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WHA51/1998/REC/1



WORLD HEALTH ORGANIZATION

FIFTY-FIRST WORLD HEALTH ASSEMBLY

GENEVA, 11-16 MAY 1998

**RESOLUTIONS AND DECISIONS
ANNEXES**

**GENEVA
1998**

WHA51/1998/REC/1

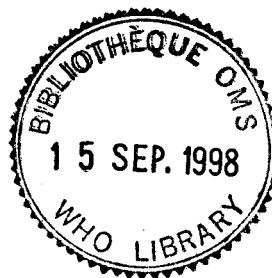


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RESOLUTIONS AND DECISIONS
ANNEXES



GENEVA
1998

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACC	- Administrative Committee on Coordination	NORAD	- Norwegian Agency for International Development
ACHR	- Advisory Committee on Health Research	OAU	- Organization of African Unity
AGFUND	- Arab Gulf Programme for United Nations Development Organizations	OECD	- Organisation for Economic Co-operation and Development
ASEAN	- Association of South-East Asian Nations	PAHO	- Pan American Health Organization
CIDA	- Canadian International Development Agency	SAREC	- Swedish Agency for Research Cooperation with Developing Countries
CIOMS	- Council for International Organizations of Medical Sciences	SIDA	- Swedish International Development Authority
DANIDA	- Danish International Development Agency	UNAIDS	- United Nations Joint Programme on HIV/AIDS
ECA	- Economic Commission for Africa	UNCTAD	- United Nations Conference on Trade and Development
ECE	- Economic Commission for Europe	UNDCP	- United Nations International Drug Control Programme
ECLAC	- Economic Commission for Latin America and the Caribbean	UNDP	- United Nations Development Programme
ESCAP	- Economic and Social Commission for Asia and the Pacific	UNEP	- United Nations Environment Programme
ESCWA	- Economic and Social Commission for Western Asia	UNESCO	- United Nations Educational, Scientific and Cultural Organization
FAO	- Food and Agriculture Organization of the United Nations	UNFPA	- United Nations Population Fund
FINNIDA	- Finnish International Development Agency	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	UNRWA	- United Nations Relief and Works Agency for Palestine Refugees in the Near East
IFAD	- International Fund for Agricultural Development	UNSCEAR	- United Nations Scientific Committee on the Effects of Atomic Radiation
ILO	- International Labour Organization (Office)	USAID	- United States Agency for International Development
IMO	- International Maritime Organization	WFP	- World Food Programme
ITU	- International Telecommunication Union	WIPO	- World Intellectual Property Organization
		WMO	- World Meteorological Organization
		WTO	- World Trade 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 Fifty-first World Health Assembly was held at the Palais des Nations, Geneva, from 11 to 16 May 1998, in accordance with the decision of the Executive Board at its 100th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, annexes - document WHA51/1998/REC/1

Verbatim records of plenary meetings, list of participants - document WHA51/1998/REC/2

Summary records and reports of committees - document WHA51/1998/REC/3

CONTENTS

	Page
Preface	iii
Agenda	vii
List of documents	xi
Officers of the Health Assembly and membership of its committees	xv

RESOLUTIONS AND DECISIONS

Resolutions

WHA51.1	Status of collection of assessed contributions	1
WHA51.2	Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution	2
WHA51.3	Temporary restoration of voting privileges	3
WHA51.4	Appointment of the Director-General	3
WHA51.5	Contract of the Director-General	4
WHA51.6	Expression of appreciation to Dr Hiroshi Nakajima	4
WHA51.7	Health-for-all policy for the twenty-first century	4
WHA51.8	Concerted public health action on anti-personnel mines	6
WHA51.9	Cross-border advertising, promotion and sale of medical products using the Internet	7
WHA51.10	Ethical, scientific and social implications of cloning in human health	9
WHA51.11	Global elimination of blinding trachoma	10
WHA51.12	Health promotion	11
WHA51.13	Tuberculosis	13
WHA51.14	Elimination of transmission of Chagas disease	14
WHA51.15	Elimination of leprosy as a public health problem	15
WHA51.16	Promotion of horizontal technical cooperation in health sector reform in developing countries	16
WHA51.17	Emerging and other communicable diseases: antimicrobial resistance	18
WHA51.18	Noncommunicable disease prevention and control	19
WHA51.19	Financial report on the accounts of WHO for the financial period 1996-1997 and report of the External Auditor to the Health Assembly	20
WHA51.20	Amendments to the Financial Regulations	21
WHA51.21	Scale of assessments for the financial period 1998-1999	21
WHA51.22	Health of children and adolescents	25
WHA51.23	Amendments to Articles 24 and 25 of the Constitution	26
WHA51.24	International Decade of the World's Indigenous People	27
WHA51.25	Salaries of staff in ungraded posts and of the Director-General	28

	Page
WHA51.26	Status of members of the Executive Board: clarification of the interpretation of Article 24 of the WHO Constitution 29
WHA51.27	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine 29
WHA51.28	Strategy on sanitation for high-risk communities 31
WHA51.29	Protection of human health from threats related to climate change and stratospheric ozone depletion 33
WHA51.30	Method of work of the Health Assembly 35
WHA51.31	Regular budget allocations to regions 35

Decisions

WHA51(1)	Composition of the Committee on Credentials 37
WHA51(2)	Composition of the Committee on Nominations 37
WHA51(3)	Election of officers of the Fifty-first World Health Assembly 37
WHA51(4)	Election of officers of the main committees 37
WHA51(5)	Establishment of the General Committee 38
WHA51(6)	Adoption of the agenda 38
WHA51(7)	Verification of credentials 38
WHA51(8)	Review of <i>The world health report 1998</i> incorporating the Director-General's report on the work of WHO 39
WHA51(9)	Election of Members entitled to designate a person to serve on the Executive Board 39
WHA51(10)	Revised drug strategy 39
WHA51(11)	United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee 39
WHA51(12)	Reports of the Executive Board on its 100th and 101st sessions 40
WHA51(13)	Selection of the country in which the Fifty-second World Health Assembly will be held 40

ANNEXES

1.	Contract of the Director-General 43
2.	Casual income 45
3.	Strategy on sanitation for high-risk communities 47

INDEX

Index to resolutions and decisions 49

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. Review and approval of the reports of the Executive Board on its 100th and 101st sessions
10. Review of *The world health report 1998*
11. [deleted]
12. Director-General
 - 12.1 Appointment
 - 12.2 Approval of contract
13. Election of Members entitled to designate a person to serve on the Executive Board
14. Awards
 - 14.1 Sasakawa Health Prize
 - 14.2 United Arab Emirates Health Foundation Prize
15. Fiftieth anniversary of WHO
16. Approval of reports of main committees
17. Closure of the Fifty-first World Health Assembly

¹ The agenda was adopted at the third plenary meeting.

COMMITTEE A

18. Election of Vice-Chairmen and Rapporteur
19. Health-for-all policy for the twenty-first century
20. Implementation of resolutions (progress reports by the Director-General)
 - Task force on health in development (resolution WHA50.23)
 - Improving technical cooperation among developing countries (resolution WHA43.9)
 - Prevention of violence (resolution WHA50.19)
 - Health systems development (resolution WHA50.27)
 - Revised drug strategy (resolution WHA49.14)
 - Cross-border advertising, promotion and sale of medical products through the Internet (resolution WHA50.4)
 - Ethical, scientific and social implications of cloning in human health (resolution WHA50.37)
 - Health promotion (resolution WHA42.44)
 - Infant and young child nutrition (resolutions WHA33.32 and EB97.R13)
 - Tuberculosis (resolution WHA46.36)
 - Global elimination of blinding trachoma (resolution WHA45.10)
21. Disease prevention and control
 - 21.1 Control of tropical diseases
 - Chagas disease
 - Leprosy
 - 21.2 Revision of the International Health Regulations: progress report
 - 21.3 Emerging and other communicable diseases: antimicrobial resistance
 - 21.4 Noncommunicable diseases

AGENDA

COMMITTEE B

- 22. Election of Vice-Chairmen and Rapporteur
- 23. Financial matters
 - 23.1 Financial report on the accounts of WHO for the financial period 1996-1997, report of the External Auditor, and comments thereon of the Administration, Budget and Finance Committee (Article 18(f); Financial Regulations 11.3 and 12.9); report of the Internal Auditor
 - 23.2 Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution (resolution WHA41.7)
 - 23.3 Casual income
 - 23.4 [deleted]
 - 23.5 Amendments to the Financial Regulations
- 24. Matters related to the programme budget
 - 24.1 Efficiency plan for the financial period 1998-1999
 - 24.2 [deleted]
- 25. Scale of assessments
 - 25.1 [deleted]
 - 25.2 Scale of assessments for the financial period 1998-1999
- 26. Real Estate Fund
- 27. WHO reform
 - 27.1 Programme budget evaluation
 - 27.2 Review of the Constitution and regional arrangements of the World Health Organization (resolution WHA48.1)
- 28. Amendments to Articles 24 and 25 of the Constitution
- 29. Collaboration within the United Nations system and with other intergovernmental organizations
 - 29.1 General matters

29.2 Environmental matters

- Strategy on sanitation for high-risk communities
- Climate change and human health - WHO participation in the interagency climate agenda

29.3 International Decade of the World's Indigenous People

30. Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine
31. Personnel matters: amendments to the Staff Rules
32. United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee
33. Method of work of the Health Assembly

LIST OF DOCUMENTS¹

Assembly documents

A51/1 Rev.1	Agenda ²
A51/2	Review and approval of the reports of the Executive Board on its 100th and 101st sessions
A51/3 and Corr.1	<i>The world health report 1998. Life in the 21st century: a vision for all. Summary</i>
A51/4	Director-General. Approval of contract ³
A51/5	Health for all in the twenty-first century
A51/6 and Add.1	Implementation of resolutions and decisions. Report by the Director-General
A51/7	Disease prevention and control. Control of tropical diseases: Chagas disease and leprosy. Report by the Director-General
A51/8	Revision of the International Health Regulations: progress report. Report by the Director-General
A51/9	Emerging and other communicable diseases: antimicrobial resistance. Report by the Director-General
A51/10	Financial matters. Appointment of an External Auditor. Report by the Director-General
A51/11	Financial Report and audited financial statements for the financial period 1 January 1996 - 31 December 1997 and Report of the External Auditor to the World Health Assembly
A51/11 Add.1	Financial Report and audited financial statements for the financial period 1 January 1996 - 31 December 1997. Annex: Extrabudgetary resources for programme activities
A51/12	Financial report and audited financial statements for the financial period 1 January 1996 - 31 December 1997 and report of the External Auditor to the World Health Assembly. First report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-first World Health Assembly
A51/13	Status of collection of assessed contributions. Report by the Director-General

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

² See page vii.

³ See Annex 1.

FIFTY-FIRST WORLD HEALTH ASSEMBLY

- A51/14 Report on casual income. Report by the Director-General¹
- A51/15 Matters related to the programme budget. Efficiency plan for the financial period 1998-1999. Report by the Director-General
- A51/16 Scale of assessments for the financial period 1998-1999. Report by the Director-General
- A51/17 Real Estate Fund. Report by the Director-General
- A51/18 Amendments to Articles 24 and 25 of the Constitution. Report by the Director-General
- A51/19 Collaboration within the United Nations system and with other intergovernmental organizations. General matters. Report by the Director-General
- A51/20 Environmental matters. Strategy on sanitation for high-risk communities. Report by the Director-General²
- A51/21 Environmental matters. Climate change and human health - WHO participation in the interagency climate agenda. Report by the Director-General
- A51/22 Collaboration within the United Nations system and with other intergovernmental organizations. International Decade of the World's Indigenous People. Report by the Director-General
- A51/23 Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine. Report by the Director-General
- A51/24 United Nations Joint Staff Pension Fund. Appointment of representatives to the WHO Staff Pension Committee
- A51/25 Method of work of the Health Assembly. Report by the Director-General
- A51/26 Financial matters. Report of the Internal Auditor
- A51/27 Financial report on the accounts of WHO for the financial period 1996-1997 and report of the External Auditor. Comments of the Director-General
- A51/28 Committee on Nominations. First report
- A51/29 Committee on Nominations. Second report
- A51/30 Committee on Nominations. Third report
- A51/31 Committee on Credentials. First report
- A51/32 First report of Committee B

¹ See Annex 2.

² See Annex 3.

LIST OF DOCUMENTS

A51/33	Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution. Second report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-first World Health Assembly
A51/34	Election of Members entitled to designate a person to serve on the Executive Board
A51/35	First report of Committee A
A51/36	Second report of Committee B
A51/37	Third report of Committee B
A51/38	Second report of Committee A
A51/39	Fourth report of Committee B
A51/40	Fifth report of Committee B
A51/41	Third report of Committee A
A51/42	Fourth report of Committee A
A51/43	Committee on Credentials. Second report
A51/44	Fifth report of Committee A
A51/45	Sixth report of Committee B

Information documents

A51/INF.DOC./1	Awards. Amendments to the Statutes governing the Dr A.T. Shousha Foundation and the Sasakawa Health Prize
A51/INF.DOC./2	Implementation of resolutions and decisions. Health promotion
A51/INF.DOC./3	Implementation of resolutions and decisions. Infant and young child nutrition
A51/INF.DOC./4	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (annual report of the Director of Health, UNRWA)
A51/INF.DOC./5	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report submitted by the Permanent Observer of Palestine to the United Nations and Other Intergovernmental Organizations)
A51/INF.DOC./6	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report by the Ministry of Health of Israel)
A51/INF.DOC./7	Financial report on the accounts of WHO for the financial period 1 January 1996 - 31 December 1997. Analysis of variances between budget and actual figures

FIFTY-FIRST WORLD HEALTH ASSEMBLY

A51/INF.DOC./8 Assessed contributions of Members and Associate Members for the second year of the financial period 1998-1999

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Dr F. R. AL-MOUSAWI (Bahrain)

Vice-Presidents

Dr N. C. DLAMINI ZUMA (South Africa)
Dr A. GUZMÁN MARCELINO (Dominican
Republic)
Professor A. INSANOV (Azerbaijan)
Mr J. Y. THINLEY (Bhutan)
Dr E. PRETRICK (Federated States of
Micronesia)

Secretary

Dr H. NAKAJIMA, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Austria, Belgium, Bolivia, Democratic People's Republic of Korea, Democratic Republic of the Congo, Gabon, Iran (Islamic Republic of), Japan, Paraguay, Qatar, Senegal, The former Yugoslav Republic of Macedonia.

Chairman: Dr H.-D. RENNAU (Austria)
Vice-Chairman: Dr R. E. DULLAK (Paraguay)
Rapporteur: Dr M. TOUNG-MVE (Gabon)
Secretary: Mr T. S. R. TOPPING, Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Bahamas, Cameroon, Canada, Comoros, Djibouti, Equatorial Guinea, Estonia, France, Guatemala, Malta, Mauritania, Palau, Peru, Philippines, Russian Federation, Sao Tome and Principe, Swaziland, Thailand, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Uruguay, Uzbekistan, Viet Nam and Yemen and India (President, Fiftieth World Health Assembly, *ex officio*).

Chairman: Mr S. I. SHERVANI (India)
Secretary: Dr H. NAKAJIMA, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Argentina, Belarus, Burundi, China, Cuba, Cyprus, France, Guinea-Bissau, Jamaica, Lebanon, Niger, Russian Federation, Sierra Leone, Spain, Uganda, United Kingdom of Great Britain and Northern Ireland, United States of America.

Chairman: Dr F. R. AL-MOUSAWI (Bahrain)
Secretary: Dr H. NAKAJIMA, Director-General

MAIN COMMITTEES

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

Committee A

Chairman: Dr G. DURHAM (New Zealand)
Vice-Chairmen: Dr E. KRAG (Denmark) and
Mr B. R. POKHREL (Nepal)
Rapporteur: Professor G. H. AYUB (Pakistan)
Secretary: Dr B.-I. THYLEFORS, Director,
Programme for the Prevention of Blindness and
Deafness

Committee B

Chairman: Mr N. S. DE SILVA (Sri Lanka)
Vice-Chairmen: Dr M. NGUEMA NTUTUMU
(Equatorial Guinea) and Dr E. PIERUZZI
(Venezuela)
Rapporteur: Dr L. ROMANOVSKÁ (Czech
Republic)
Secretary: Mr A. K. ASAMOAH, Coordinator,
Constitutional Reforms, Staff Security and
Efficiency Measures

RESOLUTIONS

WHA51.1 Status of collection of assessed contributions

The Fifty-first World Health Assembly,

Noting with concern that, as at 31 December 1997:

- (a) the rate of collection in 1997 of contributions to the effective working budget for that year amounted to 78.27%, leaving US\$ 91 110 877 unpaid;
- (b) only 105 Members had paid their contributions to the effective working budget for that year in full, and 61 Members had made no payment;
- (c) total unpaid contributions in respect of 1997 and prior years exceeded US\$ 174 million,

1. EXPRESSES deep concern at the continuing high level of outstanding contributions, which has had a deleterious effect on programmes and on the financial situation;
2. CALLS THE ATTENTION of all Members to Financial Regulation 5.6, which provides that instalments of contributions shall be considered as due and payable in full by the first day of the year to which they relate, and to the importance of paying contributions as early as possible to enable the Director-General to implement the programme budget in an orderly manner;
3. REMINDS Members that, as a result of the adoption, by resolution WHA41.12, of an incentive scheme to promote the timely payment of assessed contributions, those that pay their assessed contributions early in the year in which they are due will have their contributions payable for a subsequent programme budget reduced appreciably, whereas Members paying later will see their contributions payable for that subsequent programme budget reduced only marginally or not at all;
4. URGES Members that are systematically late in the payment of their contributions to take immediate steps to ensure prompt and regular payment;
5. REQUESTS the Director-General to continue to review, taking into account developments in other organizations in the United Nations system, all additional measures that may be appropriate to the circumstances of WHO with a view to ensuring a sound financial basis for programmes and to report on this matter to the Executive Board at its 103rd session and to the Fifty-second World Health Assembly;
6. FURTHER REQUESTS the Director-General to draw this resolution to the attention of all Members.

(Fourth plenary meeting, 12 May 1998 -
Committee B, first report)

WHA51.2 Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution

The Fifty-first World Health Assembly,

Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-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 been informed that the voting privileges of Venezuela had been restored as a result of payments made which reduced its unpaid prior years' arrears of contributions to a level below that indicated in resolution WHA41.7, and that one Member, Mauritania, had made a payment subsequent to 30 April 1998, which was sufficient for that Member's voting privileges to be restored as from the opening of the Fifty-first World Health Assembly;

Noting that, at the time of opening of the Fifty-first World Health Assembly, the voting rights of Antigua and Barbuda, Armenia, Azerbaijan, Chad, Comoros, Dominican Republic, Equatorial Guinea, Georgia, Guinea-Bissau, Iraq, Kazakhstan, Kyrgyzstan, Latvia, Liberia, Niger, Republic of Moldova, Somalia, Tajikistan, Turkmenistan, Ukraine and Yugoslavia remained suspended, such suspension to continue until the arrears of the Member States concerned have been reduced, at the present or future Health Assemblies, to a level below the amount which would justify invoking Article 7 of the Constitution;

Noting that, in accordance with resolution WHA50.8, the voting privileges of Afghanistan, Central African Republic and Djibouti and, in accordance with resolution WHA50.22, the voting privileges of Bosnia and Herzegovina, have been suspended as from 11 May 1998, such suspension to continue until the arrears of the Member States concerned have been reduced, at the present or future Health Assemblies, to a level below the amount which would justify invoking Article 7 of the Constitution;

Noting that Belarus, Burundi, Ecuador, Gambia and Mali were in arrears at the time of the opening of the Fifty-first World Health Assembly to such an extent that it was necessary for the Health Assembly to consider, in accordance with Article 7 of the Constitution, whether or not the voting privileges of these Members should be suspended at the opening of the Fifty-second World Health Assembly;

Having been informed that as a result of a payment received subsequent to 30 April 1998, the arrears of Peru have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution,

1. EXPRESSES concern at the large number of Members that have been in arrears in the payment of their contributions in recent years to an extent which would justify invoking Article 7 of the Constitution and the unprecedented level of contributions owed by them;
2. URGES the Members concerned to regularize their position at the earliest possible date;
3. FURTHER URGES Members that have not communicated their intention to settle their arrears to do so as a matter of urgency;
4. REQUESTS the Director-General to approach the Members in arrears to an extent which would justify invoking Article 7 of the Constitution, with a view to pursuing the question with the governments concerned;
5. REQUESTS the Executive Board, in the light of the Director-General's report to the Board at its 103rd session in 1999, and after the Members concerned have had an opportunity to explain their situation to the Board, to report to the Fifty-second World Health Assembly on the status of payment of contributions;

¹ Document A51/33.

6. DECIDES:

- (1) that in accordance with the statement of principles in resolution WHA41.7 if, by the time of the opening of the Fifty-second World Health Assembly, Belarus, Burundi, Ecuador, Gambia and Mali are still in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution, their voting privileges shall be suspended as from the said opening;
- (2) that any suspension which takes effect as aforesaid shall continue at the Fifty-second and subsequent Health Assemblies, until the arrears of the Member concerned have been reduced to a level below the amount which would justify invoking Article 7 of the Constitution;
- (3) that this decision shall be without prejudice to the right of any Member to request restoration of its voting privileges in accordance with Article 7 of the Constitution.

(Fourth plenary meeting, 12 May 1998 -
Committee B, first report)

WHA51.3 Temporary restoration of voting privileges

The Fifty-first World Health Assembly,

Having regard to resolutions WHA44.12, WHA45.8, WHA46.10, WHA47.18, WHA48.6, WHA49.4 and WHA50.8;

In recognition of the fiftieth anniversary of the World Health Organization,

1. DECIDES to restore, on a temporary basis only, for agenda item 12 of the Fifty-first World Health Assembly, the voting privileges of all Members whose voting privileges are currently suspended;
2. CONFIRMS that such restoration is without prejudice (i) to application of the aforesaid Health Assembly resolutions for all other agenda items of the Fifty-first World Health Assembly and (ii) to the continuing obligation of all Members to meet in full their financial commitments to the Organization.

(Fourth plenary meeting, 12 May 1998 -
Committee B, first report)

WHA51.4 Appointment of the Director-General

The Fifty-first World Health Assembly,

On the nomination of the Executive Board,

APPOINTS Dr Gro Harlem Brundtland as Director-General of the World Health Organization.

(Sixth plenary meeting, 13 May 1998)

WHA51.5 Contract of the Director-General

The Fifty-first World Health Assembly,

I

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

APPROVES the contract establishing the terms and conditions of appointment, salary and other emoluments for the post of Director-General,¹ with the addition of the following amendment to section II. (1):

“The Director-General shall not participate in the United Nations Joint Staff Pension Fund and shall instead receive as a monthly supplement the contribution that the Organization would have paid each month to the Pension Fund had the Director-General been a participant.”

II

Pursuant to Rule 112 of the Rules of Procedure of the Health Assembly,

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

(Sixth plenary meeting, 13 May 1998)

WHA51.6 Expression of appreciation to Dr Hiroshi Nakajima

The Fifty-first World Health Assembly,

Expressing its profound gratitude to Dr Hiroshi Nakajima for his outstanding services to health and development the world over throughout his long career in WHO, and in particular as its Director-General from 1988 to 1998;

Paying tribute to his personal qualities of integrity, sincerity and deep commitment to WHO and everything it stands for,

DECLARES Dr Hiroshi Nakajima Director-General Emeritus of the World Health Organization as from the date of his retirement.

(Sixth plenary meeting, 13 May 1998)

WHA51.7 Health-for-all policy for the twenty-first century

The Fifty-first World Health Assembly,

Recalling resolution WHA48.16;

Recognizing the report “Health-for-all in the twenty-first century” as a framework for the development of future policy,²

¹ See Annex 1.

² Document A51/5.

ADOPTS in the sense of Article 23 of the Constitution the World Health Declaration annexed to the present resolution.

Annex

WORLD HEALTH DECLARATION

I

We, the Member States of the World Health Organization (WHO), reaffirm our commitment to the principle enunciated in its Constitution that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being; in doing so, we affirm the dignity and worth of every person, and the equal rights, equal duties and shared responsibilities of all for health.

II

We recognize that the improvement of the health and well-being of people is the ultimate aim of social and economic development. We are committed to the ethical concepts of equity, solidarity and social justice and to the incorporation of a gender perspective into our strategies. We emphasize the importance of reducing social and economic inequities in improving the health of the whole population. Therefore, it is imperative to pay the greatest attention to those most in need, burdened by ill-health, receiving inadequate services for health or affected by poverty. We reaffirm our will to promote health by addressing the basic determinants and prerequisites for health. We acknowledge that changes in the world health situation require that we give effect to the "Health-for-all policy for the twenty-first century" through relevant regional and national policies and strategies.

III

We recommit ourselves to strengthening, adapting and reforming, as appropriate, our health systems, including essential public health functions and services, in order to ensure universal access to health services that are based on scientific evidence, of good quality and within affordable limits, and that are sustainable for the future. We intend to ensure the availability of the essentials of primary health care as defined in the Declaration of Alma-Ata¹ and developed in the new policy. We will continue to develop health systems to respond to the current and anticipated health conditions, socioeconomic circumstances and needs of the people, communities and countries concerned, through appropriately managed public and private actions and investments for health.

IV

We recognize that in working towards health for all, all nations, communities, families and individuals are interdependent. As a community of nations, we will act together to meet common threats to health and to promote universal well-being.

¹ Adopted at the International Conference on Primary Health Care, Alma-Ata, 6 to 12 September 1978, and endorsed by the Thirty-second World Health Assembly in resolution WHA32.30 (May 1979).

V

We, the Member States of the World Health Organization, hereby resolve to promote and support the rights and principles, action and responsibilities enunciated in this Declaration through concerted action, full participation and partnership, calling on all peoples and institutions to share the vision of health for all in the twenty-first century, and to endeavour in common to realize it.

(Tenth plenary meeting, 16 May 1998 -
Committee A, first report)

WHA51.8 Concerted public health action on anti-personnel mines

The Fifty-first World Health Assembly,

Noting with great concern the dramatic consequences of injuries caused by anti-personnel mines, which particularly affect civilian populations and are uniquely tragic and so deserve special attention;

Recalling the Ottawa Declaration of 5 October 1996, the Brussels Declaration of 27 June 1997, and noting the progress made by the international community towards a global ban on anti-personnel mines, and the relevant decisions and initiatives taken in other forums;

Recalling Article 6 of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction, adopted in Oslo on 18 September 1997, and opened for signature on 3 December 1997, which stipulates that assistance for the care and rehabilitation of mine victims and for mine awareness programmes may be provided, *inter alia*, through the United Nations system, and international, regional or national organizations or institutions;

Recalling paragraph C.2 of resolution EB95.R17 on emergency and humanitarian action, which requests the Director-General "to advocate the protection of non-combatants and the setting-up of effective treatment and rehabilitation programmes for the victims of anti-personnel landmines, as well as the systematic management of delayed health effects of mental and physical injuries in situations of collective violence";

Recognizing the serious consequences for health caused by anti-personnel mines because they, *inter alia*, limit population mobility, prevent access to arable land, resulting in malnutrition, hamper access to health services, contribute to the spread of communicable diseases like poliomyelitis and hinder their eradication and, lastly, generate significant psychosocial disorders;

Recognizing that a total ban on anti-personnel mines will be an important contribution to global public health;

Welcoming the participation of over 120 Member States in the Ottawa Treaty Signing Ceremony from 3 to 5 December 1997;

Recognizing that WHO should contribute to coordinated activities of the United Nations system against anti-personnel mines by developing public health programmes for the prevention and control of anti-personnel-mine injury,

1. DECLARES that damage caused by the use of anti-personnel mines is a public health problem;
2. URGES all Member States to sign and ratify the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-personnel Mines and on their Destruction as soon as possible;

3. URGES governments of affected States to incorporate, as a priority, in national health plans prevention of anti-personnel-mine injury and assistance to victims, including treatment and rehabilitation;
4. URGES Member States to give due attention to the public health aspects of the Convention and provide the necessary resources to support implementation of the WHO plan of action on anti-personnel mines, bearing in mind the need for an integrated and sustainable approach;
5. URGES governments that have planted mines in the territories of other countries to provide the latter with the required maps and identification of the minefields they planted and to cooperate in minefield clearance in the countries concerned so as to avoid further injuries and deaths of civilians;
6. REQUESTS the Director-General, within the limits of available regular and extrabudgetary resources and in close cooperation with governments, appropriate organizations of the United Nations system and intergovernmental and nongovernmental organizations:
 - (1) to strengthen the capacity of affected States for the planning and execution of programmes for:
 - (a) better assessment of the effects of anti-personnel-mine injuries on health through the establishment or reinforcement of surveillance systems;
 - (b) the promotion of mine awareness and prevention programmes through health education, in cooperation with interested parties;
 - (c) strengthening and improvement of emergency and post-emergency management of anti-personnel-mine injuries, including treatment and rehabilitation, with special attention to psychosocial rehabilitation and within the context of integrated health service delivery;
 - (2) to support policy and programme planning by establishing, with other interested parties and as part of an integrated database for the United Nations system, a clearing-house for information on public health aspects of the use of mines.

(Tenth plenary meeting, 16 May 1998 -
Committee A, second report)

WHA51.9 Cross-border advertising, promotion and sale of medical products using the Internet

The Fifty-first World Health Assembly,

Recalling resolution WHA50.4, "Cross-border advertising, promotion and sale of medical products using the Internet", requesting the Director-General to convene a WHO ad hoc working group to formulate recommendations on cross-border advertising, promotion, and sale of medical products using the Internet;

Recalling resolutions WHA41.17, WHA45.30 and WHA47.16 on ethical criteria for medicinal drug promotion;

Recognizing the value and great potential of electronic means of communication, including the Internet, for disseminating and obtaining information regarding medical products;

Recognizing the differences among Member States in their regulatory capacities, and in their approaches to cross-border advertising, promotion, and sale of medical products;

Recognizing the importance of collaboration between drug regulatory authorities in Member States and WHO, and between consumers, health professionals, and industry, on issues involving cross-border advertising, promotion, and sale of medical products using the Internet;

Recognizing the importance of national and regional legislation, regulations, guidelines, and policies to control cross-border advertising, promotion, and sale of medical products, and the importance of ensuring adherence to these regulations;

Recognizing the importance of the development and implementation of self-regulatory mechanisms, such as guidelines on good information practices, where applicable consistent with the principles embodied in the WHO Ethical Criteria for Medicinal Drug Promotion;

Bearing in mind the importance of educating and training the public to recognize the value and quality of information on medical products obtained using the Internet, and of the rational use of medical products;

Recognizing the report and recommendations of the ad hoc working group on cross-border advertising, promotion, and sale of medical products using the Internet as reflected in the Director-General's report,¹

1. URGES all Member States:

(1) to review existing legislation, regulations, and guidelines to ensure that they are applicable and adequate to cover questions of advertising, promotion, and sale of medical products using the Internet and to develop, evaluate, and implement strategies for monitoring, surveillance and enforcement;

(2) to collaborate in matters raised by use of the Internet, especially (a) the dissemination of information on difficult cases, (b) the cross-border advertising, promotion, and sale of medical products using the Internet, and (c) specific national measures for enforcement; to designate contact points for such collaboration; and to disseminate this information through WHO;

(3) to promote use of the Internet for obtaining scientific information about medical products, validated by competent health authorities to ensure the quality of this information;

2. APPEALS to industry, health professional and consumer organizations and other interested parties:

(1) to encourage their members, where appropriate, to promote the formulation and use of good information practices, where applicable consistent with the principles embodied in the WHO Ethical Criteria for Medicinal Drug Promotion;

(2) to monitor and report problem cases and aspects of cross-border advertising, promotion, and sale of medical products using the Internet;

(3) to maintain legal and ethical standards in the cross-border advertising, promotion, and sale of medical products using the Internet;

3. REQUESTS the Director-General:

(1) to encourage the international community to formulate self-regulatory guidelines for good informational practices, consistent with the principles of the WHO Ethical Criteria for Medicinal Drug Promotion;

¹ Document EB101/10, section VIII.

- (2) to develop a model guide for Member States to educate people using the Internet about the best way to obtain reliable, independent and comparative information on medical products using the Internet;
- (3) to collaborate with other appropriate international organizations and institutions on Internet issues relating to medical products;
- (4) to urge Member States to set up or strengthen mechanisms to monitor and survey cross-border advertising, promotion, and sale of medical products using the Internet, and provide technical support as required;
- (5) to urge Member States to take regulatory action, where appropriate, against violation of their national laws regarding cross-border advertising, promotion, and sale of medical products using the Internet;
- (6) to encourage Member States and nongovernmental organizations concerned to report to WHO problem cases and aspects of cross-border advertising, promotion, and sale of medical products using the Internet, and to inform Member States of problem cases and other aspects, as appropriate.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fourth report)

WHA51.10 Ethical, scientific and social implications of cloning in human health

The Fifty-first World Health Assembly,

Recalling resolution WHA50.37 and its condemnation of human cloning for reproductive purposes as contrary to human dignity;

Noting the general consensus reached at national and international levels since the Fiftieth World Health Assembly regarding human cloning for reproductive purposes;

Noting in particular UNESCO's Universal Declaration on the Human Genome and Human Rights and the Council of Europe's Additional Protocol to the Convention on Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, which deal with the prohibition of cloning of human beings;

Considering that the currently available information from animal studies involving cloning by somatic cell nuclear transfer indicates that this would be an unsafe procedure for reproductive purposes in humans;

Recognizing that developments in cloning have unprecedented ethical implications and raise serious matters for concern in terms of safety of the individual and subsequent generations of human beings,

1. REAFFIRMS that cloning for the replication of human individuals is ethically unacceptable and contrary to human dignity and integrity;
2. URGES Member States to foster continued and informed debate on these issues and to take appropriate steps, including legal and juridical measures, to prohibit cloning for the purpose of replicating human individuals;
3. REQUESTS the Director-General:
 - (1) to establish a group, involving also government experts, with the aim of clarifying concepts and developing guidelines relating to the use of cloning procedures for non-reproductive purposes;

- (2) to continue to monitor, assess and clarify, in consultation with other international organizations, national governments and professional and scientific bodies, the ethical, scientific, social and legal implications for human health of the use of cloning;
- (3) to ensure that Member States are kept informed of developments in this area in order to facilitate decisions on national regulatory frameworks;
- (4) to report to the Executive Board at its 103rd session and to the Fifty-second World Health Assembly on action taken by the Organization in this field.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fourth report)

WHA51.11 Global elimination of blinding trachoma

The Fifty-first World Health Assembly,

Recalling resolutions WHA22.29, WHA25.55 and WHA28.54 on the prevention of blindness, and WHA45.10 on disability prevention and rehabilitation;

Aware of previous efforts and progress made in the global fight against infectious eye diseases, in particular trachoma;

Noting that blinding trachoma still constitutes a serious public health problem amongst the poorest populations in 46 endemic countries;

Concerned that there are at present some 146 million active cases of the disease, mainly among children and women and that, in addition, almost six million people are blind or visually disabled as a result of trachoma;

Recognizing the need for sustainable community-based action - including surgery for intumed eyelids, antibiotics use, facial cleanliness and environmental improvement (the SAFE strategy) - for the elimination of blinding trachoma in the remaining endemic countries;

Encouraged by recent progress towards simplified assessment and enhanced management of the disease, including large-scale preventive measures, particularly for vulnerable groups;

Noting with satisfaction the recent establishment of the WHO alliance for the global elimination of trachoma, comprising certain collaborating nongovernmental organizations and foundations and other interested parties,

1. CALLS ON Member States:

- (1) to apply the new methods for the rapid assessment and mapping of blinding trachoma in the remaining endemic areas;
- (2) to implement, as required, the strategy - including surgery for intumed eyelids, antibiotics use, facial cleanliness and environmental improvement (the SAFE strategy) - for the elimination of blinding trachoma;
- (3) to collaborate in the WHO alliance for the global elimination of trachoma and its network of interested parties for the global coordination of action and specific support;

- (4) to consider all possible intersectoral approaches for community development in endemic areas, particularly for greater access to clean water and basic sanitation for the populations concerned;
2. REQUESTS the Director-General:
- (1) to intensify the cooperation needed for the elimination of blinding trachoma with Member States in which the disease is endemic;
- (2) further to refine the components of the SAFE strategy for trachoma elimination, particularly through operational research, and by considering potential antibiotic or other treatment schemes for safe large-scale application;
- (3) to strengthen interagency collaboration, particularly with UNICEF and the World Bank, for the mobilization of the necessary global support;
- (4) to facilitate the mobilization of extrabudgetary funds;
- (5) to report on progress, as appropriate, to the Executive Board and the Health Assembly.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fourth report)

WHA51.12 Health promotion

The Fifty-first World Health Assembly,

Recalling resolution WHA42.44 on health promotion, public information and education for health and the outcome of the four international conferences on health promotion (Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997);

Recognizing that the Ottawa Charter for Health Promotion has been a worldwide source of guidance and inspiration for development of health promotion through its five essential strategies to build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services;

Mindful of the clear evidence that: (a) comprehensive approaches that use combinations of the five strategies are the most effective; (b) certain settings offer practical opportunities for the implementation of comprehensive strategies, such as cities, islands, local communities, markets, schools, workplaces, and health services; (c) people have to be at the centre of health promotion action and decision-making processes if they are to be effective; (d) access to education and information is vital in achieving effective participation and the "empowerment" of people and communities; (e) health promotion is a "key investment" and an essential element of health development;

Mindful of the new challenges and determinants of health and of the need for new forms of action to free the potential for health promotion in many sectors of society, among local communities and within families, using an approach based on sound evidence;

Appreciating the potential of health promotion activities to act as a resource for societal development and the clear need to break through traditional boundaries within government sectors, between governmental and nongovernmental organizations, and between the public and private sectors;

Noting the efforts made by the 10 countries with a population of over 100 million to promote the establishment of a network of most-populous countries for health promotion;

Confirming the priorities set out in the Jakarta Declaration for Health Promotion in the Twenty-first Century,

1. URGES all Member States:

- (1) to promote social responsibility for health;
- (2) to increase investments for health development;
- (3) to consolidate and expand “partnerships for health”;
- (4) to increase community capacity and “empower” the individual in matters of health;
- (5) to strengthen consideration of health requirements and promotion in all policies;
- (6) to adopt an evidence-based approach to health promotion policy and practice, using the full range of quantitative and qualitative methodologies;

2. CALLS ON organizations of the United Nations system, intergovernmental and nongovernmental organizations and foundations, donors and the international community as a whole:

- (1) to mobilize and to cooperate with Member States to implement these strategies;
- (2) to form global, regional and local health-promotion networks;

3. CALLS ON the Director-General:

- (1) to enhance the Organization’s capacity and that of Member States to foster the development of health-promoting cities, islands, local communities, markets, schools, workplaces, and health services;
- (2) to implement strategies for health promotion throughout the life span, with particular attention to vulnerable groups, in order to reduce inequities in health;

4. REQUESTS the Director-General:

- (1) to take the lead in establishing an alliance for global health promotion and in enabling Member States to implement the Jakarta Declaration and other local or regional declarations on health promotion;
- (2) to support the development of evidence-based health promotion policy and practice within the Organization;
- (3) to give health promotion top priority in WHO in order to support its development within the Organization;
- (4) to report on progress to the Executive Board at its 105th session and to the Fifty-third World Health Assembly.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fourth report)

WHA51.13 Tuberculosis

The Fifty-first World Health Assembly,

Aware that tuberculosis is strongly associated with social and economic inequalities, especially those related to low income and gender;

Aware also that tuberculosis remains one of the most important causes of death in adults despite the existence of the highly cost-effective strategy known as “directly observed treatment, short course” (DOTS) to control the disease, and that poor treatment and inadequate control of anti-tuberculosis drugs will result in the development of drug-resistant strains that may make tuberculosis incurable;

Recognizing that the already serious situation is worsening in many countries that have been slow to implement the strategy, and that in some the disease is rapidly spreading because of HIV infection, itself facilitated by sexually transmitted diseases;

Convinced that tuberculosis can be controlled using the DOTS strategy even under difficult conditions, although the strategy presupposes strong political commitment;

Appreciating WHO’s leadership in persuading more countries to adopt the DOTS strategy (from ten in 1990 to nearly a hundred in 1997);

Acknowledging that many countries will achieve the global targets for the year 2000 set by resolutions WHA44.8 and WHA46.36;

Concerned that most countries with the greatest burden of disease will be unable to meet the targets;

Aware that delay in introducing the DOTS strategy will lead to significant increase in tuberculosis prevalence and cause millions more preventable deaths,

1. URGES all Member States:

- (1) to give high priority to intensifying tuberculosis control as an integral part of primary health care;
- (2) to improve social and economic conditions for vulnerable groups in their communities;
- (3) to ensure, before the year 2000, the effective introduction of the strategy known as “directly observed treatment, short course” (DOTS) as an integral part of primary health care if it has not yet been implemented;
- (4) to monitor implementation of the strategy and establish an effective disease surveillance system;
- (5) to take the necessary steps, especially in those 17 countries with the highest burden of disease that are not expected to meet the global targets by the year 2000:
 - (a) to improve and sustain political commitment at national and local levels;
 - (b) to review the constraints faced in meeting the targets, if necessary with support from WHO, development agencies or nongovernmental organizations;
 - (c) to meet the targets through implementation and expansion of the DOTS strategy;

- (d) to draw up a detailed plan to meet the targets as soon as feasible after 2000, clearly specifying the type, amount and phasing of support to be provided by their governments, WHO, donors or nongovernmental organizations as appropriate;
- (6) to coordinate the observance of World Tuberculosis Day on 24 March of each year as an opportunity throughout the world for organizations concerned to raise public awareness of tuberculosis as a major urgent public health problem and for countries to assess progress in tuberculosis control;
2. CALLS ON the international community, organizations and bodies of the United Nations system, donors, nongovernmental organizations and foundations:
- (1) to mobilize and sustain external financial and operational support;
- (2) to encourage cooperation from other organizations and programmes for health systems development, and prevention and control of HIV/AIDS and sexually transmitted diseases and lung diseases;
3. REQUESTS the Director-General:
- (1) to use all appropriate existing forums where Member States, including those 17 with the highest burden of disease, may present problems faced in implementation of the DOTS strategy and other strategies in order to overcome these problems and to mobilize external technical, financial and other support needed;
- (2) to encourage the access of poor countries to an adequate supply of good quality medication and of diagnostic equipment;
- (3) to encourage the establishment of networks for the surveillance of multidrug resistance at country level or in groups of poor countries;
- (4) to encourage research to ensure sustainable, cost-effective programme implementation, and action to prevent multidrug-resistant tuberculosis, including the development of tools to monitor multidrug resistance, and to design new tools to supplement the DOTS strategy (including vaccines);
- (5) to intensify collaboration and coordination with UNAIDS and other programmes and agencies;
- (6) to take all possible steps to maintain WHO's regular budget contribution for global tuberculosis control;
- (7) to keep the Executive Board and Health Assembly informed of progress.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fourth report)

WHA51.14 Elimination of transmission of Chagas disease

The Fifty-first World Health Assembly,

Encouraged by the considerable progress achieved in many countries such as Argentina, Brazil, Chile and Uruguay towards the elimination of Chagas disease;

Recognizing the support to national control activities provided by the national authorities;

Acknowledging the decision taken at recent subregional meetings of ministers of health of the Andean Region and of Central America in Santa Fe de Bogotá and in Tegucigalpa, respectively, to launch initiatives in several countries to eliminate transmission in the above subregions;

Aware of the need for additional entomological and epidemiological data to support these initiatives;

Aware that the countries in question have set national goals to ensure the interruption of transmission by the year 2010,

1. EXPRESSES its satisfaction with the progress made by Member States in eliminating the transmission of Chagas disease;
2. DECLARES its commitment to the goal of elimination of transmission of Chagas disease by the end of 2010 as technically feasible given appropriate political, technical and economic support;
3. ENDORSES a combined strategy of house disinfestation, blood-bank screening for *Trypanosoma cruzi*-infected blood, active surveillance, health education and community mobilization;
4. CALLS ON all Member States with populations still affected by Chagas disease to determine the full extent of the disease, including vector distribution, behaviour and sensitivity to insecticides, and to elaborate plans of action; to establish intercountry technical commissions to initiate certification of elimination; to coordinate the contributions of the international community, including multilateral and bilateral agencies and nongovernmental organizations; and to explore possibilities for mobilizing additional resources in order to eliminate transmission of the disease within the context of primary health care;
5. INVITES bilateral and international development agencies, nongovernmental organizations, appropriate regional organizations, foundations and other donors to help ensure that funds are available to accelerate and sustain countries' efforts to eliminate transmission of the disease;
6. URGES the Director-General:
 - (1) to support efforts to eliminate transmission of Chagas disease by the year 2010 and to provide WHO certification of elimination country by country;
 - (2) to support Member States in surveillance, programme development and implementation;
 - (3) to continue to seek extrabudgetary resources for this purpose;
 - (4) to report on progress to the Executive Board at its 105th session.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fourth report)

WHA51.15 Elimination of leprosy as a public health problem

The Fifty-first World Health Assembly,

Recalling resolution WHA44.9 and earlier resolutions of the Health Assembly and the Executive Board on leprosy;

Noting with satisfaction the progress made so far towards eliminating leprosy as a public health problem through the widespread implementation of multidrug therapy together with intensified case finding;

Recognizing the need to intensify antileprosy activities, particularly in countries with a high rate of prevalence, in order to reach the goal of elimination of leprosy as a public health problem by the year 2000,

1. URGES Member States:

- (1) to recognize the excellent opportunity to eliminate leprosy as a public health problem;
- (2) to intensify their efforts to reach remaining cases through accelerated plans, including national leprosy elimination campaigns and special initiatives to detect and treat patients in underserved communities, and by making multidrug therapy available in all peripheral health facilities;

2. REQUESTS the Director-General:

- (1) to continue to strengthen technical support to Member States in order to reach the goal of elimination of leprosy through treatment of patients with multidrug therapy, together with case finding;
- (2) to continue to mobilize and coordinate technical and additional financial resources for sustainable efforts to eliminate leprosy;
- (3) to strengthen further collaboration with national and international nongovernmental organizations in order to ensure attainment of the goal of elimination of leprosy as a public health problem;
- (4) to inform the Executive Board and the Health Assembly of progress.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fourth report)

WHA51.16 Promotion of horizontal technical cooperation in health sector reform in developing countries

The Fifty-first World Health Assembly,

Mindful of the principles of, and obvious need for technical cooperation among developing countries (TCDC) and of the interest shown by the Health Assembly by virtue of its resolutions WHA31.41, WHA31.54, WHA32.27, WHA35.24, WHA36.34, WHA37.15, WHA37.16, WHA38.23, WHA39.23, WHA40.17, WHA40.30 and WHA50.27 in strengthening this type of cooperation in order to improve the health situation in the developing countries;

Underlining the principles and purposes of the United Nations, as set out in the United Nations Charter, including the sovereign equality of States and the development of friendly relations among nations based on respect for equal rights and the self-determination of peoples, which have been consistently reaffirmed by Members of the Non-Aligned Movement;

Conscious that poverty is the main cause of ill-health, and recalling United Nations General Assembly resolutions 48/183 of 21 December 1993, 40/110 of 19 December 1994, 50/107 of 20 December 1995 and 51/178 of 16 December 1996 related to observance of the International Year for the Eradication of Poverty (1996) and to the First United Nations Decade for the Eradication of Poverty (1997-2006), and all its other relevant resolutions relating to international cooperation for the eradication of poverty in developing countries;

Recognizing that the progressive globalization of economies has resulted in the adoption of unregulated market approaches to the delivery of health services which, in certain circumstances, has been to the detriment of public health and has interfered with the ability of developing countries to adopt the appropriate corrective action;

Acknowledging the valued services that WHO has provided during its 50 years of existence to all peoples of its Member States, particularly those of developing countries;

Welcoming the overall directions and initiatives announced by the Director-General elect in the reform process of WHO,

1. REAFFIRMS its commitment to continue its efforts towards the achievement of equitable, affordable, accessible and sustainable health care systems in all Member States;
2. URGES Member States to continue the development of health systems in accordance with the principles of self-reliance, self-determination and the sovereign right of each country to adopt appropriate national health policies in response to the specific needs of their people;
3. CALLS UPON developed countries:
 - (1) to continue to facilitate the transfer of technology and resources to developing countries in the health sector, taking into account priority needs, and to support application of the principles of technical cooperation among developing countries;
 - (2) to continue to provide WHO with the necessary financial resources to enhance implementation of health programmes in the developing countries with a view to attaining the objective of health for all;
4. REQUESTS the Director-General:
 - (1) to support Member States, especially the least developed countries, in giving greater attention, at the highest political level, to the health needs of their poorest people and to strengthen the capacity of ministries of health to play a key role in intersectoral efforts to eradicate poverty;
 - (2) to place renewed emphasis on the capability of the Organization to advocate and promote a central role for health development in national and international efforts to eradicate poverty;
 - (3) to maintain the support provided to countries of the Non-Aligned Movement and other developing countries for the activities of the recently established network of institutions related to health sector reform,¹ and for technical cooperation among developing countries, including allocation of increased resources;
 - (4) to ensure wide consultation with countries of the Non-Aligned Movement and other developing countries in order to take account of their views and concerns in consideration of all aspects of organizational reform of WHO and formulation of its policies;
 - (5) to report to the Fifty-second World Health Assembly on the steps taken and progress made to implement this resolution.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fifth report)

¹ See resolution WHA50.27.

WHA51.17 Emerging and other communicable diseases: antimicrobial resistance

The Fifty-first World Health Assembly,

Having considered the report of the Director-General on emerging and other communicable diseases: antimicrobial resistance;¹

Concerned about the rapid emergence and spread of human pathogens resistant to available antibiotics;

Aware that antimicrobial resistance is increasingly hampering treatment of infectious diseases as a result either of totally ineffective antibiotics currently available or of the high cost of “new generation” agents;

Concerned about the extensive use of antibiotics in food production, which may further accelerate the development of such resistance,

1. URGES Member States:

- (1) to encourage the development of sustainable systems to detect antimicrobial-resistant pathogens, thereby increasing awareness of antimicrobial resistance, and to monitor volumes and patterns of use of antimicrobial agents and the impact of control measures;
- (2) to develop educational programmes for professional staff and the general public to encourage the appropriate and cost-effective use of antimicrobial agents;
- (3) to improve practices to prevent the spread of infection and thereby the spread of resistant pathogens, and to promote appropriate antibiotic use in health care facilities and in the community;
- (4) to develop measures to protect health workers from the hazards of resistant pathogens;
- (5) to develop measures to prohibit the dispensing of antimicrobials without the prescription of a qualified health-care professional;
- (6) to strengthen legislation to prevent the manufacture, sale and distribution of counterfeit antimicrobial agents and the sale of antibiotics on the informal market;
- (7) to take measures to encourage the reduced use of antimicrobials in food-animal production;

2. REQUESTS the Director-General:

- (1) to support countries in their efforts to control antimicrobial resistance through the strengthening of laboratory capacity for the detection of resistant pathogens;
- (2) to collaborate in developing sustainable national policies for rational antimicrobial use, not only in human medicine, but also in food-animal production;
- (3) to collaborate with the public health sector, the pharmaceutical industry, universities and institutions concerned with research, laboratory testing, marketing, prescription and consumption of antimicrobial agents, in order to encourage the sharing of knowledge and resources to combat antimicrobial resistance;
- (4) to devise means for the gathering and sharing of information by countries and regions concerning resistance in certain pathogens and to promote international cooperation among Member States;

¹ Document A51/9.

- (5) to develop programmes of information and education for prescribers and users of antimicrobial agents;
- (6) to encourage promotion of research and development of new antimicrobial agents.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fifth report)

WHA51.18 Noncommunicable disease prevention and control

The Fifty-first World Health Assembly,

Having considered the report by the Director-General on noncommunicable disease prevention and control;¹

Recalling *The world health report 1997*, which describes the high rates of mortality, morbidity and disability from major noncommunicable diseases, which account for nearly half of all deaths, a considerable proportion of them premature;

Noting that noncommunicable diseases already represent a significant burden on the public health services of Member States and that the problem is growing;

Alarmed by the rising trend and the bleak forecast for the twenty-first century as a consequence of the demographic and epidemiological transition, and the globalization of economic processes;

Recognizing that they cause enormous human suffering and threaten the economies of Member States, where costly treatment will further deprive the poor and powerless and increase the inequities in health between population groups and countries;

Mindful of common major behavioural and environmental risk factors that are more amenable to modification through the implementation of concerted essential public health action, as has been demonstrated recently in several Member States;

Aware that, as resources diminish, health professionals, particularly those in the forefront of health care delivery, often become the major source of health information as well as the providers of care and support to individuals and communities;

Recognizing the importance of, and continued need for, broad international action and cooperation in the development and promotion of policies and strategies to assist Member States in meeting the growing challenge of chronic noncommunicable diseases in the most cost-effective way,

1. ENDORSES the proposed framework for the integrated prevention and control of noncommunicable diseases, including the support of healthy lifestyles, the provision of public health services and the major involvement of health, nutrition and other relevant professions in improving the lifestyles and health of individuals and communities;²
2. URGES Member States to collaborate with WHO in developing a global strategy for the prevention and control of noncommunicable diseases based on best practices and operational research, as part of their health sector reforms, in order:

¹ Document EB101/1998/REC/1, Annex 4.

² *Ibid.*, pp. 68-69.

- (a) to promote health and reduce major common risk factors for chronic noncommunicable diseases through essential public health action and the integration of preventive measures within the functions of health services, and particularly in primary health care;
- (b) to collate information and set standards in order to ensure appropriate case detection and management;
- (c) to monitor scientific data and support research in a broad spectrum of related areas, including human genetics, nutrition and diet, matters of particular concern to women, and development of human resources for health;
- (d) to exert a concerted effort against the use of tobacco throughout the world, and especially in order to protect young people;

3. REQUESTS the Director-General:

- (1) to formulate a global strategy for prevention and control of noncommunicable diseases within the framework of the renewed WHO health-for-all policy for the twenty-first century and, in consultation with Member States and the agencies and professional organizations concerned, to give priority to such activities that help Member States develop corresponding national policies and programmes;
- (2) to ensure, while formulating the strategy, an effective managerial mechanism for collaboration and technical support involving all programmes concerned at different levels of the Organization and WHO collaborating centres, emphasizing the development and strengthening of global and regional demonstration projects;
- (3) to solicit the support of nongovernmental organizations and other international agencies by creating a forum for the exchange of experience and research findings;
- (4) to encourage cooperation with the private sector, within the current guidelines of WHO, so as to mobilize extrabudgetary resources for the implementation of plans at global and interregional level and to promote capacity-building at national level;
- (5) to submit the proposed global strategy and a plan, with a timetable for its implementation, to the Executive Board and the Health Assembly in 1999.

(Tenth plenary meeting, 16 May 1998 -
Committee A, fifth report)

WHA51.19 Financial report on the accounts of WHO for the financial period 1996-1997 and report of the External Auditor to the Health Assembly

The Fifty-first World Health Assembly,

Having examined the financial report and audited financial statements for the financial period 1 January 1996 to 31 December 1997 and the report of the External Auditor to the Health Assembly;¹

Having considered the first report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-first World Health Assembly;²

¹ Document A51/11.

² Document A51/12.

ACCEPTS the Director-General's financial report and audited financial statements for the financial period 1 January 1996 to 31 December 1997 and the report of the External Auditor to the Health Assembly.

(Tenth plenary meeting, 16 May 1998 -
Committee B, second report)

WHA51.20 Amendments to the Financial Regulations

The Fifty-first World Health Assembly,

Having considered the amendments to the Financial Regulations proposed by the Director-General and endorsed by the Executive Board at its 101st session,¹

ADOPTS the proposed amendments to the Financial Regulations.

(Tenth plenary meeting, 16 May 1998 -
Committee B, second report)

WHA51.21 Scale of assessments for the financial period 1998-1999

The Fifty-first World Health Assembly

1. DECIDES that the scale of assessments for the year 1999 shall, subject to the provisions of paragraph 2 below, be as follows:

Members and Associate Members	WHO (revised) scale 1999
	%
Afghanistan	0.003
Albania	0.003
Algeria	0.092
Andorra	0.004
Angola	0.010
Antigua and Barbuda	0.002
Argentina	1.008
Armenia	0.011
Australia	1.458
Austria	0.926
Azerbaijan	0.022
Bahamas	0.015
Bahrain	0.017
Bangladesh	0.010
Barbados	0.008
Belarus	0.081
Belgium	1.085
Belize	0.001
Benin	0.002
Bhutan	0.001
Bolivia	0.007
Bosnia and Herzegovina	0.005

¹ Document EB101/1998/REC/1, Annex 6, Appendix.

Members and Associate Members	WHO (revised) scale 1999
	%
Botswana	0.010
Brazil	1.446
Brunei Darussalam	0.020
Bulgaria	0.019
Burkina Faso	0.002
Burundi	0.001
Cambodia	0.001
Cameroon	0.013
Canada	2.710
Cape Verde	0.002
Central African Republic	0.001
Chad	0.001
Chile	0.129
China	0.957
Colombia	0.107
Comoros	0.001
Congo	0.003
Cook Islands ^a	0.001
Costa Rica	0.016
Côte d'Ivoire	0.009
Croatia	0.035
Cuba	0.025
Cyprus	0.033
Czech Republic	0.119
Democratic People's Republic of Korea	0.019
Democratic Republic of the Congo	0.007
Denmark	0.680
Djibouti	0.001
Dominica	0.001
Dominican Republic	0.015
Ecuador	0.020
Egypt	0.064
El Salvador	0.012
Equatorial Guinea	0.001
Eritrea	0.001
Estonia	0.015
Ethiopia	0.006
Fiji	0.004
Finland	0.533
France	6.435
Gabon	0.015
Gambia	0.001
Georgia	0.019
Germany	9.651
Ghana	0.007
Greece	0.345
Grenada	0.001
Guatemala	0.018
Guinea	0.003
Guinea-Bissau	0.001
Guyana	0.001
Haiti	0.002
Honduras	0.003
Hungary	0.118

^a Not a Member of the United Nations.

Members and Associate Members	WHO (revised) scale 1999
	%
Iceland	0.031
India	0.294
Indonesia	0.181
Iran (Islamic Republic of)	0.190
Iraq	0.044
Ireland	0.220
Israel	0.339
Italy	5.345
Jamaica	0.006
Japan	19.665
Jordan	0.006
Kazakhstan	0.065
Kenya	0.007
Kiribati ^a	0.001
Kuwait	0.132
Kyrgyzstan	0.008
Lao People's Democratic Republic	0.001
Latvia	0.024
Lebanon	0.016
Lesotho	0.002
Liberia	0.002
Libyan Arab Jamahiriya	0.130
Lithuania	0.022
Luxembourg	0.067
Madagascar	0.003
Malawi	0.002
Malaysia	0.177
Maldives	0.001
Mali	0.002
Malta	0.014
Marshall Islands	0.001
Mauritania	0.001
Mauritius	0.009
Mexico	0.964
Micronesia (Federated States of)	0.001
Monaco	0.004
Mongolia	0.002
Morocco	0.040
Mozambique	0.001
Myanmar	0.008
Namibia	0.007
Nauru ^a	0.001
Nepal	0.004
Netherlands	1.605
New Zealand	0.217
Nicaragua	0.001
Niger	0.002
Nigeria	0.039
Niue ^a	0.001
Norway	0.600
Oman	0.050
Pakistan	0.058
Palau	0.001
Panama	0.013

^a Not a Member of the United Nations.

Members and Associate Members	WHO (revised) scale 1999
	%
Papua New Guinea	0.007
Paraguay	0.014
Peru	0.093
Philippines	0.079
Poland	0.204
Portugal	0.410
Puerto Rico ^{a,b}	0.001
Qatar	0.032
Republic of Korea	0.978
Republic of Moldova	0.018
Romania	0.066
Russian Federation	1.463
Rwanda	0.001
Saint Kitts and Nevis	0.001
Saint Lucia	0.001
Saint Vincent and the Grenadines	0.001
Samoa	0.001
San Marino	0.002
Sao Tome and Principe	0.001
Saudi Arabia	0.560
Senegal	0.006
Seychelles	0.002
Sierra Leone	0.001
Singapore	0.173
Slovakia	0.038
Slovenia	0.060
Solomon Islands	0.001
Somalia	0.001
South Africa	0.360
Spain	2.548
Sri Lanka	0.012
Sudan	0.007
Suriname	0.004
Swaziland	0.002
Sweden	1.067
Switzerland ^a	1.196
Syrian Arab Republic	0.063
Tajikistan	0.005
Thailand	0.164
The former Yugoslav Republic of Macedonia	0.004
Togo	0.001
Tokelau ^{a,b}	0.001
Tonga ^a	0.001
Trinidad and Tobago	0.017
Tunisia	0.027
Turkey	0.433
Turkmenistan	0.008
Tuvalu ^a	0.001
Uganda	0.004
Ukraine	0.297
United Arab Emirates	0.175

^a Not a Member of the United Nations.

^b Associate Member of WHO.

Members and Associate Members	WHO (revised) scale 1999
	%
United Kingdom of Great Britain and Northern Ireland	5.009
United Republic of Tanzania	0.003
United States of America	25.000
Uruguay	0.047
Uzbekistan	0.036
Vanuatu	0.001
Venezuela	0.173
Viet Nam	0.007
Yemen	0.010
Yugoslavia	0.033
Zambia	0.002
Zimbabwe	0.009

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

(Tenth plenary meeting, 16 May 1998 -
Committee B, third report)

WHA51.22 Health of children and adolescents

The Fifty-first World Health Assembly,

Guided by the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights;

Stressing the importance of the Convention on the Rights of the Child, which *inter alia* recognizes the right of the child and adolescent to the highest attainable standard of health and access to health care;

Recalling resolutions WHA45.22 and WHA42.41 on the health of the child and of young people, respectively, and resolution 1998/76 of the United Nations Commission on Human Rights;

Reaffirming WHO's commitment to implement the relevant recommendations and commitments adopted by the World Summit for Children (1990), the International Conference on Nutrition (1992), the United Nations Conference on Environment and Development (1992), the World Conference on Human Rights (1993), the International Conference on Population and Development (1994), the World Summit for Social Development (1995), the Fourth World Conference on Women (1995) and the World Food Summit (1996);

Recognizing that the health of children and adolescents constitutes a critical element for the health of future generations and for health and human development in general;

Taking note with appreciation of the significant progress which has been achieved in the implementation of the decade goals of the World Summit for Children (1990); however, aware that child and infant mortality and morbidity are still unacceptably high in many parts of the world, and of the extent of health problems of adolescents;

Stressing the special health needs of young children, particularly those in developing countries, and adolescents worldwide;

Underlining the need for incorporating a gender perspective into all policies and programmes relating to children and adolescents,

1. CALLS UPON all Member States to undertake all appropriate measures to pursue the full implementation of the right of the child and adolescent to the highest attainable standard of health and access to health services;
2. APPEALS to States Parties to the Convention on the Rights of the Child to include information on health and health services in their reports to the Committee on the Rights of the Child and to take into account the recommendations made by the Committee in implementation of the relevant provisions of the Convention;
3. URGES the Director-General:
 - (1) to give high priority to improving the health of children and adolescents across all relevant WHO programmes as an essential contribution to reaching the highest attainable level of health for all;
 - (2) to contribute to the collective efforts of the international community to promote the effective implementation of the Convention on the Rights of the Child by the States Parties and to strengthen WHO's cooperation within the United Nations system at global, regional and country levels, in particular with ILO, UNICEF, UNDP, UNHCR, UNFPA, the Office of the United Nations High Commissioner for Human Rights, other relevant bodies and organizations of the system, and with regional organizations, and intergovernmental and nongovernmental organizations and institutions;
 - (3) to strengthen further WHO's cooperation with the Committee on the Rights of the Child and to collaborate with Member States, at their request, in preparing the relevant parts of reports to the Committee on the Rights of the Child and implementing its recommendations;
 - (4) to bring to the attention of States and relevant parts of the United Nations system, in particular the Commission on Human Rights, concern over health problems affecting the rights of children and adolescents.

(Tenth plenary meeting, 16 May 1998 -
Committee B, third report)

WHA51.23 Amendments to Articles 24 and 25 of the Constitution

The Fifty-first World Health Assembly,

Considering that the membership of the Executive Board should be increased from 32 to 34, so that the number of Members in the European Region and Western Pacific Region entitled to designate a person to serve on the Executive Board be increased to eight and five, respectively,

1. ADOPTS the following amendments to Articles 24 and 25 of the Constitution, the texts in the Arabic, Chinese, English, French, Russian and Spanish languages being equally authentic:

Article 24 - Delete and replace by

The Board shall consist of thirty-four persons designated by as many Members. The Health Assembly, taking into account an equitable geographical distribution, shall elect the Members entitled to designate a person to serve on the Board, provided that, of such Members, not less than three shall be elected from each of the regional organizations established pursuant to Article 44. Each of these Members should appoint to the Board a person technically qualified in the field of health, who may be accompanied by alternates and advisers.

Article 25 - Delete and replace by

These Members shall be elected for three years and may be re-elected, provided that of the Members elected at the first session of the Health Assembly held after the coming into force of the amendment to this Constitution increasing the membership of the Board from thirty-two to thirty-four the term of office of the additional Members elected shall, insofar as may be necessary, be of such lesser duration as shall facilitate the election of at least one Member from each regional organization in each year.

2. DECIDES that two copies of this resolution shall be authenticated by the signatures of the President of the Fifty-first World Health Assembly and the Director-General of the World Health Organization, of which one copy shall be transmitted to the Secretary-General of the United Nations, depositary of the Constitution, and one copy retained in the archives of the World Health Organization;
3. DECIDES that the notification of acceptance of these amendments by Members in accordance with the provisions of Article 73 of the Constitution shall be effected by the deposit of a formal instrument with the Secretary-General of the United Nations, as required for acceptance of the Constitution by Article 79(b) of the Constitution.

(Tenth plenary meeting, 16 May 1998 -
Committee B, fourth report)

WHA51.24 International Decade of the World's Indigenous People

The Fifty-first World Health Assembly,

Recalling the role of WHO in planning for and implementing the objectives of the International Decade of the World's Indigenous People as recognized in resolutions WHA47.27, WHA48.24, WHA49.26 and WHA50.31;

Noting the report by the Director-General to the Executive Board;¹

Further recalling United Nations General Assembly resolution 50/157 which invited specialized agencies to designate focal points for coordination of activities related to the International Decade and adopted the programme of activities for the International Decade, in which it is recommended that "specialized agencies of the United Nations system and other international and national agencies, as well as communities and private enterprises, should devote special attention to development activities of benefit to indigenous communities", and that "the governing bodies of the specialized agencies of the United Nations system should adopt programmes of action for the Decade in their own fields of competence, in close cooperation with indigenous people";

Recognizing with satisfaction the progress made in the Initiative on the Health of Indigenous People of the Americas;

Noting the importance of the traditional medical knowledge of indigenous people;

Noting with appreciation the activities of the focal point for the International Decade,

1. URGES Member States to develop and implement, in close cooperation with indigenous people, national plans of action or programmes on indigenous people's health which focus on ensuring access of indigenous people to health care; supporting the participation of indigenous representatives in WHO meetings; ensuring that health services are culturally sensitive to indigenous people; respecting, preserving and maintaining the

¹ Document EB99/23.

knowledge of traditional healing and medicine; and ensuring the active participation of indigenous people in identifying their health needs and appropriate research for developing strategies to improve their health status and the future direction of their health;

2. REQUESTS the Director-General:

- (1) to promote the inclusion of indigenous health in the work programme at country, regional and global levels;
- (2) to report annually to the Health Assembly on progress on indigenous health initiatives globally, incorporating regional updates, and highlighting significant activities at country level;
- (3) to improve and increase, in close collaboration with indigenous people, institutional and technical cooperation with Member States in the area of indigenous people's health, so that models of good practice in indigenous people's health are shared, globally, regionally and between countries in order to inspire, compare and highlight the rich diversity of projects, experiences and approaches;
- (4) to encourage the representation of health workers of indigenous origin in WHO's work, including meetings;
- (5) to promote, in close cooperation with indigenous people, the respect, preservation, and maintenance of the knowledge of traditional healing and medicine, and to promote the equitable sharing of the benefits arising from the use of such knowledge, in conformity with trade and intellectual property conventions.¹

(Tenth plenary meeting, 16 May 1998 -
Committee B, fourth report)

WHA51.25 Salaries of staff in ungraded posts and of the Director-General

The Fifty-first World Health Assembly,

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

1. ESTABLISHES the salary for the posts of Assistant Directors-General and Regional Directors at US\$ 133 994 per annum before staff assessment, resulting in a modified net salary of US\$ 93 671 (dependency rate) or US\$ 84 821 (single rate);
2. ESTABLISHES the salary for the post of Deputy Director-General at US\$ 147 420 per annum before staff assessment, resulting in a modified salary of US\$ 102 130 (dependency rate) or US\$ 91 883 (single rate);
3. ESTABLISHES the salary for the Director-General at US\$ 181 235 per annum before staff assessment, resulting in a modified net salary of US\$ 123 433 (dependency rate) or US\$ 109 670 (single rate);
4. DECIDES that those adjustments in remuneration shall come into effect on 1 March 1998.

(Tenth plenary meeting, 16 May 1998 -
Committee B, fourth report)

¹ Conventions and agreements administered by WIPO and WTO.

WHA51.26 Status of members of the Executive Board: clarification of the interpretation of Article 24 of the WHO Constitution

The Fifty-first World Health Assembly,

Recalling the role of WHO as the directing and coordinating authority on international health work;

Reaffirming that the members of the Executive Board should be technically qualified in the field of health;

Recognizing that the strength of WHO comes from the commitment of its Member States working together to pursue common health goals;

Noting the significant role played by governments in the governing bodies of other specialized agencies of the United Nations system;

Noting the ambiguity which results from the difference in the authentic languages of the Constitution concerning the status in which persons serve as members of the Executive Board;

Considering it important to clarify the provisions of Article 24 of the Constitution;

Bearing in mind the provision in Article 75 of the Constitution which allows for the Health Assembly to settle questions of interpretation of the Constitution,

DECIDES that Member States entitled to designate a representative to the Executive Board should designate them as government representatives, technically qualified in the field of health.

(Tenth plenary meeting, 16 May 1998 -
Committee B, fifth report)

WHA51.27 Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine

The Fifty-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;

Recalling the convening of the International Peace Conference on the Middle East (Madrid, 30 October 1991), on the basis of United Nations Security Council resolutions 242 (1967) of 22 November 1967 and 338 (1973) of 22 October 1973, as well as on the basis of the principle of "land for peace", and the subsequent bilateral negotiations;

Expressing the hope that the peace talks between the parties concerned in the Middle East will lead to a just and comprehensive peace in the area;

Noting the signing in Washington, D.C. on 13 September 1993 of the Declaration of Principles on Interim Self-Government Arrangements between the Government of Israel and the Palestine Liberation Organization (PLO), the commencement of the implementation of the Declaration of Principles following the signing of the Cairo Accord on 4 May 1994, the interim agreement signed in Washington, D.C. on 28 September 1995, the transfer of health services to the Palestinian Authority, and the launching of the final stage of negotiations between Israel and PLO on 5 May 1996;

Emphasizing the urgent need to implement the Declaration of Principles and the subsequent Accord;

Expressing grave concern about the decision of the Government of Israel to resume settlement activities, including the construction of the settlement in Jabal Abou Ghoneim, in violation of international law and relevant United Nations resolutions;

Stressing the need to preserve the territorial integrity of all the occupied Palestinian territory and to guarantee the freedom of movement of persons and goods within the Palestinian territory, including the removal of restrictions of movement into and from East Jerusalem, and the freedom of movement to and from the outside world having in mind the adverse consequences of the recurrent closure of the Palestinian territory on its socioeconomic development, including the health sector;

Recognizing the need for increased support and health assistance to the Palestinian population in the areas under the responsibility of the Palestinian Authority and to the Arab populations in the occupied Arab territories, including the Palestinians as well as the Syrian Arab population;

Recognizing that the Palestinian people will have to make strenuous efforts to improve their health infrastructure, and taking note of the initiation of cooperation between the Israeli Ministry of Health and the Ministry of Health of the Palestinian Authority, which emphasizes that health development is best enhanced under conditions of peace and stability;

Reaffirming the right of the Palestinian patients to be able to benefit from health facilities available in the Palestinian health institutions of occupied East Jerusalem;

Recognizing the need for support and health assistance to the Arab populations in the areas under the responsibility of the Palestinian Authority and in the occupied territories, including the occupied Golan;

Bearing in mind United Nations General Assembly resolutions 52/52 and 52/53 of 9 December 1997;

Having considered the report of the Director-General,¹

1. EXPRESSES the hope that the peace talks will lead to the establishment of a just, lasting and comprehensive peace in the Middle East;
2. CALLS UPON Israel not to hamper the Palestinian health authorities in carrying out their full responsibility for the Palestinian people, including in occupied East Jerusalem, and to lift the closure imposed on the Palestinian territory;
3. EXPRESSES the hope that the Palestinian people, having assumed responsibility for their health services, will be able themselves to carry out health plans and projects in order to participate with the peoples of the world in achievement of WHO's objectives of health for all by the year 2000;
4. AFFIRMS the need to support the efforts of the Palestinian Authority in the field of health in order to enable it to develop its own health system so as to meet the needs of the Palestinian people in administering their own affairs and supervising their own health services;
5. URGES Member States, intergovernmental organizations, nongovernmental organizations and regional organizations to provide speedy and generous assistance in the achievement of health development for the Palestinian people;
6. THANKS the Director-General for his report and efforts, and requests him:

¹ Document A51/23.

- (1) to take urgent steps in cooperation with Member States to support the Ministry of Health of the Palestinian Authority in its efforts to overcome the current difficulties, and in particular so as to guarantee free circulation of those responsible for health, of patients, of health workers and of emergency services, and the normal provision of medical goods to the Palestinian medical premises, including those in Jerusalem;
 - (2) to continue to provide the necessary technical assistance to support health programmes and projects for the Palestinian people in the transitional period;
 - (3) to take the necessary steps and make the contacts needed to obtain funding from various sources including extrabudgetary sources, to meet the urgent health needs of the Palestinian people during the transitional period;
 - (4) to continue his efforts to implement the special health assistance programme and adapt it to the health needs of the Palestinian people, taking into account the health plan of the Palestinian people;
 - (5) to activate the organizational unit at WHO headquarters concerned with the health of the Palestinian people, and continue to provide health assistance so as to improve the health conditions of the Palestinian people;
 - (6) to report on implementation of this resolution to the Fifty-second World Health Assembly;
7. EXPRESSES gratitude to all Member States, intergovernmental organizations and nongovernmental organizations and calls upon them to provide the assistance needed to meet the health needs of the Palestinian people.

(Tenth plenary meeting, 16 May 1998 -
Committee B, fifth report)

WHA51.28 Strategy on sanitation for high-risk communities

The Fifty-first World Health Assembly,

Having considered the report of the Director-General on strategy for sanitation in high-risk communities;¹

Aware of the plight of rural and urban communities with highly insanitary conditions, the importance of sanitation for health in general and in reducing the incidence and spread of infectious diseases, and the responsibility that WHO has to provide appropriate leadership;

Concerned about the vast and increasing number of people in the world who lack sanitation, living in communities that should receive the highest priority for sanitation because of the particularly high risk of disease related to insanitary conditions;

Recognizing that although full coverage by water supply and sanitation services as proclaimed by the 1990 World Summit for Children and in other forums remains the ultimate goal, higher priority should be given to these high-risk communities without delay;

Recalling resolutions WHA39.20, WHA42.25, WHA44.27, WHA44.28, WHA45.31 and WHA46.20 which *inter alia* have guided WHO's programme on community water supply and sanitation;

¹ Document A51/20.

Recalling that the Executive Board established environmental health, particularly water supply and sanitation, as one of the priority areas for WHO;

Noting that a joint water supply and environmental sanitation strategy was approved by the UNICEF/WHO Joint Committee on Health Policy in May 1997;

Noting that the topic of water, including community water supply and sanitation, is to be considered by the United Nations Commission on Sustainable Development in 1998, which will determine future priorities, action and roles in this area;

Exploring new and innovative financing mechanisms for sanitation, including community financing, private sector funding and private management of public assets,

1. ENDORSES the strategy on sanitation for high-risk communities;¹
2. URGES Member States:
 - (1) to reorient and strengthen their sanitation programmes to ensure that priority is given to communities at high risk from insanitary conditions, with the following aims:
 - (a) identifying high-risk communities and subgroups in rural, periurban and urban areas and setting priorities accordingly, through observation using health statistics and other systematic data from screening;
 - (b) carrying out studies on appropriate technologies taking into account specific national, regional and local conditions for the improvement of water supply and sanitation;
 - (c) overcoming obstacles to sanitation such as difficult geological, social, economic and legal conditions;
 - (d) mobilizing communities and involving them in the planning and implementation of their sanitation systems through collaboration with nongovernmental organizations and others with successful experience in community participation;
 - (2) to give higher priority to sanitation in national planning for health and investment in infrastructure, with the following aims:
 - (a) integrating sanitation in related programmes for development such as environmental health, child survival, maternal and child health, communicable diseases, essential drugs and agricultural development;
 - (b) advocating sanitation in order to increase political will and commitment at every level;
 - (c) including sanitation in the preparation of national action plans on health and environment and, in particular, in urban and rural community development programmes;
3. CALLS UPON the United Nations and other international organizations to give high-risk communities priority for sanitation, and invites donors to provide adequate funding for the necessary measures;
4. REQUESTS the Director-General:

¹ See Annex 3.

- (1) to support Member States in implementing sanitation programmes, ensuring that sanitation is assured by appropriate programmes in a coordinated and coherent way;
- (2) to undertake advocacy for the recognition of high-risk groups and their needs as a priority;
- (3) to support efforts by Member States to identify high-risk communities and give them priority, suggest appropriate methodology and collaborate in gathering information;
- (4) to support applied research on appropriate sanitation technology and community involvement for high-risk areas, including the review of cases and establishment of models of “good practice”;
- (5) to support training of extension workers in methodology for involving communities in their sanitation development;
- (6) to integrate sanitation in action such as development of health-promoting cities, islands, villages and markets, the “School health initiative” and national action plans for environmental health;
- (7) to convene an expert consultation on the financial, cultural and legal obstacles to reaching high-risk communities, and to advise Member States on measures to overcome them;
- (8) to strengthen internal coordination and cooperation with other United Nations organizations in the promotion of sanitation with particular emphasis on high-risk communities, and especially with UNICEF in the UNICEF/WHO joint water supply and environmental sanitation strategy.

(Tenth plenary meeting, 16 May 1998 -
Committee B, fifth report)

WHA51.29 Protection of human health from threats related to climate change and stratospheric ozone depletion

The Fifty-first World Health Assembly,

Having considered the report of the Director-General on WHO’s activities on the health effects of climate change and stratospheric ozone depletion, and its association with the work on the “climate agenda”;¹

Recalling resolutions WHA46.20 and WHA48.13 on the endorsement of the WHO global strategy for health and environment in full compliance with “Agenda 21” adopted by the United Nations Conference on Environment and Development in 1992, and on WHO’s efforts to combat emerging and re-emerging infectious diseases associated with greater human mobility, global environmental changes and spreading drug resistance;

Aware of the growing scientific evidence that the steady increase of atmospheric greenhouse gases caused by human activities may seriously affect the global climate with grave consequences for human health and the environment;

Aware of the serious threat to the environment and health of the depletion of ozone from the earth’s stratosphere due to emissions of chlorofluorocarbons and other gases with ozone-destroying properties, used for refrigeration and for other industrial purposes, that might increase the incidence of diseases related to ultraviolet radiation, such as melanomas, non-melanomous skin cancers, immune defects and nutritional deficiencies;

¹ Document A51/21.

Equally aware that the consequences of these phenomena for human health and well-being should be considered within the overall context of other global environmental changes, many of which are related, such as desertification, deforestation, transboundary air and water pollution and loss of biodiversity;

Acknowledging the leading role of WHO, in collaboration with UNEP and WMO, in bringing the potentially grave threats to human health of these global environmental phenomena to the attention of the international community through mechanisms provided by the Intergovernmental Panel on Climate Change and the United Nations Framework Convention on Climate Change,

1. ENDORSES WHO's participation in the "climate agenda" established by FAO, UNESCO and its Intergovernmental Oceanographic Commission (IOC), WMO, UNEP and the International Council of Scientific Unions (ICSU) in order to deal more effectively with climate-related issues among appropriate intergovernmental and international agencies;¹

2. URGES Member States:

(1) to consider the potential threats to human health of climate change and other factors in global environmental change and to take these into account in national planning for sustainable development;

(2) wherever appropriate, to consider new approaches to tackling these threats through greater use of weather and climate forecasts in disease prevention and control;

(3) to adopt other strategies, as appropriate, to face up to the human health consequences of climate change and other factors in global environmental change;

(4) to improve prevention of climate change and of health effects of stratospheric ozone depletion through increased public awareness programmes and action;

(5) to encourage applied research and capacity-building in all of these areas;

3. REQUESTS the Director-General:

(1) to develop further WHO's relations with WMO and other appropriate organizations of the United Nations system in order to ensure the continuation of international efforts to foster understanding of the correlation between climate and health and pursuance of ways and means of mitigating public health effects of global environmental change;

(2) to collect and review epidemiological information on risks related to climate and stratospheric ozone depletion for human health and to make such information accessible to policy-makers and research institutions in Member States;

(3) to pursue the assessment of research needs and priorities concerning risks related to climate and stratospheric ozone depletion for human health and the environment, and to promote further research in this area, in particular in support of improved strategies for response at national level, in close cooperation with meteorological services;

(4) to secure adequate human and financial resources for these activities, in consultation with other agencies concerned and interested donors.

(Tenth plenary meeting, 16 May 1998 -
Committee B, fifth report)

¹ Document WHO/EHG/96.7.

WHA51.30 Method of work of the Health Assembly

The Fifty-first World Health Assembly,

Recalling resolution WHA50.32 on respect for equality among official languages, which requested the Director-General to ensure that the documents related to the agendas of the governing bodies were distributed simultaneously and in good time in the six official languages and that they were not distributed until they were available in all the official languages, in order to respect the principle of equality of treatment of Member States;

Stressing the importance of multilingualism and equality among official languages of WHO;

Taking note of the report by the Director-General on the implementation of resolution WHA50.32, in particular the fact that governing body documents have been made available in all languages on the Internet once dispatched;¹

Recognizing that those countries whose national languages are not one of the official languages of the Organization require more time to translate and study the documents in their own languages,

REQUESTS the Director-General to ensure that the governing body documents for forthcoming sessions are dispatched and made available on the Internet in the six official languages not less than 30 days before the date fixed for the opening of the session.

(Tenth plenary meeting, 16 May 1998 -
Committee B, fifth report)

WHA51.31 Regular budget allocations to regions

The Fifty-first World Health Assembly,

Recalling resolution EB99.R24 on regional arrangements within the context of WHO reform;

Noting that regular budget allocations to regions have not been based on objective criteria but rather on the basis of history and previous practice;

Concerned that, as a result, each region's share of such allocations has remained largely unchanged since the Organization's inception;

Recalling that two basic principles governing the work of WHO are those of equity and support to countries in greatest need, and stressing the need for the Organization to apply principles which Member States have adopted collectively;

Noting that other organizations of the United Nations system, particularly UNICEF, have already adopted models based on objective criteria to ensure a more equitable distribution of programme resources to countries,

1. THANKS the Executive Board and its special group for the review of the Constitution for the comprehensive study of allocations from the regular budget to regions;²
2. REAFFIRMS Article 55 of the Constitution which stipulates that it is the Director-General's prerogative to prepare and submit to the Board the budget estimates of the Organization, and requests her or him to take into

¹ Document A51/25.

² Document EB101/1998/REC/1, Annex 3.

account the discussion on this matter during the Fifty-first World Health Assembly when preparing future programme budgets;

3. RECOMMENDS that, globally, the regional, intercountry and country allocation in future programme budgets approved by the Health Assembly should for the most part be guided by a model that:

- (a) draws upon UNDP's Human Development Index, possibly adjusted for immunization coverage;
- (b) incorporates population statistics of countries calculated according to commonly accepted methods, such as "logarithmic smoothing";
- (c) can be implemented gradually so that the reduction for any region would not exceed 3% per year and would be spread over a period of three bienniums;

4. REQUESTS the Director-General to present a thorough evaluation of that model to the Fifty-seventh World Health Assembly for the purpose of continuing response to health needs and equitable allocation of the resources of WHO;

5. DECIDES that the model should be applied in a flexible, rather than a mechanical, manner so as to minimize, to the extent possible, any adverse effects on countries whose budgetary allocations will be reduced;

6. REQUESTS the Director-General:

(1) to ensure that during the 2000-2001 biennium all least developed countries will be guaranteed that their regular budget allocation will not be less than that of the 1998-1999 budget by use of the 2% transfer from global and interregional activities foreseen in resolution WHA48.26 and by casual income if available; and to continue in subsequent bienniums to give high priority to protect the situation of least developed countries;

(2) while emphasizing that any additional funds resulting from the present process of reallocation should flow to country level, to enable regions to determine for themselves within the terms of the Constitution the partition between country, intercountry and regional office budgets;

(3) to monitor and evaluate closely the working and the impact of this new process in the light, in particular, of changes in international social and economic conditions, and to report annually to the Executive Board and the Health Assembly with a view to any further refinement, development or modification in order to ensure response to health needs and the equitable allocation of the resources of WHO;

(4) to report to the Executive Board at its 103rd session and to the Fifty-second World Health Assembly on the details of the model and the regional, intercountry and country allocations to be applied to the 2000-2001 biennium;

(5) further to report to the Executive Board at its 103rd session and to the Fifty-second World Health Assembly within the context of the request in paragraph 4 above, on the use of extrabudgetary allocations in regional, intercountry and country programmes in the previous three bienniums.

(Tenth plenary meeting, 16 May 1998 -
Committee B, sixth report)

DECISIONS

WHA51(1) Composition of the Committee on Credentials

The Fifty-first World Health Assembly appointed a Committee on Credentials consisting of delegates of the following 12 Member States: Austria, Belgium, Bolivia, Democratic People's Republic of Korea, Democratic Republic of the Congo, Gabon, Iran (Islamic Republic of), Japan, Paraguay, Qatar, Senegal, The former Yugoslav Republic of Macedonia.

(First plenary meeting, 11 May 1998)

WHA51(2) Composition of the Committee on Nominations

The Fifty-first World Health Assembly elected a Committee on Nominations consisting of delegates of the following Member States: Bahamas, Cameroon, Canada, Comoros, Djibouti, Equatorial Guinea, Estonia, France, Guatemala, Malta, Mauritania, Palau, Peru, Philippines, Russian Federation, Sao Tome and Principe, Swaziland, Thailand, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Uruguay, Uzbekistan, Viet Nam and Yemen, and India (President, Fiftieth World Health Assembly, *ex officio*).

(First plenary meeting, 11 May 1998)

WHA51(3) Election of officers of the Fifty-first World Health Assembly

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

President:	Dr F.R. Al-Mousawi (Bahrain)
Vice-Presidents:	Dr N.C. Dlamini Zuma (South Africa) Dr A. Guzmán Marcelino (Dominican Republic) Professor A. Insanov (Azerbaijan) Mr J.Y. Thinley (Bhutan) Dr E. Pretrick (Federated States of Micronesia)

(Second plenary meeting, 11 May 1998)

WHA51(4) Election of officers of the main committees

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

Committee A:	Chairman	Dr G. Durham (New Zealand)
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Committee B: Chairman Mr N.S. de Silva (Sri Lanka)

(Second plenary meeting, 11 May 1998)

The main committees subsequently elected the following officers:

Committee A: Vice-Chairmen Dr E. Krag (Denmark)
Mr B.R. Pokhrel (Nepal)
Rapporteur Professor G.H. Ayub (Pakistan)

Committee B: Vice-Chairmen Dr M. Nguema Ntutumu (Equatorial Guinea)
Dr E. Pieruzzi (Venezuela)
Rapporteur Dr L. Romanovská (Czech Republic)

(First meetings of Committees B and A, 11 and 12 May 1998)

WHA51(5) Establishment of the General Committee

The Fifty-first World Health Assembly, after considering the recommendations of the Committee on Nominations, elected the delegates of the following 17 countries as members of the General Committee: Argentina, Belarus, Burundi, China, Cuba, Cyprus, France, Guinea-Bissau, Jamaica, Lebanon, Niger, Russian Federation, Sierra Leone, Spain, Uganda, United Kingdom of Great Britain and Northern Ireland, United States of America.

(Second plenary meeting, 11 May 1998)

WHA51(6) Adoption of the agenda

The Fifty-first World Health Assembly adopted the provisional agenda prepared by the Executive Board at its 101st session with the deletion of four items.

(Third plenary meeting, 11 May 1998)

WHA51(7) Verification of credentials

The Fifty-first World Health Assembly recognized the validity of the credentials of the following delegations: Afghanistan; Albania; Algeria; Andorra; Angola; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia; Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian

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

(Sixth and tenth plenary meetings, 13 and 16 May 1998)

WHA51(8) Review of *The world health report 1998* incorporating the Director-General's report on the work of WHO

The Fifty-first World Health Assembly, after reviewing *The world health report 1998*, incorporating the Director-General's report on the work of the Organization in 1997,¹ commended the Director-General and expressed its satisfaction with the manner in which the programme of the Organization was being implemented.

(Seventh plenary meeting, 13 May 1998)

WHA51(9) Election of Members entitled to designate a person to serve on the Executive Board

The Fifty-first World Health Assembly, after considering the recommendations of the General Committee,² elected the following as Members entitled to designate a person to serve on the Executive Board: Bangladesh, Cape Verde, Central African Republic, Chile, China, France, Lao People's Democratic Republic, Qatar, Russian Federation, Trinidad and Tobago, United States of America, Yemen.

(Ninth plenary meeting, 14 May 1998)

WHA51(10) Revised drug strategy

The Fifty-first World Health Assembly, taking into account discussions in Committee A and in a drafting group, decided to refer resolution EB101.R24 on the revised drug strategy back to the Executive Board for further consideration at its 103rd session.

(Tenth plenary meeting, 16 May 1998)

WHA51(11) United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee

The Fifty-first World Health Assembly appointed Dr J. Larivière, delegate of Canada, as a member of the WHO Staff Pension Committee, and Dr B. Wasisto, delegate of Indonesia, as alternate member of the Committee, the appointments being for a period of three years; Professor J. Leowski, delegate of Poland, was appointed to replace Professor B.A. Roos, the appointment being for a period of two years.

(Tenth plenary meeting, 16 May 1998)

¹ *The world health report 1998*, Geneva, World Health Organization, 1998.

² Document A51/34.

WHA51(12) Reports of the Executive Board on its 100th and 101st sessions

The Fifty-first World Health Assembly, after reviewing the Executive Board's reports on its 100th¹ and 101st² 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 closure of the Assembly.

(Tenth plenary meeting, 16 May 1998)

WHA51(13) Selection of the country in which the Fifty-second World Health Assembly will be held

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

(Tenth plenary meeting, 16 May 1998)

¹ Document EB100/1997/REC/1.

² Documents EB101/1998/REC/1 and EB101/1998/REC/2.

ANNEXES

ANNEX 1

Contract of the Director-General¹

THIS CONTRACT is made this thirteenth day of May one thousand nine hundred and ninety-eight between the World Health Organization (hereinafter called the Organization) of the one part and Dr Gro Harlem Brundtland (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 thirteenth day of May one thousand nine hundred and ninety-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 ninety-eight until the twentieth day of July two thousand and three on which date the 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 or her 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 or her. In particular he or she 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 or she shall not engage in business or in any employment or activity which would interfere with his or her duties in the Organization.

(4) The Director-General, during the term of this appointment, shall enjoy all the privileges and immunities in keeping with the 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 such 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 the appointment and this Contract shall terminate.

¹ See resolution WHA51.5.

(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 ninety-eight the Director-General shall receive from the Organization an annual salary of one hundred and seventy-five thousand three hundred and forty-four United States dollars, before staff assessment, resulting in a net salary (to be paid monthly) of one hundred and nineteen thousand seven hundred and twenty-two United States dollars per annum at the dependency rate (one hundred and six thousand two hundred and fifty-five 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, the Director-General 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 ninety-eight. The representation allowance shall be used at his or her discretion entirely in respect of representation in connection with his or her official duties. He or she 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 Health 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) G.H. BRUNDTLAND
Director-General

(signed) F.R. AL-MOUSAWI
President of the
World Health Assembly

ANNEX 2

Casual income¹

Report by the Director-General

[A51/14 - 15 April 1998]

1. The Executive Board was informed at its 101st session in January 1998 that the estimated balance of casual income as at 31 December 1997 was US\$ 17 679 636.
2. The Director-General is pleased to inform the Health Assembly that, following the closure of the accounts as at 31 December 1997 and as indicated in the financial report for 1996-1997, Schedule 5 - Casual Income Account, the actual amount of casual income available before appropriation as at 31 December 1997 is US\$ 30 148 404. The major development from the earlier estimate is the fact that US\$ 10 million of casual income appropriated by the Assembly for country programmes has been allotted in 1998 and not in 1997.
3. The current situation of casual income is thus as follows:

	US\$	US\$
Balance as at 31 December 1997		30 148 404
Less:		
(a) Appropriation for programmes financed from casual income (resolution WHA48.32) being the second and final instalment of the total amount of US\$ 20 000 000 appropriated	10 000 000	
(b) Interest earned in 1997 to be apportioned among Members in accordance with the incentive scheme (resolution WHA41.12) for the 2000-2001 regular budget	<u>3 891 640</u>	<u>13 891 640</u>
Net amount of casual income to be returned to Member States to apply to their assessments in 1999 (resolution WHA50.25)		<u><u>16 256 764</u></u>

The above amount of US\$ 16 256 764 will be deducted accordingly from the assessments due from Members for 1999.

¹ See summary record of the second meeting of Committee B, section 1, second part (document WHA51/1998/REC/3).

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

4. [The Health Assembly was invited to note the use of casual income available as at 31 December 1997.]
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ANNEX 3

Strategy on sanitation for high-risk communities¹

Report by the Director-General

[A51/20 - 9 March 1998]

.....

NEW STRATEGY

13. Given the persisting low sanitation coverage, the high prevalence of diseases caused by poor environmental conditions, low investment in sanitation, and population growth and urbanization, a new approach to sanitation is considered to be the best course of action. Focus on high-risk communities will allow maximum health benefits to be derived from investments in sanitation and related programmes. In the context of the health-for-all strategy this approach has to be an integrated and interdisciplinary one, based on strengthened internal coordination and cooperation among organizations of the United Nations system and with appropriate nongovernmental organizations.

14. Consequently, it is proposed that Member States of WHO and all other organizations concerned should focus sanitation efforts on high-risk communities, with renewed emphasis on sanitation as a whole, in terms both of overall investment and of integration with related development activities. Of great importance to the success of this effort will be the involvement of communities in planning, implementing and maintaining their services and the development of sanitation technology suitable for difficult geographical and residential conditions, taking into account cultural beliefs and habits, and long-term ecological and financial sustainability.

15. No illusions should be nourished, however, that sanitation for the rural and urban poor could be provided on a full-cost-recovery or even on a self-financing basis, as is increasingly the case of urban water supply, with its current trend towards privatization. In the case of sanitation, gains for public health more than justify public expenditure. Considerable community involvement and self-help will be needed in order to offset costs and to ensure greater sustainability of sanitation systems.

16. The high-risk approach must be both ethical and promotional (see paragraph 17(2) below). Public health principles demand that those at highest risk should be given priority. Lack of social equity in supporting communities' efforts for sanitation is a main reason for the heavy disease burden and many epidemics observed today. Environmental sanitation has therefore to be closely linked, and provide support, to the reduction of infectious disease transmission, with particular emphasis on children and women of child-bearing age.

17. The main elements of the new strategy are:

- (1) **focus on communities at high risk from diseases related to insanitary conditions:** Member States should: identify and give high priority to high-risk communities and subgroups in urban and rural

¹ See resolution WHA51.28.

areas according to existing conditions, taking into account health statistics (including intraurban health differentials) and other systematic data from screening, where available and relevant; support and participate in research on sanitation methods and technology specially suited to the needs of communities in difficult geographical and social conditions (e.g., rocky soil, high water-table, extreme crowding, no legal status, extreme poverty), and should analyse successful cases and establish models of "good practice"; and ensure the suitability and sustainability of sanitation services through programmes of meaningful community involvement, stimulating community action and self-help, and remaining sensitive to cultural and ecological needs. The competent authorities and agencies could greatly benefit from collaboration with nongovernmental organizations and other groups with successful experience in community participation;

(2) **higher priority to sanitation in national planning for health and investment in infrastructure:** Member States, international development organizations and nongovernmental organizations should begin a sanitation promotion programme to increase political will at every level; priorities should be established in the preparation of national action plans for health and environment, and should be firmly integrated into programmes for implementation; sanitation should be integrated into as many other aspects of development as possible, such as programmes on child survival, maternal and child health, communicable disease control, essential drugs, and agricultural development (with recycling of waste where feasible and appropriate).

WHO'S ROLE

18. WHO has a responsibility to provide leadership in sanitation as a major determinant of health, bearing in mind that most of the public works and other measures are undertaken by authorities other than health agencies, such as municipal services and local government.

19. WHO's mandate includes support to such programmes initiated by authorities in other sectors than the health sector (see the corresponding provisions in paragraph 4 of resolution WHA51.28).

20. Thus WHO, in cooperation with other appropriate organizations in the health sector will play an effective and dynamic role in changing attitudes and establishing priority for sanitation.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

21. [The Health Assembly adopted as resolution WHA51.28 the text recommended by the Executive Board in its resolution EB101.R14.]

INDEX TO RESOLUTIONS AND DECISIONS

*(Numerals bearing the symbol "WHA51..." refer to resolutions;
numerals alone in parentheses refer to decisions)*

	Page		Page
Adolescents and children, health of (WHA51.22)	25	Declaration, World Health (WHA51.7)	4
Antimicrobial resistance (WHA51.17)	18	Director-General, appointment (WHA51.4) contract (WHA51.5)	3 4
Anti-personnel mines, public health action (WHA51.8)	6	expression of appreciation (WHA51.6) .	4
Assessments, scale for 1998-1999 (WHA51.21)	21	salary (WHA51.25)	28
status of collection (WHA51.1)	1	Drugs, revised strategy (10)	9
Blinding trachoma, global elimination (WHA51.11)	10	Ethical Criteria for Medicinal Drug Promotion (WHA51.9)	9
Chagas disease, elimination of transmission (WHA51.14)	14	Executive Board, election of Members entitled to designate a person to serve on (9)	39 40
Children and adolescents, health of (WHA51.22)	25	reports on 100th and 101st sessions (12)	40
Climate change and stratospheric ozone depletion, protection of human health (WHA51.29)	33	status of members (WHA51.26)	29
Cloning, ethical, scientific and social implications (WHA51.10)	9	Financial Regulations, amendments (WHA51.20)	21
Communicable diseases, antimicrobial resistance (WHA51.17)	18	Financial report for 1996-1997 (WHA51.19)	20
Constitution of the World Health Organization, amendments (WHA51.23)	26	General Committee, establishment (5)	38
Contributions, Members in arrears (WHA51.2, WHA51.3)	2,3	Health Assembly, <i>see</i> World Health Assembly	
Credentials, Committee on, composition (1)	37	Health-for-all policy for the twenty-first century (WHA51.7)	4
verification (7)	38	Health promotion (WHA51.12)	11
		Health sector reform, technical cooperation (WHA51.16)	16

	Page		Page
Indigenous People, International Decade of (WHA51.24)	27	Regular budget, allocation to regions (WHA51.31)	35
Internet, advertising, promotion and sale of medical products (WHA51.9)	7	Salaries for ungraded posts and the Director- General (WHA51.25)	28
Leprosy, elimination (WHA51.15)	15	Sanitation in high-risk communities, strategy (WHA51.28)	31
Medical products, advertising, promotion and sale (WHA51.9)	7	Staff, Pension Fund (11)	39
Members in arrears (WHA51.2, WHA51.3)	2,3	<i>see also</i> Salaries	
Mines, anti-personnel, public health action (WHA51.8)	6	Technical cooperation, health sector reform (WHA51.16)	16
Nominations, Committee on, composition (2)	37	<i>The world health report 1998</i> (8)	39
Noncommunicable disease prevention and control (WHA51.18)	19	Trachoma, blinding, global elimination (WHA51.11)	10
Ozone depletion, protection of human health (WHA51.29)	33	Tuberculosis (WHA51.13)	13
Palestine, health conditions in the occupied Arab territories including (WHA51.27)	29	Ungraded posts and the Director-General, salaries (WHA51.25)	28
Pension Fund, United Nations Joint Staff (11)	39	United Nations Joint Staff Pension Fund (11)	39
Regions, WHO, allocations from the regular budget (WHA51.31)	35	Voting privileges, restoration, Members in arrears (WHA51.3)	3
		World Health Assembly, Fifty-first, agenda (6)	38
		officers (3)	37
		main committees (4)	37
		Fifty-second, country of meeting (13) ..	40
		method of work (WHA51.30)	35
		World Health Declaration (WHA51.7)	4

WHA51/1998/REC/1

FIFTY-FIRST WORLD HEALTH ASSEMBLY

Geneva, 11-16 May 1998

RESOLUTIONS AND DECISIONS
ANNEXES

Addendum

Please insert the attached page at the end of the Index to resolutions and decisions.