty-one United States dollars, before staff assessment, resulting in a net salary (to be paid monthly) of seventy-eight thousand four hundred and thirty United States dollars per annum at the dependency rate (sixty-nine thousand one hundred and seventy-eight United States dollars at the single rate) or its equivalent in such other currency as may be mutually agreed between the parties to this Contract.

(2) In addition to the normal adjustments and allowances authorized to staff members under the Staff Rules, he shall receive an annual representation allowance of twenty thousand United States dollars or its equivalent in such other currency as may be mutually agreed between the parties to this Contract, to be paid monthly commencing on the twenty-first day of July One Thousand Nine Hundred and Eighty-eight. The representation allowance shall be used at his discretion entirely in respect of representation in connection with his official duties. He shall be entitled to such reimbursable allowances as travel allowances and removal costs on appointment, on subsequent change of official station, on termination of appointment, or on official travel and home leave travel.

III. The terms of the present Contract relating to rates of salary and representation allowance are subject to review and adjustment by the Health Assembly on the proposal of the Board, and after consultation with the Director-General, to bring them into conformity with any provision regarding the conditions of employment of staff members which the Assembly may decide to apply to staff members already in the service.

IV. If any question of interpretation or any dispute arises concerning this Contract, which is not settled by negotiation or agreement, the matter shall be referred for final decision to the competent tribunal provided for in the Staff Rules.

WHEREUNTO we have set our hands the day and year first above written.

(signed) H. NAKAJIMA

Director-General

(signed) D. NGANDU-KABEYA

President of the
World Health Assembly

ANNEX 2

PROGRAMME BUDGET REDUCTION FOR 1988-1989
PROPOSED BY THE DIRECTOR-GENERAL¹

[A41/25 Annex 1: EB81/CFI/3 - 2 May 1988]

Report by the Director-General

1. As reported to the Executive Board at its eighty-first session (January 1988),² the status of collection of assessed contributions to finance the effective working budget for 1986-1987 was as follows: out of a total amount due of US\$ 484 861 000, contributions collected amounted to US\$ 428 604 192, or 88.40%. Payments by the largest contributor for the biennium amounted to US\$ 87 438 470, or 69.63% of its total assessment for the biennium of US\$ 125 576 525. It thus still owed US\$ 38 138 055 for 1986-1987.

2. As a result, the Organization was faced at the end of the financial period 1986-1987 with a shortfall in contributions of US\$ 56 256 808 (i.e., the difference between the contributions of US\$ 484 861 000 assessed and the contributions of US\$ 428 604 192 collected), or 11.60% of the total assessments for the biennium - the highest shortfall ever recorded at the end of a biennium. The non-payment by the Organization's largest contributor of US\$ 38 138 055 of its assessed contributions for 1986-1987 accounted for over two-thirds of this shortfall. In order to cover the shortfall on 31 December 1987, the Organization - notwithstanding the programme implementation reductions of the order of US\$ 35 000 000 effected during the biennium - had not only to withdraw the full amount standing to the credit of the Working Capital Fund (US\$ 11 048 950) but also to borrow internally from casual income (US\$ 10 207 858) in accordance with Financial Regulation 5.1.³

3. In view of these circumstances, the Director-General reported to the eighty-first session of the Executive Board that, much to his regret, he was not in a position to propose the reduction in the approved budget for 1988-1989 that he had envisaged at the time of the Fortieth World Health Assembly (May 1987) on the firm assumption that the largest contributor would, by the end of 1987, have paid its outstanding contributions for 1986-1987.⁴ However, the Director-General informed the Executive Board that, if the largest contributor would pay its arrears prior to the Forty-first World Health Assembly and could give a reasonable assurance that the assessed contribution for 1988-1989 would be fully forthcoming, he would review the situation with a view to meeting Members' concern about the burden of their assessments.⁵ When the Board appointed its Committee to Consider Certain Financial Matters prior to the Forty-First World Health Assembly (resolution EB81.R19), the Director-General proposed, and the Board agreed, that he should keep the Committee informed about possible changes in the programme budget for 1988-1989 in the light of developments that might have occurred by the time the Committee met.⁶

¹ See resolution WHA41.10.

² Document EB81/1988/REC/1, p. 124.

³ WHO Basic Documents, 37th ed., 1988, p. 79.

⁴ Document EB81/1988/REC/1, pp. 121-122.

⁵ Document EB81/1988/REC/2, p. 166.

⁶ Document EB81/1988/REC/2, p. 191.

4. On 29 April 1988 the Director-General received a letter from the Ambassador and Permanent Representative in Geneva of the largest contributor informing him that action had been initiated by his Government to deposit into the WHO account at the Federal Reserve Bank in New York new payments totalling US\$ 20 525 000. According to this letter, these payments include US\$ 17 855 000 in regard to the assessment for the calendar year 1987, thus signifying that 100% of the assessment for that year had been paid, as well as US\$ 2 670 000 which is to be attributed to the assessed contribution for the calendar year 1986. The letter also includes the following paragraphs:

I am pleased to be able to point out that the Government of the United States, upon completion of these payments, will have paid WHO \$ 100 594 000 in assessed contributions within the last nine months. Of that amount, \$ 80 million was provided before the end of 1987. In addition, as the WHO Financial Report for 1986-87 reveals, the United States provided \$ 29 736 826 in resources to WHO's voluntarily funded programs during the biennium just completed. This financial support is testimony to the high regard in which the United States Government holds WHO.

I wish to point out that the full payment of assessments by the United States for 1987 is being made despite the fact that funds appropriated by the United States Congress for the payment of the United States' assessments for 46 international organizations were not sufficient to permit full payment to all of those organizations. The United States was able to make full payment to WHO only by according more favorable treatment to WHO than to some of the other major organizations in the UN system, including the United Nations itself.

5. The receipt by WHO of the payments announced in the letter referred to above would reduce the balance of outstanding contributions owed by the largest contributor from US\$ 38 138 055 to US\$ 17 613 055, and, taking into account US\$ 4 569 150 of arrears of assessed contributions for 1986-1987 collected from other Members during the period 1 January to 29 April 1988, would reduce the total balance of outstanding assessed contributions for the financial period 1986-1987 from US\$ 56 256 808 to US\$ 31 162 658. While upon receipt by WHO of the announced payments the largest contributor would still owe arrears in a significant amount, the Director-General believes that the recent developments described above are sufficiently encouraging for the Health Assembly to be able to address the very real concerns expressed at the Fortieth World Health Assembly, particularly by the developing countries, and to lighten the financial burden of all Members. He therefore proposes that, in addition to appropriating a further US\$ 13 961 000 of casual income to reduce the contributions of Members for the 1988-1989 programme budget, as recommended by the Executive Board in resolution EB81.R13, the Health Assembly should reduce the level of the approved effective working budget for 1988-1989 by US\$ 25 000 000.

6. Should the Health Assembly agree with this proposal, the measure of financial relief to Members would be considerable. The level of the effective working budget for 1988-1989 would be reduced from US\$ 633 980 000 to US\$ 608 980 000, representing a reduction in the budget increase over 1986-1987 from 16.69% to 12.09%. Assessments towards the effective working budget would be reduced from US\$ 604 980 000 to US\$ 566 019 000; instead of an increase in assessments of 25.64% over 1986-1987, Members would have to face an increase in assessments of only 17.55% for the biennium. The entire reduction in assessments would be applicable to the assessed contributions due from Members in 1989. While the 1989 assessments for the effective working budget now total US\$ 314 990 000, they would, if the Health Assembly approves the Director-General's proposal, be only US\$ 276 029 000.

7. The Director-General proposes to allocate the proposed reduction in the effective working budget of US\$ 25 million to the different appropriation sections of the appropriation resolution and to the different programmes in approximately the same proportions as the US\$ 50 million programme budget implementation reductions for 1988-1989, made necessary by the continuing shortfall in the collection of contributions

and already envisaged in the contingency plan which the Director-General submitted to the Executive Board and the World Health Assembly in 1987.¹ This would result in the transformation of the programme budget implementation reductions of US\$ 50 million, previously planned to be undertaken within the approved budget level, to (a) a reduction in the effective working budget of US\$ 25 million, and (b) additional programme budget implementation reductions of US\$ 25 million without a corresponding reduction in the effective working budget level. The proposed reduction in the budget level would thus not have any impact on the level of planned programme delivery in 1988-1989. In this connection it should be recalled that the Programme Committee of the Executive Board has agreed with the Director-General that his budgetary proposals for 1990-1991 should provide for a budget reduction in real terms of US\$ 25 000 000 as compared with the approved budget for 1988-1989 of US\$ 633 980 000, leading to an effective working budget level in real terms of US\$ 608 980 000, that is, the same level to which it is now proposed to reduce the effective working budget for 1988-1989.² The Executive Board and the World Health Assembly will thus have the opportunity, in connection with the review of the Director-General's programme budget proposals for 1990-1991, to examine in detail in 1989 which programmes have been affected by the reduction in the budget levels proposed for 1988-1989 and 1990-1991.

¹ Document EB79/1987/REC/1, Part II, Annexes 1 and 2.

² Document EB81/1988/REC/2, pp. 105-106; document EB81/1988/REC/1, p. 123.

ANNEX 3

ETHICAL CRITERIA FOR MEDICINAL DRUG PROMOTION¹

CONTENTS

	<u>Paragraph</u>
Introduction	1
Objective	2
Ethical criteria	3
Applicability and implementation of criteria	4 - 5
Promotion	6 - 9
Advertising	10 - 16
Medical representatives	17 - 19
Free samples of prescription drugs for promotional purposes	20
Free samples of non-prescription drugs to the general public for promotional purposes	21
Symposia and other scientific meetings	22 - 24
Post-marketing scientific studies, surveillance and dissemination of information.....	25 - 27
Packaging and labelling	28
Information for patients: package inserts, leaflets and booklets	29 - 30
Promotion of exported drugs	31
Appendix - Sample drug information sheet	

Introduction

1. Following the WHO Conference of Experts on the Rational Use of Drugs held in Nairobi in November 1985, WHO prepared a revised drug strategy which was endorsed by the Thirty-ninth World Health Assembly in May 1986 in resolution WHA39.27. This strategy includes, among other components, the establishment of ethical criteria for drug promotion based on the updating and extension of the ethical and scientific criteria established in 1968 by the Twenty-first World Health Assembly in resolution WHA21.41. The criteria that follow have been prepared in compliance with the above on the basis of a draft elaborated by an international group of experts.

¹ See resolution WHA41.17.

Objective

2. The main objective of ethical criteria for medicinal drug promotion is to support and encourage the improvement of health care through the rational use of medicinal drugs.

Ethical criteria

3. The interpretation of what is ethical varies in different parts of the world and in different societies. The issue in all societies is what is proper behaviour. Ethical criteria for drug promotion should lay the foundation for proper behaviour concerning the promotion of medicinal drugs, consistent with the search for truthfulness and righteousness. The criteria should thus assist in judging if promotional practices related to medicinal drugs are in keeping with acceptable ethical standards.

Applicability and implementation of criteria

4. These criteria constitute general principles for ethical standards which could be adapted by governments to national circumstances as appropriate to their political, economic, cultural, social, educational, scientific and technical situation, laws and regulations, disease profile, therapeutic traditions and the level of development of their health system. They apply to prescription and non-prescription medicinal drugs ("over-the-counter drugs"). They also apply generally to traditional medicines as appropriate, and to any other product promoted as a medicine. The criteria could be used by people in all walks of life; by governments; the pharmaceutical industry (manufacturers and distributors); the promotion industry (advertising agencies, market research organizations and the like); health personnel involved in the prescription, dispensing, supply and distribution of drugs; universities and other teaching institutions; professional associations; patients' and consumer groups; and the professional and general media (including publishers and editors of medical journals and related publications). All these are encouraged to use the criteria as appropriate to their spheres of competence, activity and responsibility. They are also encouraged to take the criteria into account in developing their own sets of ethical standards in their own field relating to medicinal drug promotion.

5. The criteria do not constitute legal obligations; governments may adopt legislation or other measures based on them as they deem fit. Similarly, other groups may adopt self-regulatory measures based on them. All these bodies should monitor and enforce their standards.

Promotion

6. In this context, "promotion" refers to all informational and persuasive activities by manufacturers and distributors, the effect of which is to induce the prescription, supply, purchase and/or use of medicinal drugs.

7. Active promotion within a country should take place only with respect to drugs legally available in the country. Promotion should be in keeping with national health policies and in compliance with national regulations, as well as with voluntary standards where they exist. All promotion-making claims concerning medicinal drugs should be reliable, accurate, truthful, informative, balanced, up-to-date, capable of substantiation and in good taste. They should not contain misleading or unverifiable statements or omissions likely to induce medically unjustifiable drug use or to give rise to undue risks. The word "safe" should only be used if properly qualified. Comparison of products should be factual, fair and capable of substantiation. Promotional material should not be designed so as to disguise its real nature.

8. Scientific data in the public domain should be made available to prescribers and any other person entitled to receive it, on request, as appropriate to their requirements. Promotion in the form of financial or material benefits should not be offered to or sought by health care practitioners to influence them in the prescription of drugs.

9. Scientific and educational activities should not be deliberately used for promotional purposes.

Advertising

(a) Advertisements in all forms to physicians and health-related professionals

10. The wording and illustrations in advertisements to physicians and related health professionals should be fully consistent with the approved scientific data sheet for the drug concerned or other source of information with similar content. The text should be fully legible.

11. Some countries require that advertisements should contain full product information, as defined by the approved scientific data sheet or similar document, for a given period from the date of first promotion or for the full product life. Advertisements that make a promotional claim should at least contain summary scientific information.

12. The following list, based on the sample drug information sheet contained in the second report of the WHO Expert Committee on the Use of Essential Drugs¹ and appended for ease of reference, can serve as an illustration of the type of information that such advertisements should usually contain, among others:

- the name(s) of the active ingredient(s) using either international nonproprietary names (INN) or the approved generic name of the drug;
- the brand name;
- content of active ingredient(s) per dosage form or regimen;
- name of other ingredients known to cause problems;
- approved therapeutic uses;
- dosage form or regimen;
- side-effects and major adverse drug reactions;
- precautions, contra-indications and warnings;
- major interactions;
- name and address of manufacturer or distributor;
- reference to scientific literature as appropriate.

13. Where advertisements are permitted without claims (reminder advertisements), they ought to include at least the brand name, the international nonproprietary name or approved generic name, the name of each active ingredient, and the name and address of the manufacturer or distributor for the purpose of receiving further information.

(b) Advertisements in all forms to the general public

14. Advertisements to the general public should help people to make rational decisions on the use of drugs determined to be legally available without a prescription. While they should take account of people's legitimate desire for information regarding their health, they should not take undue advantage of people's concern for their health. They should not generally be permitted for prescription drugs or to promote drugs for certain

¹ WHO Technical Report Series, No. 722, 1985, p. 43.

serious conditions that can be treated only by qualified health practitioners, for which certain countries have established lists. To fight drug addiction and dependency, scheduled narcotic and psychotropic drugs should not be advertised to the general public. While health education aimed at children is highly desirable, drug advertisements should not be directed at children. Advertisements may claim that a drug can cure, prevent, or relieve an ailment only if this can be substantiated. They should also indicate, where applicable, appropriate limitations to the use of the drug.

15. When lay language is used, the information should be consistent with the approved scientific data sheet or other legally determined scientific basis for approval. Language which brings about fear or distress should not be used.

16. The following list serves as an illustration of the type of information advertisements to the general public should contain, taking into account the media employed:

- the name(s) of the active ingredient(s) using either international nonproprietary names (INN) or the approved generic name of the drug;
- the brand name;
- major indication(s) for use;
- major precautions, contra-indications and warnings;
- name and address of manufacturer or distributor.

Information on price to the consumer should be accurately and honestly portrayed.

Medical representatives

17. Medical representatives should have an appropriate educational background. They should be adequately trained. They should possess sufficient medical and technical knowledge and integrity to present information on products and carry out other promotional activities in an accurate and responsible manner. Employers are responsible for the basic and continuing training of their representatives. Such training should include instruction regarding appropriate ethical conduct taking into consideration the WHO criteria. In this context, exposure of medical representatives and trainees to feedback from the medical and allied professions and from independent members of the public, particularly regarding risks, can be salutary.

18. Medical representatives should make available to prescribers and dispensers complete and unbiased information for each product discussed, such as an approved scientific data sheet or other source of information with similar content.

19. Employers should be responsible for the statements and activities of their medical representatives. Medical representatives should not offer inducements to prescribers and dispensers. Prescribers and dispensers should not solicit such inducements. In order to avoid over-promotion, the main part of the remuneration of medical representatives should not be directly related to the volume of sales they generate.

Free samples of prescription drugs for promotional purposes

20. Free samples of legally available prescription drugs may be provided in modest quantities to prescribers, generally on request.

Free samples of non-prescription drugs to the general public for promotional purposes

21. Countries vary in their practices regarding the provision of free samples of non-prescription drugs to the general public, some countries permitting it, some not. Also, a distinction has to be made between provision of free drugs by health agencies for

the care of certain groups and the provision of free samples to the general public for promotional purposes. The provision of free samples of non-prescription drugs to the general public for promotional purposes is difficult to justify from a health perspective. If this practice is legally permitted in any country, it should be handled with great restraint.

Symposia and other scientific meetings

22. Symposia are useful for disseminating information. The objective scientific content of such meetings should be paramount, and presentations by independent scientists and health professionals are helpful to this end. Their educational value may be enhanced if they are organized by scientific or professional bodies.

23. The fact of sponsorship by a pharmaceutical manufacturer or distributor should be clearly stated in advance, at the meeting and in any proceedings. The latter should accurately reflect the presentations and discussions. Entertainment or other hospitality, and any gifts offered to members of the medical and allied professions, should be secondary to the main purpose of the meeting and should be kept to a modest level.

24. Any support to individual health practitioners to participate in any domestic or international symposia should not be conditional upon any obligation to promote any medicinal product.

Post-marketing scientific studies, surveillance and dissemination of information

25. Post-marketing clinical trials for approved medicinal drugs are important to ensure their rational use. It is recommended that appropriate national health authorities be made aware of any such studies and that relevant scientific and ethical committees confirm the validity of the research. Inter-country and regional cooperation in such studies may be useful. Substantiated information on such studies should be reported to the appropriate national health authorities and disseminated as soon as possible.

26. Post-marketing scientific studies and surveillance should not be misused as a disguised form of promotion.

27. Substantiated information on hazards associated with medicinal drugs should be reported to the appropriate national health authority as a priority, and should be disseminated internationally as soon as possible.

Packaging and labelling

28. Appropriate information being important to ensure the rational use of drugs, all packaging and labelling material should provide information consistent with that approved by the country's drug regulatory authority. Where one does not exist or is rudimentary, such material should provide information consistent with that approved by the drug regulatory authority of the country from which the drug is imported or other reliable sources of information with similar content. Any wording and illustration on the package and label should conform to the principles of ethical criteria enunciated in this document.

Information for patients: package inserts, leaflets and booklets

29. Adequate information on the use of medicinal drugs should be made available to patients. Such information should be provided by physicians or pharmacists whenever possible. When package inserts or leaflets are required by governments, manufacturers or distributors should ensure that they reflect only the information that has been approved by the country's drug regulatory authority. If package inserts or leaflets are used for promotional purposes, they should comply with the ethical criteria enunciated in this document. The wording of the package inserts or leaflets, if prepared specifically for patients, should be in lay language on condition that the medical and scientific content is properly reflected.

30. In addition to approved package inserts and leaflets wherever available, the preparation and distribution of booklets and other informational material for patients and consumers should be encouraged as appropriate. Such material should also comply with the ethical criteria enunciated in this document.

Promotion of exported drugs

31. Ethical criteria for the promotion of exported drugs should be identical with those relating to drugs for domestic use. It is desirable that exporting and importing countries that have not already done so should use the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce.

Appendix

SAMPLE DRUG INFORMATION SHEET¹

Drug information sheets

Various types of information are needed by prescribers and consumers to ensure the safe and effective use of drugs. The following list is a sample that should be adjusted to meet the needs and abilities of the prescriber.

- (1) International Nonproprietary Name (INN) of each active substance.
- (2) Pharmacological data: a brief description of pharmacological effects and mechanism of action.
- (3) Clinical information:
 - (a) Indications: whenever appropriate, simple diagnostic criteria should be provided.
 - (b) Dosage regimen and relevant pharmacokinetic data:
 - average and range for adults and children;
 - dosing interval;
 - average duration of treatment;
 - special situations, e.g., renal, hepatic, cardiac, or nutritional insufficiencies that require either increased or reduced dosage.
 - (c) Contra-indications.
 - (d) Precautions and warnings (reference to pregnancy, lactation, etc.).
 - (e) Adverse effects (quantify by category, if possible).
 - (f) Drug interactions (include only if clinically relevant; drugs used for self-medication should be included).
 - (g) Overdosage:
 - brief clinical description of symptoms;
 - non-drug treatment and supportive therapy;
 - specific antidotes.

¹ Reproduced from The use of essential drugs: second report of the WHO Expert Committee on the Use of Essential Drugs (WHO Technical Report Series, No. 722, 1985, p. 43).

(4) Pharmaceutical information:

- (a) Dosage forms.
 - (b) Strength of dosage form.
 - (c) Excipients.
 - (d) Storage conditions and shelf-life (expiry date).
 - (e) Pack sizes.
 - (f) Description of the product and package.
 - (g) Legal category (narcotic or other controlled drug, prescription or non-prescription).
 - (h) Name and address of manufacturer(s) and importer(s).
-

ANNEX 4

WHO CERTIFICATION SCHEME ON THE QUALITY OF PHARMACEUTICAL PRODUCTS MOVING IN INTERNATIONAL COMMERCE¹

Part I - Certification of a Pharmaceutical Product

1. For the purpose of this Certification Scheme "pharmaceutical product" means any medicine intended for human use, or a veterinary product administered to food-producing animals, presented in its finished dosage form or as a starting material for use in such a dosage form, when it is subject to control by legislation in the exporting Member State and in the importing Member State. It should be noted that, as a matter of policy, some Member States do not inspect manufacturers of starting materials, while in other countries such inspection is limited to selected active ingredients.

2. A pharmaceutical product exported or imported under this Certification Scheme would be certified by the competent authority of the exporting Member State on a Certificate of a Pharmaceutical Product, issued at the request of the interested party, to be sent to the competent authority of the importing Member State, which would decide to grant or to refuse the authorization for sale or distribution of the certified product, or to make the authorization conditional on the submission of supplementary data.

3. The issue of the Certificate of a Pharmaceutical Product would be subject to the conditions required by the competent authority of the exporting Member State in order to certify that:

(a) the product is authorized for sale or distribution within the exporting Member State (if not, the reasons therefore would be stated on the certificate); and

(b) the manufacturing plant in which the product is produced is subject to inspection at suitable intervals to show that the manufacturer conforms to requirements for good practices in manufacture and quality control, as recommended by the World Health Organization, in respect of products to be sold or distributed within the country of origin or to be exported.

A suggested layout of a Certificate of a Pharmaceutical Product with explanatory notes is attached.

4. Certification of individual batches of pharmaceutical products and substances is only undertaken exceptionally by the competent authorities of Member States. Even then, it is rarely applied other than to vaccines and other biologicals. If certificates of individual batches of a product covered by a Certificate of a Pharmaceutical Product are required, such certificates could be issued either by the manufacturer or by the competent authority of the exporting Member State, according to the nature of the product and the requirements of the exporting Member State or of the importing Member State. The batch certificate would indicate the name and dosage form of the product, the batch number, the expiry date and storage conditions, a reference to the Certificate of a Pharmaceutical Product, and a statement that the batch conforms either to the requirements of the competent authority for sale or distribution within the exporting

¹ See resolution WHA41.18.

Member State (with reference to the authorization) or, as the case may be, to published specifications, or to established specifications to be provided by the manufacturer. The certificate could also include data on packaging, labelling, nature of the container, the date of manufacture, results of analysis, stability data and other information such as an approved technical summary of the data regarding safety and efficacy on which the domestic marketing authorization is based.

Part II - Exchange of Information

1. Upon the request of the competent authority of the Member State into which a pharmaceutical product covered by this Certification Scheme is to be or has been imported, the competent authority of the exporting Member State should provide:

(a) information on the implementation of the Requirements for Good Practices in the Manufacture and Quality Control of Drugs as recommended by the World Health Organization;¹

(b) information on controls of the product as exercised by the competent authority of the exporting Member State;

(c) the names and functions of the persons designated to sign certificates of individual batches of the product to be exported;

(d) copies of all information and labelling supplied with the product, as provided on packaging materials and package inserts, and whether directed to the prescriber or the patient, that have been approved by the competent authority in the exporting Member State, together with the date(s) on which such approval was accorded.

Information on general and specific standards for quality control of the product to be exported, in so far as they are required to comply with legislative provisions of the importing Member State, could also be supplied with the consent of the manufacturer.

2. In the case of quality defects of products imported under this Certification Scheme that are considered to be of a serious nature by the importing country, not attributable to local conditions and circumstances, and appearing after the introduction of a particular batch into the importing Member State, the competent authority should notify the occurrence, together with the relevant facts, to the competent authority of the exporting Member State that had issued the Certificate for the product concerned, with a request to institute inquiries. Conversely, if the competent authority of the exporting Member State ascertains serious quality defects, that competent authority should notify the competent authority of the importing Member State.

Part III - Participating Member States

1. Each Member State agreeing to participate in the Certification Scheme shall communicate (a) the name and address of its principal authority to be considered as competent within the meaning of the Certification Scheme, and (b) any significant reservations relating to its participation, to the Director-General of the World Health Organization, who would notify all other Member States.

2. Exporting Member States participating in the Certification Scheme shall ensure that:

(a) authorization for sale or distribution of pharmaceutical products is subject to appropriate testing measures, by the competent authority, designed to ensure their quality and stability, and that adequate laboratory facilities are available for this purpose;

¹ It is realized that in some countries this may require the consent of the manufacturer.

(b) the pharmaceutical industry is obliged to conform to requirements for good practices in the manufacture and quality control of drugs as recommended by the World Health Organization;

(c) the competent authority is empowered to conduct appropriate investigations to ensure that manufacturers conform to the requirements referred to in (b), including, for example, the examination of records and the taking of samples;

(d) the inspectors in the services of its competent authority have appropriate qualifications and experience.

3. Exporting Member States participating in the Certification Scheme should, whenever possible, ensure that the international nonproprietary names, whenever available, are used in the description of the composition of the product on the Certificate and, as far as possible, appear on the labelling of pharmaceutical products to be exported under the Certification Scheme.

CERTIFICATE OF A PHARMACEUTICAL PRODUCT¹

Name and dosage form of product:

Name and amount of each active ingredient:²

.....

Manufacturer, and/or when applicable, the person responsible for placing the product on the market:

Address(es):

It is certified that:

This product has been authorized to be placed on the market for use in this country.

Number of permit and date of issue (if applicable):

The enclosed documents constitute the complete text of all labelling and prescribing information which is authorized for use in this country.

This product has not been authorized to be placed on the market for use in this country for the following reasons:

It is also certified that (a) the manufacturing plant in which the product is produced is subject to inspections at suitable intervals and (b) the manufacturing conforms to requirements for good practices in the manufacture and quality control, as recommended by the World Health Organization, in respect of products to be sold or distributed within the country of origin or to be exported. (See Explanatory Notes.)

.....
(Signature of designated authority)

.....
(Place and date)

¹ The certificate is intended to be product-specific. The approved information for different dosage forms of the same active substance frequently differs in fundamental aspects. Confusion will inevitably arise if information relating to different products, or even different dosage forms, is attached to the same certificate.

² Use, whenever possible, international nonproprietary names (INN) or national nonproprietary names.

Explanatory NotesCertificate of a Pharmaceutical Product

This certificate is intended to define the status of the pharmaceutical product and its manufacturer in the exporting country. It is issued by the competent authority in the exporting country in accordance with the requirements of the competent authority of the importing country. It may be required by the importing country at the time of the first importation and subsequently if confirmation or updating is required.

The requirements for good practices in the manufacture and quality control of drugs mentioned in the certificate refer to the text adopted by the Twenty-eighth World Health Assembly in its resolution WHA28.65 (see WHO Official Records No. 226, 1975, Annex 12, Part 1).

Batch certificates

Certification of individual batches of a pharmaceutical product or substance is only undertaken exceptionally by the competent authorities of Member States. Even then, it is rarely applied other than to vaccines and other biologicals. If certificates of individual batches of products covered by a Certificate of a Pharmaceutical Product are required, such certificates could be issued either by the manufacturer or by the competent authority of the exporting Member State, according to the nature of the product and the requirements of the exporting Member State or of the importing Member State. The batch certificate would indicate the name and dosage form of the product, the batch number, the expiry date and storage conditions, a reference to the Certificate of a Pharmaceutical Product and a statement that the batch conforms either to the requirements of the competent authority for sale or distribution within the exporting Member State (with reference to the authorization) or, where appropriate, to published specifications or to established specifications to be provided by the manufacturer. The certificate could also include data on packaging, labelling, nature of the container, the date of manufacture, results of analysis, stability data and other information such as an approved technical summary of the data regarding safety and efficacy on which the domestic marketing authorization is based.

ANNEX 5

TOBACCO OR HEALTH¹

Report by the Director-General

[A41/4 - 23 March 1988]

Resolution WHA39.14 (May 1986), in its operative paragraph 6(7), requested the Director-General to report on progress to the Executive Board at its eighty-first session and to the Forty-first World Health Assembly. During the discussion of this report on progress at the Board's eighty-first session, members of the Board welcomed the report and commented on the WHO programme; the Board agreed to transmit the report, which has meanwhile been updated, to the Health Assembly, with the summary record of its discussions (see summary records of the second meeting, section 3, and the third meeting, section 1, in document EB81/1988/REC/2).

I. BACKGROUND

1. Resolution WHA39.14 (May 1986), entitled "Tobacco or health" requested the Director-General, inter alia, to "strengthen the present programme on smoking and health without waiting for its official introduction in the Eighth General Programme of Work" and "to report on progress to the Executive Board at its eighty-first session and to the Forty-first World Health Assembly". Affirming that "the use of tobacco in all its forms is incompatible with the attainment of health for all by the year 2000", the resolution intimated - through its title - that WHO should address not only smoking but also other forms of tobacco use, including certain new ones that the tobacco industry is now actively promoting. Indeed, the "Smoking and health" programme is being renamed "Tobacco or health".

II. SITUATION ANALYSIS

2. The evidence linking tobacco use to numerous types of major disease and disease conditions has grown extensively in recent years and has established itself on a very solid basis. The well-known causal relationship of smoking with cancer of the lung and of the upper respiratory tract, with cardiovascular diseases and with chronic bronchitis and emphysema has been further strengthened; and new evidence has accumulated linking smoking to cancer of the urinary bladder and of the pancreas, decreased male and female fertility and pregnancy complications, as well as low birth weight and other conditions.

3. In an attempt to offset the decrease in cigarette consumption that is occurring in many industrialized countries, the tobacco industry has been actively expanding its markets in developing countries. Its ruthless approach includes promoting new types of dangerous habits. For instance, tobacco chewing - which is an old habit in the Indian sub-continent, where it is the cause of 90% of cases of oral cancer as well as widespread tooth and gum decay - is now being attractively advertised in North America and northern Europe, and it is feared it may spread to other countries. New types of so-called "very low tar" cigarettes, cigarillos and "smokeless" cigarettes are being promoted. These products mislead smokers into a wrong assumption of "safer" tobacco use and, in reality, perpetuate the cigarette-smoking habit. Toothpastes containing tobacco are also appearing on the market.

¹ See resolution WHA41.25.

III. WORLD TRENDS

4. Recent statistics confirm previous findings that smoking is decreasing among the better educated males in developed countries, and among male teenagers. Among females the previous tendency for smoking to increase seems to be levelling off. Cigarette consumption in the totality of industrialized countries is practically static in relation to population increase, but in Latin America - between 1971 and 1981 - it increased by 28% over the level attributable to population increase, in Asia by 30%, and in Africa by an appalling 77%. This is a striking indication of an increased prevalence of smoking in Third World countries. Appendices 1 and 2 contain data on the per capita consumption of manufactured cigarettes in various countries or areas in 1985 and the prevalence of smoking.

5. As regards the use of "smokeless" tobacco, it is estimated that there are 100 million users in the Indian sub-continent and about 10 million, most of them teenagers, in the United States of America.

IV. WHO ACTION

6. Since resolution WHA39.14 was adopted the following action has been taken by WHO:

(1) The collection and dissemination of information and data on smoking trends, smoking control legislation and germane topics have been strengthened and several technical reports have been published. It is hoped to reach a "clearing-house" operational level in order to provide developing countries with information on tobacco or health issues.

(2) The reduction of smoking in aircraft is a continuing project in collaboration with the International Air Transport Association. Questionnaires on non-smoking policies on board aircraft have been circulated to all major airlines. There are distinct trends towards an increase in the number of non-smoker seats and a total ban on smoking on some flights (usually domestic flights of two to four hours' duration).

(3) A new project aiming at stimulating countries to adopt policies restricting smoking in public transport has just started.

(4) In June 1987 a WHO Study Group on Smokeless Tobacco Control reviewed the geographical pattern of usage and the health hazards of tobacco chewing and snuff taking, and made recommendations on how to stop the dangerous habit taking root. A "pre-emptive" total ban on the import, production and sale of all types of smokeless tobacco is one of the most relevant recommendations.¹

(5) WHO contributed actively to the sixth World Conference on Smoking and Health (Tokyo, 9-12 November 1987). The Director-General gave an address, and brochures and other printed material and an information kit were supplied by WHO.

(6) As a major sign of concern and as an example to other United Nations agencies, health organizations, and employers in general, WHO headquarters and all the regional offices have become no-smoking premises.

(7) On the occasion of the fortieth anniversary of WHO, World Health Day (7 April 1988) was celebrated as a world no-smoking day in response to resolution WHA40.38 of 15 May 1987. Thousands of information kits bearing the slogan "Tobacco or health: choose health", have been distributed to ministries of health, nongovernmental organizations, national focal points and interested individuals throughout the world.

¹ Report to be published in the WHO Technical Report Series.

(8) WHO is playing an increasing role in global advocacy, through close collaboration with various nongovernmental organizations (particularly the International Organization of Consumers Unions, the International Union against Cancer and the International Union against Tuberculosis and Lung Disease), and through extensive media coverage of the Organization's activities worldwide.

(9) Studies on tobacco and health economics and on tobacco crop alternatives, as well as projections to the year 2000 regarding tobacco and disease, are under way in collaboration with FAO and the National Cancer Institute (National Institutes of Health, USA).

(10) Of particular interest is the Action Plan on Tobacco in the European Region, which aims at intensifying and coordinating anti-tobacco activities in all countries of the Region. Preparations are under way for a European conference on tobacco and health, to be held in Madrid in November 1988.

(11) All the other WHO regional offices are also carrying out activities on smoking and health, at different levels of intensity. In collaboration with nongovernmental organizations, namely the International Union against Cancer and the International Union against Tuberculosis and Lung Disease, seminars have been held in recent years in Buenos Aires, Caracas, Khartoum, Kingston, Nairobi, Riyadh, Tianjin (China) and Tokyo.

7. Fuller orientation on activities of the type described above can be obtained from the list of WHO publications and documents (Appendix 3).

8. The reoriented programme (Tobacco or health) appears as programme 8.4 in the Eighth General Programme of Work. The work is carried out in close collaboration with several other WHO programmes (e.g., those on cancer, cardiovascular diseases, health legislation, epidemiological surveillance and health situation and trend assessment, and public information and education for health), as well as with the regional offices. The major constraints continue to be insufficient regular budget funds and unpredictable extrabudgetary resources. This situation makes it difficult to implement medium-term plans and to secure adequate staff support for the programme at both professional and general service levels.

9. At the invitation of the Director-General an Advisory Group met from 1 to 3 March 1988 to make specific proposals for a global plan of action (see Appendix 4). The Group's proposals have major implications for WHO. For example, it proposes that a special action programme on tobacco or health (with a special advisory committee) should be established, reporting directly to the Director-General. The special action programme's activities would be reviewed every two years by the Executive Board and the World Health Assembly. Such a special action programme would require a large increase in staff, to be financed from the WHO regular budget and from extrabudgetary resources. Since the proposals of the Advisory Group have far-reaching budgetary implications, the Director-General is studying them in relation to the proposed programme budget for the financial period 1990-1991. All the Group's proposals will be reviewed by the Programme Committee of the Executive Board in October 1988 and by the Board itself in January 1989, before being submitted to the Forty-second World Health Assembly in May 1989.

Appendix 1ADULT PER CAPITA CONSUMPTION OF MANUFACTURED CIGARETTES IN 1985¹
(ARRANGED IN ASCENDING ORDER)

Burkina Faso	30	Paraguay	1 000
Guinea	30	Chile	1 000
Papua New Guinea	30	Honduras	1 010
Afghanistan	50	Indonesia	1 050
Ethiopia	60	Morocco	1 070
Niger	100	Guadeloupe	1 080
Sudan	130	Democratic People's Republic of Korea	1 180
Nepal	150	Mexico	1 190
Burma	150	Fiji	1 320
Chad	150	Costa Rica	1 340
India	160	Nicaragua	1 380
Zaire	210	Barbados	1 380
Cape Verde	210	Tunisia	1 470
Haiti	240	South Africa	1 550
Uganda	260	Hong Kong	1 580
Bangladesh	270	China	1 590
Central African Republic	280	Algeria	1 590
United Republic of Tanzania	330	Trinidad and Tobago	1 600
Bolivia	330	Suriname	1 660
Peru	350	Sweden	1 660
Nigeria	370	Netherlands	1 690
Ghana	380	Mauritius	1 700
Malawi	390	Brazil	1 700
Zambia	400	Jordan	1 700
Mozambique	430	Finland	1 720
Liberia	450	Portugal	1 730
Madagascar	450	Uruguay	1 760
Togo	460	Argentina	1 780
Lao People's Democratic Republic	490	Malaysia	1 840
Sri Lanka	500	Egypt	1 860
Zimbabwe	500	Venezuela	1 890
Angola	530	Philippines	1 910
Kenya	550	Colombia	1 920
Guatemala	550	Norway	1 920
Cameroon	610	Turkey	1 970
Senegal	610	Belgium	1 990
Iran (Islamic Republic of)	620	Syrian Arab Republic	2 050
Pakistan	660	Romania	2 110
Viet Nam	670	Saudi Arabia	2 110
Côte d'Ivoire	710	Denmark	2 110
Benin	740	United Kingdom of Great Britain and Northern Ireland	2 120
El Salvador	750	Union of Soviet Socialist Republics	2 170
Jamaica	820	Singapore	2 280
Sierra Leone	830	Israel	2 310
Panama	850	German Democratic Republic	2 340
Ecuador	880	Germany, Federal Republic of	2 380
Thailand	900	France	2 400
Congo	920	Bulgaria	2 410
Réunion	940	Italy	2 460
Dominican Republic	980		
Iraq	980		
Guyana	1 000		

¹ Adult defined as 15 years of age and over.

New Zealand	2 510	Yugoslavia	3 000
Czechoslovakia	2 550	Iceland	3 100
Ireland	2 560	Canada	3 180
Austria	2 560	Hungary	3 260
Republic of Korea	2 660	Japan	3 270
Australia	2 720	United States of America	3 270
Spain	2 740	Poland	3 300
Kuwait	2 760	Greece	3 640
Libyan Arab Jamahiriya	2 850	Cuba	3 920
Lebanon	2 880	Cyprus	4 050
Switzerland	2 960		

Appendix 2

SMOKING PREVALENCE IN THE YEAR SHOWN AND ADULT PER CAPITA CIGARETTE CONSUMPTION IN 1985 IN 65 COUNTRIES OR AREAS¹

	Smoking prevalence (%)			Date of prevalence survey	Adult per capita consumption (male + female)
	Total	Male	Female		
Barbados		10			1 380
Côte d'Ivoire		24	1	1981	710
Ethiopia	15	28	3	1978	60
Canada		31	28	1981	3 180
Austria	27	33	22	1981	2 560
Egypt	16	33	2	1981	1 860
Hong Kong	19	33	4	1984	1 580
Uganda		33			260
Peru		34	7		350
Belgium	28	35	21	1984	1 990
New Zealand		35	29	1981	2 510
United States of America		35	30	1983	3 270
Guatemala		36	10		550
United Kingdom of Great Britain and Northern Ireland		36	32	1984	2 120
Australia		37	30	1983	2 720
Portugal		37	10	1984	1 730
Finland	28	39	21	1980	1 720
Ireland	35	39	32	1982	2 560
Zambia	24	39	7	1983	400
Greece		41	2	1985	3 640
Netherlands		41	33	1982	1 690
Sweden	40	41	34	1980	1 660
Senegal		43	35		610
Germany, Federal Republic of	36	44	29	1984	2 380
Israel	37	44	30	1982	2 310
Pakistan	29	44	6	1982	660

¹ Adult defined as 15 years of age and over.

SMOKING PREVALENCE IN THE YEAR SHOWN AND ADULT PER CAPITA CIGARETTE
CONSUMPTION IN 1985 IN 65 COUNTRIES OR AREAS¹ (continued)

	Smoking prevalence (%)			Date of prevalence survey	Adult per capita consumption (male + female)
	Total	Male	Female		
Mexico		45	18		1 190
Uruguay	45	45	45	1985	1 760
Norway		46	39	1980	1 920
Switzerland		46	29	1981	2 960
Guyana		48	4		1 000
Romania		48	13	1980	2 110
Sri Lanka		48	2	1984	500
Union of Soviet Socialist Republics	27	48	11		2 170
Singapore		49	8		2 280
France	38	50	26	1981	2 400
Ghana	25	50	1	1975	380
Hungary		50	25	1980	3 260
French Polynesia		50	46		2 500
Turkey		50	50		1 970
Chile		52	18		1 000
India		52	3	1984	160
Kuwait		52	12		2 760
Nigeria		53	3		370
Venezuela		53	26		1 890
Italy	35	54	17	1980	2 460
Malaysia	20	56	2	1975	1 840
Czechoslovakia		57	14	1984	2 550
Denmark	50	57	44	1980	2 110
Yugoslavia		57	10		3 000
Argentina		58	18		1 780
Spain	40	58	23	1986	2 740
Tunisia		58	6	1984	1 470
Brazil		59	53	1980	1 700
Thailand	36	59	13	1981	900
China	30	62	8		1 590
Poland		63	29	1983	3 300
Japan		66	14	1984	3 270
Republic of Korea		69	7	1981	2 660
Bangladesh		70	20	1984	270
Indonesia		75	5	1984	1 050
Philippines		78			1 910
Nepal		79	58	1981	150
Fiji		80	40	1986	1 320
Papua New Guinea		85	80	1981	30

¹ Adult defined as 15 years of age and over.

Appendix 3

WHO PUBLICATIONS AND DOCUMENTS ON TOBACCO AND HEALTH

1. REPORTS OF WHO EXPERT COMMITTEES

- (a) WHO Technical Report Series, No. 568, 1975 (Smoking and its effects on health)
- (b) WHO Technical Report Series, No. 636, 1979 (Controlling the smoking epidemic)
- (c) WHO Technical Report Series, No. 695, 1983 (Smoking control strategies in developing countries)

2. REPORT OF A WHO STUDY GROUP

WHO Technical Report Series (Smokeless tobacco control) (in press)

3. LEGISLATIVE ACTION

- (a) World Health Organization. Legislative action to combat smoking around the world: a survey of existing legislation. International digest of health legislation, 27: 493-517 (1976)
- (b) Roemer, R.J. Legislative action to combat the world smoking epidemic. Geneva, World Health Organization, 1982
- (c) Roemer, R.J. Recent developments in legislation to combat the world smoking epidemic (unpublished WHO document WHO/SMO/HLE/86.1)

4. SMOKING TRENDS IN THE WORLD

- (a) Benjamin, B. Tobacco smoking in the world (unpublished WHO document CVD/S/EC/78.23)
- (b) Smoking in developing countries. Paper presented at a WHO workshop, Colombo, Sri Lanka, 18-20 November 1981 (unpublished WHO document WHO/SMO/83.2)
- (c) Masironi, R. & Roy, L. Smoking in developing countries (unpublished WHO document WHO/SMO/83.1)
- (d) Masironi, R. & Rothwell, K. Smoking in developing countries (unpublished WHO document WHO/SMO/85.1)
- (e) Masironi, R. & Roy, L. Cigarette smoking in young age groups: geographic prevalence (unpublished WHO document WHO/SMO/82.3)
- (f) Masironi, R. & Geizerova, H. Smoking in children and adolescents: a world review (in preparation)
- (g) Rothwell, K. & Masironi, R. Cigarette smoking in developed countries outside Europe (unpublished WHO document WHO/SMO/86.2)
- (h) Smoking - world-wide trends and their implications. In: World Health Statistics Annual, Geneva, World Health Organization, 1986, pp. 16-19
- (i) Rothwell, K. et al. Smoking in Europe (unpublished WHO document WHO/SMO/EUR/87.1)

5. REPORTS OF SEMINARS ON SMOKING AND HEALTH IN DEVELOPING COUNTRIES

- (a) Smoking and health issues in developing countries. Report of a WHO workshop, Colombo, Sri Lanka, 18-20 November 1981 (unpublished WHO document WHO/SMO/82.2)
- (b) Smoking and health. Report of an international conference, Mbabane, Swaziland, 26-28 April 1982 (unpublished WHO document WHO/SMO/82.4)
- (c) Smoking and health issues in selected English-speaking African countries. Report of an international seminar, Lusaka, Zambia, 26-28 June 1984 (unpublished WHO document WHO/SMO/84.5)
- (d) World Health Organization. Smoking and health: Report of a regional seminar, Kathmandu, Nepal, 26-30 March 1984. New Delhi, 1985 (SEARO Technical Publications Series, No. 7)
- (e) Tabac et santé: le rôle des médias. Report of a WHO regional workshop for French-speaking countries of Africa, Lomé, Togo, 25-30 November 1985 (unpublished WHO document SMO/86.3) (French only)
- (f) Pan American Health Organization. Control of smoking: subregional workshop for countries of the Southern Cone and Brazil, Buenos Aires, Argentina, 18-22 November 1985. Washington, DC, 1986 (Technical Paper, No. 2)
- (g) Pan American Health Organization. Control of smoking: second subregional workshop - Andean area, Caracas, Venezuela, 16-21 November 1986. Washington, DC, 1987 (Technical Paper, No. 9) (Spanish only)

6. ECONOMICS OF TOBACCO AND HEALTH

Thompson, M. & Forbes, W. Estimating economic benefits and losses associated with cigarette smoking (unpublished WHO document WHO/SMO/83.3)

7. GUIDELINES AND QUESTIONNAIRES

- (a) Guidelines for the conduct of tobacco-smoking surveys of the general population. Report of a WHO meeting, Helsinki, Finland, 29 November - 4 December 1982 (unpublished WHO document WHO/SMO/83.4)
- (b) Guidelines for the conduct of tobacco-smoking surveys among health professionals. Report of a WHO meeting, Winnipeg, Canada, 7-9 July 1983 (unpublished WHO document WHO/SMO/84.1)
- (c) Guidelines for the conduct of tobacco-habits surveys among school teachers. Report of a WHO meeting, Padua, Italy, 15-17 December 1987 (unpublished WHO document WHO/TOH/88.1)

8. MISCELLANEOUS

- (a) Smoking in aircraft. Report of a WHO/IATA/ICAO consultation, Geneva, 14-15 December 1983 (unpublished WHO document WHO/SMO/84.3)
- (b) Rankin, D. Smoking in hospitals (unpublished WHO document WHO/SMO/85.2)
- (c) Frecker, R.C. & Pischkitl, H. Constituents of cigarettes from developing countries: nicotine, tar and carbon monoxide values for 50 brands selected by the World Health Organization (unpublished WHO document WHO/SMO/84.4)
- (d) WHO Quarterly Newsletter - Tobacco alert

Appendix 4REPORT OF THE ADVISORY GROUP ON A WHO GLOBAL ACTION PLAN
ON TOBACCO OR HEALTH

(Geneva, 1-3 March 1988)

[A41/INF.DOC./6 - 25 April 1988]

The dangers of tobacco use have long been established beyond any credible doubt. Health Assembly resolutions WHA31.56 and WHA33.35 on these dangers led to the Thirty-ninth World Health Assembly's urgent request to the Director-General that the programme on smoking and health should be strengthened (resolution WHA39.14). Accordingly, the Director-General invited an Advisory Group to make specific proposals for the implementation of an action plan by WHO. The Advisory Group came to the conclusion that a special action programme was the only practical way of responding to the pandemic of diseases caused by tobacco and of implementing the resolutions of the Health Assembly. This report outlines the essential components of such a programme, suggests how it could be established, and proposes a strategy to cover the interim period.

CONTENTS

	<u>Page</u>
1. Introduction	65
2. Proposed special action programme on tobacco or health	66
3. Complementary roles of WHO and nongovernmental organizations	68
4. Regional action	68
5. Targets and timetable	68
6. Means of implementation	69
7. Funding	69
8. List of members	70

1. INTRODUCTION

1.1 In recent years the World Health Assembly has shown strong leadership by its resolutions on the problem of tobacco use, one of the world's most important causes of preventable ill-health.

1.2 A resolution adopted in 1980 by the Thirty-third World Health Assembly (resolution WHA33.35) was followed by a detailed one (resolution WHA39.14) which was supported by all Member States at the Thirty-ninth World Health Assembly. The latter resolution requested the Director-General inter alia to strengthen the programme on smoking and health. The request was timely because:

- (a) there are irrefutable data on the dangers of tobacco to the user;

- (b) there is now conclusive evidence that involuntary or enforced smoking is dangerous to the non-smoker;
- (c) tobacco consumption in developing countries is increasing;
- (d) there is an increasing threat to health posed by tobacco use in women and children in many countries;
- (e) there is clear evidence that programmes for reduction in tobacco use can be highly effective;
- (f) the climate of medical and social opinion has progressed and is now strongly favourable to expanded action.

1.3 Although reports of WHO's expert committees have had considerable international influence, and WHO has produced other useful materials, the resources devoted by WHO to the tobacco or health programme have not expanded in proportion to the size of the tobacco pandemic. The Advisory Group regards WHO's resource commitment as wholly inadequate to accomplish the numerous recommendations for action specified in successive Health Assembly resolutions, and incommensurate with the task.

1.4 For the reasons mentioned above, and because tobacco use in all its forms is incompatible with the attainment of health for all by the year 2000, a new initiative by WHO would be enthusiastically received. Indeed, it is the opinion of the Advisory Group, in view of the magnitude of the tobacco pandemic, that inspirational leadership by WHO is crucial.

1.5 Accordingly, at the request of the Director-General the Advisory Group made specific proposals for the implementation of an action plan by WHO.

2. PROPOSED SPECIAL ACTION PROGRAMME ON TOBACCO OR HEALTH

2.1 The Advisory Group was of the unanimous opinion that the magnitude of the problem was such that it could be successfully addressed only by a special action programme on tobacco or health.

2.2 While the detailed formulation of such a special programme would be the task of the Secretariat, its essential components would be as follows.

2.2.1 It should focus primarily on helping individual countries to develop and implement practical strategies and targets for reducing tobacco use, including:

- (a) the establishment of national coordinating mechanisms on tobacco or health, in collaboration with the WHO regional offices;
- (b) publicity and information with particular emphasis on the education of children;
- (c) tobacco price and taxation policies;
- (d) legislative measures, e.g., policies on tobacco promotion, on smoking on health-related premises and in public places, transport and the workplace, and on traditional and new forms of smokeless tobacco; strong, rotating and prominent health warnings; and limits on harmful substances;
- (e) the training and utilization of health professionals;
- (f) evaluation of the above, an essential component of which is to identify the most effective methods of reducing tobacco use. This would involve reporting back by countries on a regular, biennial basis on their achievement in reducing tobacco use, preferably as part of reporting progress in achieving health for all by the year 2000.

2.2.2 The programme should include the re-establishment and development of a clearing-house for the collection and energetic dissemination of up-to-date information on all aspects of tobacco, including:

- (a) global prevalence, mortality and morbidity;
- (b) global, regional and national progress in tobacco policies;
- (c) specific subject areas, including special legislation with regard to tobacco use; taxation/price policy; professional training; public information campaigns; model studies, e.g., epidemiological and clinical studies and trend assessments; health education programmes; practical help in smoking cessation; and community-based programmes.

There is also a need for a second clearing-house more appropriately operated by a nongovernmental organization, for example, for information on advocacy and campaigning. The two clearing-houses would be complementary and WHO should provide appropriate support to the latter.

2.2.3 An essential component of the special programme would be that it should work in close cooperation with a wide range of other WHO programmes whose important activities would in no way be diminished. The special programme should play the lead in coordinating all WHO activities related to tobacco use.

2.2.4 The programme should provide inspiration, coordination and support to regional initiatives in reducing tobacco use, including, in the early stages, the provision of funds.

2.2.5 The programme should continue to develop a United Nations system-wide policy on tobacco or health and coordinate its implementation.

2.2.6 The programme should include provision for high-level international and regional meetings, symposia and workshops, particularly in support of developing countries, preferably in conjunction with nongovernmental organizations.

2.2.7 The programme should include provision for further study or exchange of information, including sociobehavioural and economic studies on tobacco use and evaluation of intervention measures. Certain studies may be more appropriately delegated to other organizations.

2.2.8 The programme should identify special topics, e.g., involuntary smoking, tobacco addiction, for consideration by future expert committees.

2.2.9 The programme should cooperate with nongovernmental organizations on policy, in organizing workshops and conferences, and in research and other activities, e.g., collaboration with employers and trade unions regarding smoke-free workplaces.

2.3 The overall objective of the programme should be to achieve implementation of the recommendations of the Health Assembly and WHO expert committees on tobacco. Particular emphasis should be on:

- (a) protection against involuntary or enforced smoking;
- (b) developing countries;
- (c) women and children;
- (d) price policies;
- (e) curtailing tobacco promotion.

3. COMPLEMENTARY ROLES OF WHO AND NONGOVERNMENTAL ORGANIZATIONS

3.1 Nongovernmental organizations have a role complementary to that of WHO. In particular they can be more activist than is appropriate for WHO, which works through governments.

3.2 There is a long and successful history of collaboration between WHO and certain nongovernmental organizations in the area of tobacco control.

3.3 Given the increasing commitment of WHO and nongovernmental organizations to tobacco or health issues, and assuming WHO's commitment to an expanded programme, nongovernmental organizations should collaborate actively in coordinated international, regional and national programmes directed to persuading governments to adopt measures aimed at reducing the use of tobacco.

3.4 The role of nongovernmental organizations should continue to include the development of policies and strategies, and mobilizing, training, and informing their constituents to press and lobby for national action. Such pressure should be directed at health and other governmental departments, politicians, and other relevant organizations.

3.5 To complement this activity WHO should recognize the role of the nongovernmental organizations, involve them in planning, and undertake responsibility for arranging collaboration.

3.6 WHO should further complement the activities of nongovernmental organizations by directly encouraging Member States to undertake national action aimed at reducing tobacco use.

4. REGIONAL ACTION

4.1 Aims. To stimulate and support both national and cooperative regional activities for reducing tobacco use. In each WHO region there should be a senior officer responsible for these activities.

4.2 Methods

4.2.1 The special programme should assist regional offices in preparing regional tobacco or health programmes and should coordinate activities.

4.2.2 Each regional office should produce a regional tobacco or health action plan.

4.2.3 Each regional office, either directly or through a collaborating centre, should form a regional clearing-house, which would include statistical information for countries within the region; and education and information materials suitable for regional and national use, including use by WHO representatives.

4.2.4 Each regional office should promote regional and national workshops, and arrange to provide expert advice to individual countries as required.

5. TARGETS AND TIMETABLE

5.1 Setting targets is an indispensable step in the establishment of action plans which requires specific skills and methodology. Regular evaluation should be planned at each level to assess progress. Much detailed work must be undertaken to develop objective strategies and targets, but the overall timetable should be as follows.

5.2 By the end of 1988 a special advisory committee should be established and there should be an initial increase in staff to undertake the necessary planning.

5.3 By 1990 the special action programme on tobacco or health should have been established at WHO headquarters and a global action plan should have been completed which would include targets and evaluation schemes based on resolution WHA39.14.

5.4 By 1992 all WHO regions should have developed specific tobacco or health action plans to support the development and implementation of national tobacco or health policies. Emphasis should be directed particularly towards involving facilitators, e.g., political, social and religious leaders, health professionals, teachers and organizations, including those concerned with health, youth, community affairs and sports.

5.5 By 1994 all Member States should have planned, developed and implemented country-specific tobacco or health policies and targets with support and collaboration from WHO, including an evaluation scheme. Emphasis should be on children and young adults, women and vulnerable groups as identified in individual countries.

5.6 By 2000 all Member States should have achieved a demonstrable reduction in tobacco use.

6. MEANS OF IMPLEMENTATION

6.1 A multidisciplinary special advisory committee, appointed by the Director-General and including members drawn from nongovernmental organizations, would monitor progress and advise the Director-General on the special programme. The precise structure of this committee would be elaborated by the Director-General.

6.2 The Advisory Group suggests that, because of the intersectoral nature of tobacco or health issues, the special programme should ideally be located as a separate entity in the Office of the Director-General.

6.3 It is suggested that the special programme should be the subject of a report to the Executive Board in non-budget years, and subsequently to the Health Assembly.

6.4 As with other special programmes, the proposed special action programme on tobacco or health would require leadership at senior professional level, and recognition of the leader's wide responsibilities through an appropriate place in the organizational structure of the Secretariat.

6.5 The responsible officer would require support from a wide range of professional and support staff.

6.6 Initially, the minimum requirement from the WHO regular budget should be three additional professional and five support staff in the financial period 1990-1991, supplemented by staff funded from extrabudgetary sources. As the special programme gains momentum, substantially increased resources would be required.

7. FUNDING

7.1 A main objective of recommending the establishment of a special action programme is to facilitate the acquisition of adequate funding for the important tasks to be carried out. However, if such a programme is to be successfully launched, it is imperative that it should receive adequate initial funding from the WHO regular budget. The earliest this could be implemented would be from the 1990-1991 programme budget. The Advisory Group suggests that the Programme Committee of the Executive Board should consider the matter at its meeting in October 1988. The Executive Board would then reach its conclusions in January 1989 as part of its consideration of the proposed 1990-1991 programme budget.

7.2 Once established, the special programme could also draw on many potential sources of financial and other help. These would include:

- (a) Specific requests to individual countries. In recognition of the international dimension of tobacco problems this might take the form of setting aside a proportion of tobacco-related taxes or a percentage of the country's budget for tobacco or health activities.
- (b) Seeking funds from governmental and other donor agencies.

(c) Seeking funds for specific projects from trusts or philanthropists. It is, however, emphasized that ad hoc funding is unsuitable for continuing programmes.

(d) Cooperating with nongovernmental organizations and business and other organizations in joint ventures, e.g., shared projects, activities, or services such as the loan of personnel.

(e) The use of collaborating centres.

7.2.1 There remains the gap between the current situation and the establishment of a special action programme on tobacco or health, for which enhanced financial provision in the 1990-1991 programme budget would be required.

7.2.2 Much work on filling in the details of the programme must be carried out in the interim. It is understood that, through the good offices of the Surgeon General of the United States of America, there is a conditional offer of at least US\$ 200 000 over a two-year period. It is also understood that if the Health Assembly accepts the Advisory Group's proposal for the establishment of a special action programme, these resources could be made available during 1988, for a period of two years, on the clear understanding that the special programme, with the enhanced regular budget commitment described above, would be established within that time.

7.3 The Advisory Group hopes that the Forty-first World Health Assembly, in the light of the Director-General's report on tobacco or health and the comments of the Executive Board on the subject,¹ accepts the specific proposals in this report. The Advisory Group further hopes that Member States will consider making immediate financial contributions towards a special action programme on tobacco or health.

8. LIST OF MEMBERS

Members

Dr C. Alvarez-Herrera, Chairman, Latin American Committee on Smoking and Health, Buenos Aires, Argentina

Dr K. Bjartveit, Chairman, National Council on Smoking and Health, Oslo, Norway

Dr J. Cullen, Deputy Director, Cancer Prevention and Control Division, National Cancer Institute, National Institutes of Health, Bethesda, USA

Mr M. Daube, Director, Health Promotion and Education Services, Health Department of Western Australia, Perth, Australia²

Dr J. MacKay, Director, Council on Smoking and Health, Hong Kong

Sir John Reid, Consultant Adviser on International Health, Department of Health and Social Security, London, England

Dr J. R. Seffrin, Vice-Chairman, American Cancer Society, New York, USA²

Mr D. Simpson, Director, Action on Smoking and Health, London, England

Dr Weng Xin-zhi, Deputy Director, Heart, Lung and Blood Vessels Institute, Beijing, China

Representatives of nongovernmental organizations

International Organization of Consumers Unions: Mr M. Abraham

International Union against Cancer: Dr N. Gray

International Union against Tuberculosis and Lung Disease: Sir John Crofton

¹ See document EB81/1988/REC/2, pp. 36-43.

² Unable to attend.

ANNEX 6

DECLARATION OF TALLOIRES¹

[A41/10 Add.1, Annex - 12 April 1988]

Remarkable progress in health has been achieved during the past decade. Global recognition that healthy children and healthy families are essential for human and national development is steadily increasing. Consensus has been reached on the strategy for providing primary health care programmes. The international community has become engaged in partnership with national governments in the creation of successful global programmes, ensuring the availability of financial support and appropriate technologies. These include:

- (1) immunization programmes which now protect over 50% of infants in developing countries with polio or DPT vaccines, preventing some 200 000 children from becoming paralysed with poliomyelitis and over a million children each year from dying of measles, whooping-cough or neonatal tetanus;
- (2) diarrhoeal diseases control programmes which now make available for 60% of the developing world population life-saving fluids (particularly oral rehydration salts) the use of which may be preventing as many as a million deaths annually from diarrhoea;
- (3) initiatives to control respiratory infections which hold promise in the years ahead of averting many of the three million childhood deaths from acute respiratory infections occurring each year in developing countries and that are not prevented currently by immunization;
- (4) safe motherhood and family planning programmes which are so important in protecting the well-being of families.

Progress to date demonstrates that resources can be mobilized and that rapid and effective action can be taken to combat dangerous threats to the health of children and mothers, particularly in developing countries.

This progress is the result of:

- enthusiastic worldwide agreement on the development of health strategies based on primary health care;
- the commitment of national governments, multi- and bilateral development agencies, nongovernmental organizations, private and voluntary groups and people in all walks of life to give priority to these programmes;
- coordinated action by the sponsors of the Task Force for Child Survival: WHO, UNICEF, the World Bank, UNDP and the Rockefeller Foundation.

¹ See resolution WHA41.28. This Declaration was issued on 12 March 1988 by the Task Force for Child Survival (established in 1984 by WHO, UNICEF, the World Bank, UNDP, and the Rockefeller Foundation) at the conclusion of its meeting held in Talloires, France.

We, the Task Force for Child Survival, conveners of the meeting "Protecting the World's Children - An Agenda for the 1990s" in Talloires, France, 10-12 March 1988:

1. EXPRESS appreciation and admiration for the efforts made by the developing countries to reduce infant and child deaths through primary health care and child survival actions;
2. COMMIT OURSELVES to pursue and expand these initiatives in the 1990s;
3. URGE national governments, multi- and bilateral development agencies, United Nations agencies, nongovernmental organizations and private and voluntary groups to commit themselves to:
 - increase national resources from both developing and industrialized countries devoted to health in the context of overall development and self-reliance,
 - improve women's health and education, recognizing the importance for women themselves, recognizing women's contributions to national development, and recognizing that mothers are by far the most important primary health care workers,
 - accelerate progress to achieve universal childhood immunization by 1990 and to sustain it thereafter,
 - accelerate progress to eliminate or markedly reduce as public health problems the other main preventable causes of child and maternal mortality and morbidity, striving to reach sustained universal coverage of children and mothers by the year 2000,
 - assure the development of new vaccines and technologies and their application, particularly in developing countries, as they become appropriate for public health use,
 - promote expanded coverage of water supply and sanitation,
 - pursue research and development, including technology transfer, in support of the above actions;
4. SUGGEST that the following should be considered by national and international bodies as targets to be achieved by the year 2000:
 - the global eradication of poliomyelitis,
 - the virtual elimination of neonatal tetanus deaths,
 - a 90% reduction in measles cases and a 95% reduction in measles deaths compared with pre-immunization levels,
 - a 70% reduction in the 7.4 million annual deaths that would occur due to diarrhoea in children under the age of 5 years in the year 2000 in the absence of oral rehydration therapy, and a 25% reduction in the diarrhoea incidence rate,
 - a 25% reduction in case/fatality rates associated with acute respiratory infection in children under 5 years,
 - reduction of infant and under-5 child mortality rates in all countries by at least half (1980-2000), or to 50 and 70 per 1 000 live births respectively, whichever achieves the greater reduction,
 - reduction of current maternal mortality rates in all countries by at least half.

Achievement of these targets would result in the avoidance of tens of millions of child deaths and disabilities by the year 2000, as well as a balanced population growth as parents become more confident their children will survive and develop. The eradication of poliomyelitis would, with the eradication of smallpox, represent a fitting gift from the twentieth to the twenty-first century.

5. DRAW world attention to the potential for enlarging upon the successes outlined above to encompass low-cost, effective initiatives to:

- improve the quality and coverage of educational services so as to obtain universal primary education and 80% female literacy, and
- reduce to less than 1% severe malnutrition in children under 5 while also significantly reducing moderate and mild malnutrition in each country.

6. WELCOME the progress being made in drafting the Convention on the Rights of the Child, and join the United Nations General Assembly in urging completion of the Convention in 1989, the tenth anniversary of the International Year of the Child.

We are convinced that vigorous pursuit of these initiatives aimed at protecting the world's children will ensure that children and mothers - indeed whole families - will benefit from the best of available health technologies, making an essential contribution to human and national development and to the attainment of health for all by the year 2000.

ANNEX 7

ALMA-ATA REAFFIRMED AT RIGA¹

[A41/19 - 26 April 1988]

THE PERMANENCE OF HEALTH FOR ALL

I. Maintaining health for all as a permanent goal of all nations up to and beyond the year 2000

Reaffirm health for all as the permanent goal of all nations, as stressed in the Declaration of Alma-Ata, and establish a process for examining the longer-term challenges to health for all that will extend into the twenty-first century.

INTENSIFYING SOCIAL AND POLITICAL ACTION FOR THE FUTURE - AGENDA/2000

II. Renewing and strengthening strategies for health for all

Encourage each country to continue to monitor its own health problems and develop its own health strategies in the spirit of health for all. This will reveal its most pressing health problems and identify the most seriously underserved and vulnerable populations. Programmes should be directed towards those populations in a spirit of equity, inviting their active participation in the development and implementation of the strategies.

III. Intensifying social and political action for health for all

Intensify the social and political action necessary to support the shifts in policy and the allocation of resources required to progress towards health for all, including the involvement of other sectors, nongovernmental organizations, communities and other interested groups to seek mechanisms for promoting new partnerships for health among them and with governments.

IV. Developing and mobilizing leadership for health for all

Give strong emphasis in every country to developing and stimulating the interest and support of current and potential leaders in the health and other sectors, at community, district and national levels, in order to bring creativity, advocacy, commitment and resources to bear on the challenge of health development.

V. Empowering people

Empower people by providing information, technical support and decision-making possibilities, so as to enable them to share in opportunities and responsibilities for action in the interest of their own health. Give special attention to the role of women in health and development.

¹ See resolution WHA41.34. At a meeting held in March 1988 in Riga, USSR, to mark the tenth anniversary of the Declaration of Alma-Ata, the Declaration was strongly reaffirmed and the following action was recommended.

VI. Making intersectoral collaboration a force for health for all

Support the creation of sustained intersectoral collaboration for health by incorporating health objectives into the public policies of other sectors and activating potential mechanisms at all levels.

ACCELERATING ACTION FOR HEALTH FOR ALL - AGENDA/2000**VII. Strengthening district health systems based on primary health care**

Strengthen district health systems based on primary health care, as a key action point for focusing national policies and resources and local concerns on the most pressing health needs and on underserved people.

VIII. Planning, preparing and supporting health personnel for health for all

Reorient education and training programmes for health personnel, emphasizing relevance to health services requirements, by locating learning experiences in functioning health systems based on primary health care. Provide strong moral and resource support for personnel, particularly those working in remote areas or difficult circumstances.

IX. Ensuring the development and rational use of science and appropriate technology

Emphasize the applications of science and appropriate technology to the critical health problems that threaten populations in all parts of the world, and strengthen the research capacities of Third World countries, with emphasis on research aimed at improving the health of the most deprived people.

X. Overcoming problems that continue to resist solution

Establish priority programmes aimed at overcoming serious problems, where underdevelopment or disturbances in development are major contributing factors and progress has been very limited, such as high infant, child and maternal mortality rates, abuse of substances such as tobacco and alcohol, and the imbalance between population growth and environmental and socioeconomic resources. Develop improved approaches through primary health care, emphasizing intersectoral action.

**SPECIAL PRIORITY INITIATIVE IN SUPPORT OF THE LEAST DEVELOPED
COUNTRIES BY WHO AND THE INTERNATIONAL COMMUNITY**

Establish a special international initiative focused on the tragic circumstances of the least developed countries, mostly on the continent of Africa, and especially those with markedly elevated infant, under-five-year-old and maternal mortality rates, which will address specific obstacles to progress and will set targets to be reached by the year 2000.

ANNEX 8

CONVENTIONS CONCERNING NUCLEAR ACCIDENTS¹

[A41/11 - 17 March 1988]

CONVENTION ON EARLY NOTIFICATION OF A NUCLEAR ACCIDENT

THE STATES PARTIES TO THIS CONVENTION,

AWARE that nuclear activities are being carried out in a number of States,

NOTING that comprehensive measures have been and are being taken to ensure a high level of safety in nuclear activities, aimed at preventing nuclear accidents and minimizing the consequences of any such accident, should it occur,

DESIRING to strengthen further international co-operation in the safe development and use of nuclear energy,

CONVINCED of the need for States to provide relevant information about nuclear accidents as early as possible in order that transboundary radiological consequences can be minimized,

NOTING the usefulness of bilateral and multilateral arrangements on information exchange in this area,

HAVE AGREED as follows:

Article 1

Scope of application

1. This Convention shall apply in the event of any accident involving facilities or activities of a State Party or of persons or legal entities under its jurisdiction or control, referred to in paragraph 2 below, from which a release of radioactive material occurs or is likely to occur and which has resulted or may result in an international transboundary release that could be of radiological safety significance for another State.
2. The facilities and activities referred to in paragraph 1 are the following:
 - (a) any nuclear reactor wherever located;
 - (b) any nuclear fuel cycle facility;

¹ See decision WHA41(9).

- (c) any radioactive waste management facility;
- (d) the transport and storage of nuclear fuels or radioactive wastes;
- (e) the manufacture, use, storage, disposal and transport of radioisotopes for agricultural, industrial, medical and related scientific and research purposes; and
- (f) the use of radioisotopes for power generation in space objects.

Article 2

Notification and information

In the event of an accident specified in article 1 (hereinafter referred to as a "nuclear accident"), the State Party referred to in that article shall:

- (a) forthwith notify, directly or through the International Atomic Energy Agency (hereinafter referred to as the "Agency"), those States which are or may be physically affected as specified in article 1 and the Agency of the nuclear accident, its nature, the time of its occurrence and its exact location where appropriate; and
- (b) promptly provide the States referred to in sub-paragraph (a), directly or through the Agency, and the Agency with such available information relevant to minimizing the radiological consequences in those States, as specified in article 5.

Article 3

Other Nuclear Accidents

With a view to minimizing the radiological consequences, States Parties may notify in the event of nuclear accidents other than those specified in article 1.

Article 4

Functions of the Agency

The Agency shall:

- (a) forthwith inform States Parties, Member States, other States which are or may be physically affected as specified in article 1 and relevant international intergovernmental organizations (hereinafter referred to as "international organizations") of a notification received pursuant to sub-paragraph (a) of article 2; and
- (b) promptly provide any State Party, Member State or relevant international organization, upon request, with the information received pursuant to sub-paragraph (b) of article 2.

Article 5

Information to be provided

1. The information to be provided pursuant to sub-paragraph (b) of article 2 shall comprise the following data as then available to the notifying State Party:

- (a) the time, exact location where appropriate, and the nature of the nuclear accident;
 - (b) the facility or activity involved;
 - (c) the assumed or established cause and the foreseeable development of the nuclear accident relevant to the transboundary release of the radioactive materials;
 - (d) the general characteristics of the radioactive release, including, as far as is practicable and appropriate, the nature, probable physical and chemical form and the quantity, composition and effective height of the radioactive release;
 - (e) information on current and forecast meteorological and hydrological conditions, necessary for forecasting the transboundary release of the radioactive materials;
 - (f) the results of environmental monitoring relevant to the transboundary release of the radioactive materials;
 - (g) the off-site protective measures taken or planned;
 - (h) the predicted behaviour over time of the radioactive release.
2. Such information shall be supplemented at appropriate intervals by further relevant information on the development of the emergency situation, including its foreseeable or actual termination.
 3. Information received pursuant to sub-paragraph (b) of article 2 may be used without restriction, except when such information is provided in confidence by the notifying State Party.

Article 6

Consultations

A State Party providing information pursuant to sub-paragraph (b) of article 2 shall, as far as is reasonably practicable, respond promptly to a request for further information or consultations sought by an affected State Party with a view to minimizing the radiological consequences in that State.

Article 7

Competent authorities and points of contact

1. Each State Party shall make known to the Agency and to other States Parties, directly or through the Agency, its competent authorities and point of contact responsible for issuing and receiving the notification and information referred to in article 2. Such points of contact and a focal point within the Agency shall be available continuously.
2. Each State Party shall promptly inform the Agency of any changes that may occur in the information referred to in paragraph 1.
3. The Agency shall maintain an up-to-date list of such national authorities and points of contact as well as points of contact of relevant international organizations and shall provide it to States Parties and Member States and to relevant international organizations.

Article 8

Assistance to States Parties

The Agency shall, in accordance with its Statute and upon a request of a State Party which does not have nuclear activities itself and borders on a State having an active nuclear programme but not Party, conduct investigations into the feasibility and establishment of an appropriate radiation monitoring system in order to facilitate the achievement of the objectives of this Convention.

Article 9

Bilateral and multilateral arrangements

In furtherance of their mutual interests, States Parties may consider, where deemed appropriate, the conclusion of bilateral or multilateral arrangements relating to the subject matter of this Convention.

Article 10

Relationship to other international agreements

This Convention shall not affect the reciprocal rights and obligations of States Parties under existing international agreements which relate to the matters covered by this Convention, or under future international agreements concluded in accordance with the object and purpose of this Convention.

Article 11

Settlement of disputes

1. In the event of a dispute between States Parties, or between a State Party and the Agency, concerning the interpretation or application of this Convention, the parties to the dispute shall consult with a view to the settlement of the dispute by negotiation or by any other peaceful means of settling disputes acceptable to them.
2. If a dispute of this character between States Parties cannot be settled within one year from the request for consultation pursuant to paragraph 1, it shall, at the request of any party to such dispute, be submitted to arbitration or referred to the International Court of Justice for decision. Where a dispute is submitted to arbitration, if, within six months from the date of the request, the parties to the dispute are unable to agree on the organization of the arbitration, a party may request the President of the International Court of Justice or the Secretary-General of the United Nations to appoint one or more arbitrators. In cases of conflicting requests by the parties to the dispute, the request to the Secretary-General of the United Nations shall have priority.
3. When signing, ratifying, accepting, approving or acceding to this Convention, a State may declare that it does not consider itself bound by either or both of the dispute settlement procedures provided for in paragraph 2. The other States Parties shall not be bound by a dispute settlement procedure provided for in paragraph 2 with respect to a State Party for which such a declaration is in force.
4. A State Party which has made a declaration in accordance with paragraph 3 may at any time withdraw it by notification to the depositary.

Article 12

Entry into force

1. This Convention shall be open for signature by all States and Namibia, represented by the United Nations Council for Namibia, at the Headquarters of the International Atomic Energy Agency in Vienna and at the Headquarters of the United Nations in New York, from 26 September 1986 and 6 October 1986 respectively, until its entry into force or for twelve months, whichever period is longer.
2. A State and Namibia, represented by the United Nations Council for Namibia, may express its consent to be bound by this Convention either by signature, or by deposit of an instrument of ratification, acceptance or approval following signature made subject to ratification, acceptance or approval, or by deposit of an instrument of accession. The instruments of ratification, acceptance, approval or accession shall be deposited with the depositary.
3. This Convention shall enter into force thirty days after consent to be bound has been expressed by three States.
4. For each State expressing consent to be bound by this Convention after its entry into force, this Convention shall enter into force for that State thirty days after the date of expression of consent.
5.
 - (a) This Convention shall be open for accession, as provided for in this article, by international organizations and regional integration organizations constituted by sovereign States, which have competence in respect of the negotiation, conclusion and application of international agreements in matters covered by this Convention.
 - (b) In matters within their competence such organizations shall, on their own behalf, exercise the rights and fulfil the obligations which this Convention attributes to States Parties.
 - (c) When depositing its instrument of accession, such an organization shall communicate to the depositary a declaration indicating the extent of its competence in respect of matters covered by this Convention.
 - (d) Such an organization shall not hold any vote additional to those of its Member States.

Article 13

Provisional application

A State may, upon signature or at any later date before this Convention enters into force for it, declare that it will apply this Convention provisionally.

Article 14

Amendments

1. A State Party may propose amendments to this Convention. The proposed amendment shall be submitted to the depositary who shall circulate it immediately to all other States Parties.
2. If a majority of the States Parties request the depositary to convene a conference to consider the proposed amendments, the depositary shall invite all States Parties to attend such a conference to begin

not sooner than thirty days after the invitations are issued. Any amendment adopted at the conference by a two-thirds majority of all States Parties shall be laid down in a protocol which is open to signature in Vienna and New York by all States Parties.

3. The protocol shall enter into force thirty days after consent to be bound has been expressed by three States. For each State expressing consent to be bound by the protocol after its entry into force, the protocol shall enter into force for that State thirty days after the date of expression of consent.

Article 15

Denunciation

1. A State Party may denounce this Convention by written notification to the depositary.
2. Denunciation shall take effect one year following the date on which the notification is received by the depositary.

Article 16

Depositary

1. The Director General of the Agency shall be the depositary of this Convention.
2. The Director General of the Agency shall promptly notify States Parties and all other States of:
 - (a) each signature of this Convention or any protocol of amendment;
 - (b) each deposit of an instrument of ratification, acceptance, approval or accession concerning this Convention or any protocol of amendment;
 - (c) any declaration or withdrawal thereof in accordance with article 11;
 - (d) any declaration of provisional application of this Convention in accordance with article 13;
 - (e) the entry into force of this Convention and of any amendment thereto; and
 - (f) any denunciation made under article 15.

Article 17

Authentic texts and certified copies

The original of this Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Director General of the International Atomic Energy Agency who shall send certified copies to States Parties and all other States.

IN WITNESS WHEREOF the undersigned, being duly authorized, have signed this Convention, open for signature as provided for in paragraph 1 of article 12.

ADOPTED by the General Conference of the International Atomic Energy Agency meeting in special session at Vienna on the twenty-sixth day of September one thousand nine hundred and eighty-six.

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CONVENTION ON ASSISTANCE IN THE CASE OF A NUCLEAR ACCIDENT OR RADIOLOGICAL EMERGENCY

THE STATES PARTIES TO THIS CONVENTION,

AWARE that nuclear activities are being carried out in a number of States,

NOTING that comprehensive measures have been and are being taken to ensure a high level of safety in nuclear activities, aimed at preventing nuclear accidents and minimizing the consequences of any such accident, should it occur,

DESIRING to strengthen further international co-operation in the safe development and use of nuclear energy,

CONVINCED of the need for an international framework which will facilitate the prompt provision of assistance in the event of a nuclear accident or radiological emergency to mitigate its consequences,

NOTING the usefulness of bilateral and multilateral arrangements on mutual assistance in this area,

NOTING the activities of the International Atomic Energy Agency in developing guidelines for mutual emergency assistance arrangements in connection with a nuclear accident or radiological emergency,

HAVE AGREED as follows:

Article 1

General provisions

1. The States Parties shall cooperate between themselves and with the International Atomic Energy Agency (hereinafter referred to as the "Agency") in accordance with the provisions of this Convention to facilitate prompt assistance in the event of a nuclear accident or radiological emergency to minimize its consequences and to protect life, property and the environment from the effects of radioactive releases.
2. To facilitate such cooperation States Parties may agree on bilateral or multilateral arrangements or, where appropriate, a combination of these, for preventing or minimizing injury and damage which may result in the event of a nuclear accident or radiological emergency.
3. The States Parties request the Agency, acting within the framework of its Statute, to use its best endeavours in accordance with the provisions of this Convention to promote, facilitate and support the cooperation between States Parties provided for in this Convention.

Article 2

Provision of assistance

1. If a State Party needs assistance in the event of a nuclear accident or radiological emergency, whether or not such accident or emergency originates within its territory, jurisdiction or control, it may call for such assistance from any other State Party, directly or through the Agency, and from the Agency, or, where appropriate, from other international intergovernmental organizations (hereinafter referred to as "international organizations").
2. A State Party requesting assistance shall specify the scope and type of assistance required and, where practicable, provide the assisting party with such information as may be necessary for that party to determine the extent to which it is able to meet the request. In the event that it is not practicable for the requesting State Party to specify the scope and type of assistance required, the requesting State Party and the assisting party shall, in consultation, decide upon the scope and type of assistance required.
3. Each State Party to which a request for such assistance is directed shall promptly decide and notify the requesting State Party, directly or through the Agency, whether it is in a position to render the assistance requested, and the scope and terms of the assistance that might be rendered.
4. States Parties shall, within the limits of their capabilities, identify and notify the Agency of experts, equipment and materials which could be made available for the provision of assistance to other States Parties in the event of a nuclear accident or radiological emergency as well as the terms, especially financial, under which such assistance could be provided.
5. Any State Party may request assistance relating to medical treatment or temporary relocation into the territory of another State Party of people involved in a nuclear accident or radiological emergency.
6. The Agency shall respond, in accordance with its Statute and as provided for in this Convention, to a requesting State Party's or a Member State's request for assistance in the event of a nuclear accident or radiological emergency by:
 - (a) making available appropriate resources allocated for this purpose;
 - (b) transmitting promptly the request to other States and international organizations which, according to the Agency's information, may possess the necessary resources; and
 - (c) if so requested by the requesting State, co-ordinating the assistance at the international level which may thus become available.

Article 3

Direction and control of assistance

Unless otherwise agreed:

- (a) the overall direction, control, co-ordination and supervision of the assistance shall be the responsibility within its territory of the requesting State. The assisting party should, where the assistance involves personnel, designate in consultation with the requesting State, the person who should be in charge of and retain immediate operational supervision over the personnel and the equipment provided by it. The designated person should exercise such supervision in cooperation with the appropriate authorities of the requesting State;

- (b) the requesting State shall provide, to the extent of its capabilities, local facilities and services for the proper and effective administration of the assistance. It shall also ensure the protection of personnel, equipment and materials brought into its territory by or on behalf of the assisting party for such purpose;
- (c) ownership of equipment and materials provided by either party during the periods of assistance shall be unaffected, and their return shall be ensured;
- (d) a State Party providing assistance in response to a request under paragraph 5 of article 2 shall co-ordinate that assistance within its territory.

Article 4

Competent authorities and points of contact

1. Each State Party shall make known to the Agency and to other States Parties, directly or through the Agency, its competent authorities and point of contact authorized to make and receive requests for and to accept offers of assistance. Such points of contact and a focal point within the Agency shall be available continuously.
2. Each State Party shall promptly inform the Agency of any changes that may occur in the information referred to in paragraph 1.
3. The Agency shall regularly and expeditiously provide to States Parties, Member States and relevant international organizations the information referred to in paragraphs 1 and 2.

Article 5

Functions of the Agency

The States Parties request the Agency, in accordance with paragraph 3 of article 1 and without prejudice to other provisions of this Convention, to:

- (a) collect and disseminate to States Parties and Member States information concerning:
 - (i) experts, equipment and materials which could be made available in the event of nuclear accidents or radiological emergencies;
 - (ii) methodologies, techniques and available results of research relating to response to nuclear accidents or radiological emergencies;
- (b) assist a State Party or a Member State when requested in any of the following or other appropriate matters:
 - (i) preparing both emergency plans in the case of nuclear accidents and radiological emergencies and the appropriate legislation;
 - (ii) developing appropriate training programmes for personnel to deal with nuclear accidents and radiological emergencies;
 - (iii) transmitting requests for assistance and relevant information in the event of a nuclear accident or radiological emergency;
 - (iv) developing appropriate radiation monitoring programmes, procedures and standards;
 - (v) conducting investigations into the feasibility of establishing appropriate radiation monitoring systems;

- (c) make available to a State Party or a Member State requesting assistance in the event of a nuclear accident or radiological emergency appropriate resources allocated for the purpose of conducting an initial assessment of the accident or emergency;
- (d) offer its good offices to the States Parties and Member States in the event of a nuclear accident or radiological emergency;
- (e) establish and maintain liaison with relevant international organizations for the purposes of obtaining and exchanging relevant information and data, and make a list of such organizations available to States Parties, Member States and the aforementioned organizations.

Article 6

Confidentiality and public statements

1. The requesting State and the assisting party shall protect the confidentiality of any confidential information that becomes available to either of them in connection with the assistance in the event of a nuclear accident or radiological emergency. Such information shall be used exclusively for the purpose of the assistance agreed upon.
2. The assisting party shall make every effort to coordinate with the requesting State before releasing information to the public on the assistance provided in connection with a nuclear accident or radiological emergency.

Article 7

Reimbursement of costs

1. An assisting party may offer assistance without costs to the requesting State. When considering whether to offer assistance on such a basis, the assisting party shall take into account:
 - (a) the nature of the nuclear accident or radiological emergency;
 - (b) the place of origin of the nuclear accident or radiological emergency;
 - (c) the needs of developing countries;
 - (d) the particular needs of countries without nuclear facilities; and
 - (e) any other relevant factors.
2. When assistance is provided wholly or partly on a reimbursement basis, the requesting State shall reimburse the assisting party for the costs incurred for the services rendered by persons or organizations acting on its behalf, and for all expenses in connection with the assistance to the extent that such expenses are not directly defrayed by the requesting State. Unless otherwise agreed, reimbursement shall be provided promptly after the assisting party has presented its request for reimbursement to the requesting State, and in respect of costs other than local costs, shall be freely transferrable.
3. Notwithstanding paragraph 2, the assisting party may at any time waive, or agree to the postponement of, the reimbursement in whole or in part. In considering such waiver or postponement, assisting parties shall give due consideration to the needs of developing countries.

Article 8**Privileges, immunities and facilities**

1. The requesting State shall afford to personnel of the assisting party and personnel acting on its behalf the necessary privileges, immunities and facilities for the performance of their assistance functions.
2. The requesting State shall afford the following privileges and immunities to personnel of the assisting party or personnel acting on its behalf who have been duly notified to and accepted by the requesting State:
 - (a) immunity from arrest, detention and legal process, including criminal, civil and administrative jurisdiction, of the requesting State, in respect of acts or omissions in the performance of their duties; and
 - (b) exemption from taxation, duties or other charges, except those which are normally incorporated in the price of goods or paid for services rendered, in respect of the performance of their assistance functions.
3. The requesting State shall:
 - (a) afford the assisting party exemption from taxation, duties or other charges on the equipment and property brought into the territory of the requesting State by the assisting party for the purpose of the assistance; and
 - (b) provide immunity from seizure, attachment or requisition of such equipment and property.
4. The requesting State shall ensure the return of such equipment and property. If requested by the assisting party, the requesting State shall arrange, to the extent it is able to do so, for the necessary decontamination of recoverable equipment involved in the assistance before its return.
5. The requesting State shall facilitate the entry into, stay in and departure from its national territory of personnel notified pursuant to paragraph 2 and of equipment and property involved in the assistance.
6. Nothing in this article shall require the requesting State to provide its nationals or permanent residents with the privileges and immunities provided for in the foregoing paragraphs.
7. Without prejudice to the privileges and immunities, all beneficiaries enjoying such privileges and immunities under this article have a duty to respect the laws and regulations of the requesting State. They shall also have the duty not to interfere in the domestic affairs of the requesting State.
8. Nothing in this article shall prejudice rights and obligations with respect to privileges and immunities afforded pursuant to other international agreements or the rules of customary international law.
9. When signing, ratifying, accepting, approving or acceding to this Convention, a State may declare that it does not consider itself bound in whole or in part by paragraphs 2 and 3.
10. A State Party which has made a declaration in accordance with paragraph 9 may at any time withdraw it by notification to the depositary.

Article 9**Transit of personnel, equipment and property**

Each State Party shall, at the request of the requesting State or the assisting party, seek to facilitate the transit through its territory of duly notified personnel, equipment and property involved in the assistance to and from the requesting State.

Article 10**Claims and compensation**

1. The States Parties shall closely cooperate in order to facilitate the settlement of legal proceedings and claims under this article.
2. Unless otherwise agreed, a requesting State shall in respect of death or of injury to persons, damage to or loss of property, or damage to the environment caused within its territory or other area under its jurisdiction or control in the course of providing the assistance requested:
 - (a) not bring any legal proceedings against the assisting party or persons or other legal entities acting on its behalf;
 - (b) assume responsibility for dealing with legal proceedings and claims brought by third parties against the assisting party or against persons or other legal entities acting on its behalf;
 - (c) hold the assisting party or persons or other legal entities acting on its behalf harmless in respect of legal proceedings and claims referred to in sub-paragraph (b); and
 - (d) compensate the assisting party or persons or other legal entities acting on its behalf for:
 - (i) death of or injury to personnel of the assisting party or persons acting on its behalf;
 - (ii) loss of or damage to non-consumable equipment or materials related to the assistance;except in cases of wilful misconduct by the individuals who caused the death, injury, loss or damage.
3. This article shall not prevent compensation or indemnity available under any applicable international agreement or national law of any State.
4. Nothing in this article shall require the requesting State to apply paragraph 2 in whole or in part to its nationals or permanent residents.
5. When signing, ratifying, accepting, approving or acceding to this Convention, a State may declare:
 - (a) that it does not consider itself bound in whole or in part by paragraph 2;
 - (b) that it will not apply paragraph 2 in whole or in part in cases of gross negligence by the individuals who caused the death, injury, loss or damage.
6. A State Party which has made a declaration in accordance with paragraph 5 may at any time withdraw it by notification to the depositary.

Article 11

Termination of assistance

The requesting State or the assisting party may at any time, after appropriate consultations and by notification in writing, request the termination of assistance received or provided under this Convention. Once such a request has been made, the parties involved shall consult with each other to make arrangements for the proper conclusion of the assistance.

Article 12

Relationship to other international agreements

This Convention shall not affect the reciprocal rights and obligations of States Parties under existing international agreements which relate to the matters covered by this Convention, or under future international agreements concluded in accordance with the object and purpose of this Convention.

Article 13

Settlement of disputes

1. In the event of a dispute between States Parties, or between a State Party and the Agency, concerning the interpretation or application of this Convention, the parties to the dispute shall consult with a view to the settlement of the dispute by negotiation or by any other peaceful means of settling disputes acceptable to them.
2. If a dispute of this character between States Parties cannot be settled within one year from the request for consultation pursuant to paragraph 1, it shall, at the request of any party to such dispute, be submitted to arbitration or referred to the International Court of Justice for decision. Where a dispute is submitted to arbitration, if, within six months from the date of the request, the parties to the dispute are unable to agree on the organization of the arbitration, a party may request the President of the International Court of Justice or the Secretary-General of the United Nations to appoint one or more arbitrators. In cases of conflicting requests by the parties to the dispute, the request to the Secretary-General of the United Nations shall have priority.
3. When signing, ratifying, accepting, approving or acceding to this Convention, a State may declare that it does not consider itself bound by either or both of the dispute settlement procedures provided for in paragraph 2. The other States Parties shall not be bound by a dispute settlement procedure provided for in paragraph 2 with respect to a State Party for which such a declaration is in force.
4. A State Party which has made a declaration in accordance with paragraph 3 may at any time withdraw it by notification to the depositary.

Article 14

Entry into force

1. This Convention shall be open for signature by all States and Namibia, represented by the United Nations Council for Namibia, at the Headquarters of the International Atomic Energy Agency in Vienna and at the Headquarters of the United Nations in New York, from 26 September 1986 and

6 October 1986 respectively, until its entry into force or for twelve months, whichever period is longer.

2. A State and Namibia, represented by the United Nations Council for Namibia, may express its consent to be bound by this Convention either by signature, or by deposit of an instrument of ratification, acceptance or approval following signature made subject to ratification, acceptance or approval, or by deposit of an instrument of accession. The instruments of ratification, acceptance, approval or accession shall be deposited with the depositary.
3. This Convention shall enter into force thirty days after consent to be bound has been expressed by three States.
4. For each State expressing consent to be bound by this Convention after its entry into force, this Convention shall enter into force for that State thirty days after the date of expression of consent.
5.
 - (a) This Convention shall be open for accession, as provided for in this article, by international organizations and regional integration organizations constituted by sovereign States, which have competence in respect of the negotiation, conclusion and application of international agreements in matters covered by this Convention.
 - (b) In matters within their competence such organizations shall, on their own behalf, exercise the rights and fulfil the obligations which this Convention attributes to States Parties.
 - (c) When depositing its instrument of accession, such an organization shall communicate to the depositary a declaration indicating the extent of its competence in respect of matters covered by this Convention.
 - (d) Such an organization shall not hold any vote additional to those of its Member States.

Article 15

Provisional application

A State may, upon signature or at any later date before this Convention enters into force for it, declare that it will apply this Convention provisionally.

Article 16

Amendments

1. A State Party may propose amendments to this Convention. The proposed amendment shall be submitted to the depositary who shall circulate it immediately to all other States Parties.
2. If a majority of the States Parties request the depositary to convene a conference to consider the proposed amendments, the depositary shall invite all States Parties to attend such a conference to begin not sooner than thirty days after the invitations are issued. Any amendment adopted at the conference by a two-thirds majority of all States Parties shall be laid down in a protocol which is open to signature in Vienna and New York by all States Parties.
3. The protocol shall enter into force thirty days after consent to be bound has been expressed by three States. For each State expressing consent to be bound by the protocol after its entry into force, the protocol shall enter into force for that State thirty days after the date of expression of consent.

Article 17**Denunciation**

1. A State Party may denounce this Convention by written notification to the depositary.
2. Denunciation shall take effect one year following the date on which the notification is received by the depositary.

Article 18**Depositary**

1. The Director General of the Agency shall be the depositary of this Convention.
2. The Director General of the Agency shall promptly notify States Parties and all other States of:
 - (a) each signature of this Convention or any protocol of amendment;
 - (b) each deposit of an instrument of ratification, acceptance, approval or accession concerning this Convention or any protocol of amendment;
 - (c) any declaration or withdrawal thereof in accordance with articles 8, 10 and 13;
 - (d) any declaration of provisional application of this Convention in accordance with article 15;
 - (e) the entry into force of this Convention and of any amendment thereto; and
 - (f) any denunciation made under article 17.

Article 19**Authentic texts and certified copies**

The original of this Convention, of which the Arabic, Chinese, English, French, Russian and Spanish texts are equally authentic, shall be deposited with the Director General of the International Atomic Energy Agency who shall send certified copies to States Parties and all other States.

IN WITNESS WHEREOF the undersigned, being duly authorized, have signed this Convention, open for signature as provided for in paragraph 1 of article 14.

ADOPTED by the General Conference of the International Atomic Energy Agency meeting in special session at Vienna on the twenty-sixth day of September one thousand nine hundred and eighty-six.

MEMBERSHIP OF THE HEALTH ASSEMBLY

LIST OF DELEGATES AND OTHER PARTICIPANTS¹

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Alternate

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¹ Bilingual list, as issued in document WHA41/DIV/3 Rev.1 on 6 May 1988, with the incorporation of corrections subsequently received.

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BURUNDI

Chief Delegate

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Delegate

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CENTRAL AFRICAN REPUBLIC

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CHILEChief Delegate

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CHINAChief Delegate

Professor CHEN Minzhang, Minister of Public Health

Deputy Chief Delegate

Mr SONG Yunfu, Director, Bureau of Foreign Affairs, Ministry of Public Health

Delegate

Mr CAO Yonglin, Deputy Director, Bureau of Foreign Affairs, Ministry of Public Health (Chief Delegate from 7 May)

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Deputy Chief Delegate

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COMOROSDelegate

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CONGOChief Delegate

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COOK ISLANDSChief Delegate

Dr T. MAOATE, Minister of Health

Delegate

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COSTA RICAChief Delegate

Dr E. MOHS, Ministre de la Santé

Delegates

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DEMOCRATIC KAMPUCHEA

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Deputy Chief Delegate

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Delegate

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DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

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DEMOCRATIC YEMENChief Delegate

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DJIBOUTIChief Delegate

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Delegate

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EQUATORIAL GUINEA

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Delegate

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ETHIOPIA

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FINLANDChief Delegate

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GABON

Chief Delegate

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Deputy Chief Delegate

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GAMBIA

Chief Delegate

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GERMAN DEMOCRATIC REPUBLIC

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Professor R. MÜLLER, Deputy Minister of Health
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GERMANY, FEDERAL REPUBLIC OF

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GUINEAChief Delegate

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Deputy Chief Delegate

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Delegate

Dr M. CISSE, Directeur des Maladies
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GUINEA-BISSAUChief Delegate

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ICELANDChief Delegate

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Delegates

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(Chief Delegate from 7 May)

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INDIAChief Delegate

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IRAN (ISLAMIC REPUBLIC OF)

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IRELAND

Chief Delegate

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Deputy Chief Delegate

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Nations Office and the Specialized Agencies
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(Chief Delegate from 6 May)

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ISRAEL

Chief Delegate

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Deputy Chief Delegate

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(Chief Delegate on 2 and 3 May)

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(Chief Delegate from 7 May)

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ITALYChief Delegate

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Deputy Chief Delegate

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 Professeur F. POCCHIARI, Directeur général de l'Istituto Superiore di Sanità
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Deputy Chief Delegate

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 (Chief Delegate from 8 May)

Delegate

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LAO PEOPLE'S DEMOCRATIC REPUBLICChief Delegate

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Delegate

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LEBANONChief Delegate

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Delegates

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Alternate

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LESOTHOChief Delegate

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Deputy Chief Delegate

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LIBERIAChief Delegate

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Delegates

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Dr Leonora I. LARTSON, Ministry of Health and Social Welfare

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LIBYAN ARAB JAMAHIRIYAChief Delegate

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Delegates

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LUXEMBOURG

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Deputy Chief Delegate

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MADAGASCAR

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MALAWI

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Deputy Chief Delegate

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MAURITIUSChief Delegate

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Dr J. C. MOHITH, Chief Medical Officer,
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INDEX TO RESOLUTIONS AND DECISIONS

(Numerals bearing the symbol "WHA41..." refer to resolutions; numerals alone in parentheses refer to decisions)

	<u>Page</u>		<u>Page</u>
Accidents, nuclear, conventions (9) ..	36	Director-General, appointment	
Afghanistan, health assistance		(WHA41.1)	1
(WHA41.33)	31	contract (WHA41.2)	1
Africa, southern, liberation struggle		financial report for 1986-1987	
(WHA41.23)	19	(WHA41.5)	2
Agenda, adoption (6)	35	report on the work of WHO in	
AIDS, avoidance of discrimination		1986-1987 (8)	36
regarding patients and infected		salary and allowances (WHA41.14) ...	12
persons (WHA41.24)	20	Director-General Emeritus, title	
Appropriation resolution for		conferred on Dr Mahler (WHA41.3) .	1
1988-1989, revised (WHA41.10)	7	Director-General's Development	
Arab population of the occupied Arab		Programme (WHA41.23)	19
territories, including Palestine,		Displaced persons and refugees, health	
health conditions (WHA41.8)	4	assistance, in Cyprus (WHA41.22) .	19
Assistant Directors-General, salaries		in southern Africa (WHA41.23)	19
and allowances (WHA41.14)	12	Drugs, medicinal, ethical criteria for	
Breast-feeding (WHA41.11)	9	promotion (WHA41.17)	14
Budget, <u>see</u> Appropriation Resolution		rational use of (WHA41.16)	13
Certification Scheme on the Quality of		<u>see also</u> Medicinal plants;	
Pharmaceutical Products Moving in		Pharmaceutical products	
International Commerce (WHA41.18). .	15	Eastern Mediterranean, Regional	
Children, nutrition (WHA41.11)	9	Office, extension (WHA41.13)	11
Code of marketing, breast-milk		Embargo on medical supplies and its	
substitutes (WHA41.11).....	9	effects on health care (WHA41.31). .	30
Committee on Credentials,		Environment and Development, World	
composition (1)	34	Commission, report (WHA41.15)	12
Committee on Nominations,		Epidemiology, role in attaining health	
composition (2)	34	for all (WHA41.27)	25
Contributions, incentive scheme for		Ethical criteria for medicinal drug	
payment of (WHA41.12)	10	promotion (WHA41.17)	14
Members in arrears (WHA41.20)	16	Executive Board, election of Members	
statement of principles (WHA41.7). .	3	entitled to designate a person to	
status of collection (WHA41.6)	3	serve on (10)	36
Conventions concerning nuclear		reports on eightieth and	
accidents (9)	36	eighty-first sessions (13)	37
Credentials, Committee on,		Expanded Programme on Immunization	
composition (1)	34	(WHA41.28)	26
verification (7)	35	External Auditor, report to the Health	
Cyprus, health assistance to refugees		Assembly (WHA41.5).....	2
and displaced persons (WHA41.22) .	19	Family planning, integration of	
Deputy Director-General, salary and		activities with those of maternal	
allowances (WHA41.14)	12	and child health (WHA41.9)	6

	<u>Page</u>		<u>Page</u>
Financial Regulations, amendment (WHA41.12)	10	Officers of the Forty-first World Health Assembly (3)	34
Financial report for 1986-1987 (WHA41.5)	2	main committees (4)	34
Food, radionuclides in, WHO guidelines for derived intervention levels (WHA41.29)	28	Organization of African Unity (WHA41.23)	19
Front-line States in southern Africa, assistance to (WHA41.23)	19	Palestine Liberation Organization (WHA41.8)	4
General Committee, establishment (5) .	35	Panama, difficult health situation (WHA41.32)	30
Health Assembly, <u>see</u> World Health Assembly		Pension Board, United Nations Joint Staff, annual report for 1986 (11)	37
Health for All by the Year 2000, Global Strategy (WHA41.34)	31	Pension Committee, WHO Staff, appointment of representatives (12)	37
leadership development for (WHA41.26)	22	Pharmaceutical Products Moving in International Commerce, WHO Certification Scheme on Quality of (WHA41.18)	15
role of epidemiology in attaining (WHA41.27)	25	Poliomyelitis, global eradication by the year 2000 (WHA41.28)	26
HIV-infected people, avoidance of discrimination (WHA41.24)	20	Primary health care, strengthening (WHA41.34)	31
Human reproduction research (WHA41.9)	6	Radionuclides in food, WHO guidelines for derived intervention levels (WHA41.29)	28
Immunization, expanded programme (WHA41.28)	26	Rational use of drugs (WHA41.16)	13
Incentive scheme for payment of contributions (WHA41.12)	10	Real Estate Fund (WHA41.13)	11
Infant and young child nutrition (WHA41.11)	9	Refugees and displaced persons, health assistance, in Cyprus (WHA41.22) .	19
International Code of Marketing of Breast-milk Substitutes (WHA41.11)	9	in southern Africa (WHA41.23)	19
Leadership development for health for all (WHA41.26)	22	Regional Directors, salaries and allowances (WHA41.14)	12
Lebanon, health and medical assistance (WHA41.21)	17	Regional Office for the Eastern Mediterranean, extension (WHA41.13)	11
Lesotho, health assistance (WHA41.23). 19	19	Research on human reproduction (WHA41.9)	6
Liberation struggle in southern Africa (WHA41.23)	19	Rotary International, "Polio Plus" initiative (WHA41.28)	26
Mahler, Dr Halfdan T., expression of appreciation to (WHA41.3)	1	Rules of Procedure of the Health Assembly, amendments (WHA41.4) ...	2
Medical supplies, effects on health care of withholding (WHA41.31) ...	30	Salaries and allowances, for ungraded posts and the Director-General (WHA41.4)	2
Medicinal plants (WHA41.19)	15	Smoking (WHA41.25)	22
Nominations, Committee on, composition (2)	1	Southern Africa, liberation struggle (WHA41.23)	19
Non-aligned and other developing countries, technical cooperation (WHA41.30)	29	Special Programme of Research, Development and Research Training in Human Reproduction (WHA41.9) ..	6
Nuclear accidents, conventions (9) ...	36	Staff Pension Committee, WHO, appointment of representatives (12)	37
Nutrition, infant and young child (WHA41.11)	9	Supplies, medical, effects on health care of withholding (WHA41.31) ...	30

	<u>Page</u>		<u>Page</u>
Swaziland, health assistance (WHA41.23)	19	United Nations Relief and Works Agency for Palestine refugees in the Near East (WHA41.8)	4
Technical cooperation among developing countries (WHA41.30; WHA41.32) ..	29,30	United Nations system, collaboration regarding health assistance, Afghanistan (WHA41.33)	31
Technical Discussions, report on (WHA41.26)	22	Cyprus (WHA41.22)	19
Tobacco (WHA41.25)	22	Lebanon (WHA41.21)	17
Traditional medicine (WHA41.19)	15	WHO Staff Pension Committee, appointment of representatives (12)	37
United Nations Children's Fund, collaboration in Expanded Programme on Immunization (WHA41.28)	26	Working Capital Fund, status of advances (WHA41.6)	3
United Nations Development Programme, co-sponsorship of special programme on human reproduction (WHA41.9) ..	6	World Bank, co-sponsorship of special programme on human reproduction (WHA41.9)	6
United Nations Joint Staff Pension Board, annual report for 1986 (11)	37	World Commission on Environment and Development, report (WHA41.15) ...	12
United Nations Population Fund, co-sponsorship of special programme on human reproduction (WHA41.9)	6	World Health Assembly, amendments to the Rules of Procedure (WHA41.4) .	2
		Forty-first, officers (3)	34
		Forty-second, country of meeting (14)	37