WORLD HEALTH ORGANIZATION

THIRTY-FOURTH
WORLD HEALTH ASSEMBLY

GENEVA, 4-22 MAY 1981

SUMMARY RECORDS OF COMMITTEES

GENEVA
1981
ABBREVIATIONS

The following abbreviations are used in WHO documentation:

ACABQ - Advisory Committee on Administrative and Budgetary Questions
ACAST - Advisory Committee on the Application of Science and Technology to Development
ACC - Administrative Committee on Coordination
CIDA - Canadian International Development Agency
CIOMS - Council for International Organizations of Medical Sciences
DANIDA - Danish International Development Agency
ECA - Economic Commission for Africa
ECE - Economic Commission for Europe
ECLA - Economic Commission for Latin America
ECWA - Economic Commission for Western Asia
ESCAP - Economic and Social Commission for Asia and the Pacific
FAO - Food and Agriculture Organization of the United Nations
IAEA - International Atomic Energy Agency
IARC - International Agency for Research on Cancer
IBRD - International Bank for Reconstruction and Development
ICAO - International Civil Aviation Organization
IFAD - International Fund for Agricultural Development
ILO - International Labour Organization (Office)
IMCO - Inter-Governmental Maritime Consultative Organization
ITU - International Telecommunication Union
NORAD - Norwegian Agency for International Development
OAU - Organization of African Unity

OECD - Organisation for Economic Co-operation and Development
PAHO - Pan American Health Organization
PASB - Pan American Sanitary Bureau
SIDA - Swedish International Development Authority
UNCTAD - United Nations Conference on Trade and Development
UNDP - United Nations Development Programme
UNDRO - Office of the United Nations Disaster Relief Coordinator
UNEP - United Nations Environment Programme
UNESCO - United Nations Educational, Scientific and Cultural Organization
UNFDAC - United Nations Fund for Drug Abuse Control
UNFPA - United Nations Fund for Population Activities
UNHCR - Office of the United Nations High Commissioner for Refugees
UNICEF - United Nations Children's Fund
UNIDO - United Nations Industrial Development Organization
UNITAR - United Nations Institute for Training and Research
UNRWA - United Nations Relief and Works Agency for Palestine Refugees in the Near East
UNSCEAR - United Nations Scientific Committee on the Effects of Atomic Radiation
USAID - United States Agency for International Development
UNICEF - United Nations Children's Fund
WHO - World Health Organization
WIPO - World Intellectual Property Organization
WMO - World Meteorological Organization

The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation "country or area" appears in the headings of tables, it covers countries, territories, cities or areas.
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The Thirty-fourth World Health Assembly was held at the Palais des Nations, Geneva, from 4 to 22 May 1981, in accordance with the decision of the Executive Board at its sixty-sixth session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

- Resolutions and decisions, and list of participants - document WHA34/1981/REC/1
- Verbatim records of plenary meetings, and committee reports - document WHA34/1981/REC/2
- Summary records of committees - document WHA34/1981/REC/3

1 The resolutions, which are reproduced in the order in which they were adopted, have been cross-referenced to the relevant sections of the WHO Handbook of Resolutions and Decisions, and are grouped in the table of contents under the appropriate subject headings. This is to ensure continuity with the Handbook, Volumes I and II of which contain most of the resolutions adopted by the Health Assembly and the Executive Board between 1948 and 1980. A list of the dates of sessions, indicating resolution symbols and the volumes in which the resolutions and decisions were first published, is given in Volume II of the Handbook (page xiii).
OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President:
Dr Méropi VIOLAKI-PARASKEVA (Greece)

Vice-Presidents:
Mr M. C. JALLOW (Gambia)
Mr M. M. HUSSAIN (Maldives)
Dr J. ANXONIE FERNÁNDEZ (Honduras)
Dr QIAN Xinzhung (China)
Dr G. RIFAI (Syrian Arab Republic)

Secretary:
Dr H. MAILER, Director-General

Committee on Credentials
The Committee on Credentials was composed of delegates of the following Member States: Argentina, Bahrain, Belgium, Bulgaria, Denmark, Jamaica, Kenya, New Zealand, Nigeria, Senegal, Sudan, Thailand.

Chairman: Mr J. NJIRU (Kenya)
Later: Dr F. M. MUEKE (Kenya)
Vice-Chairman: Dr H. J. H. HIDDLESTONE (New Zealand)
Rapporteur: Mr V. BEAUGE (Argentina)
Secretary: Mr H. J. SCHLENZKA (Assistant Legal Counsel)

Committee on Nominations
The Committee on Nominations was composed of delegates of the following Member States: Chile, China, Ecuador, France, Guatemala, Hungary, India, Ivory Coast, Lesotho, Libyan Arab Jamahiriya, Mexico, Morocco, Oman, Singapore, Sri Lanka, Trinidad and Tobago, Tunisia, Union of Soviet Socialist Republics, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Cameroon, United Republic of Tanzania, Zaire, Zambia.

Chairman: Dr Elizabeth QUAMINA (Trinidad and Tobago)
Secretary: Dr H. MAHLER, 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: Chile, Costa Rica, France, German Democratic Republic, Kuwait, Libyan Arab Jamahiriya, Malaysia, Mongolia, Nigeria, Senegal, Tunisia, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United Republic of Cameroon, United States of America, Zimbabwe.

Chairman: Dr Méropi VIOLAKI-PARASKEVA (Greece), President of the Health Assembly
Secretary: Dr H. MAHLER, Director-General

MAIN COMMITTEES

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

Committee A
Chairman: Dr E. P. F. BRAGA (Brazil)
Vice-Chairmen: Dr J. ROgowski (Poland) and Dr A. K. AL-GHASSANY (Oman)
Rapporteur: Dr J. M. KASONDE (Zambia)
Secretary: Mrs I. BRUGGEMANN (Development of Health Programme Evaluation)

Committee B
Chairman: Dr Z. M. DLAMINI (Swaziland)
Vice-Chairmen: Dr L. SÁNCHEZ-HARGUINDEY (Spain) - Later: Dr M. DE LA MATA (Spain) - and Dr A. HASSOUN (Iraq)
Rapporteur: Dr Deanna ASHLEY (Jamaica)
Secretary: Dr O. W. CHRISTENSEN (Coordination with Other Organizations)
AGENDA

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 sixty-sixth and sixty-seventh sessions
10. Review of the report of the Director-General on the work of WHO in 1980
11. [deleted]
12. Election of Members entitled to designate a person to serve on the Executive Board
13. Presentation of the Léon Bernard Foundation Medal and Prize
14. Presentation of the Dr A. T. Shousha Foundation Medal and Prize
15. Presentation of the Jacques Parisot Foundation Medal
16. Approval of reports of main committees
17. Closure of the Thirty-fourth World Health Assembly

COMMITTEE A

18. Election of Vice-Chairmen and Rapporteur
19. Programme budget for the financial period 1982-1983
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   19.2 Budget level and Appropriation Resolution for the financial period 1982-1983
20. Tentative budgetary projections for the financial period 1984-1985
21. Health for all by the year 2000
   21.1 Global Strategy
   21.2 The contribution of health to socioeconomic development and peace - implementation of resolution 34/58 of the United Nations General Assembly and of resolutions WHA32.24 and WHA33.24
22. The meaning of WHO's international health work through coordination and technical cooperation
23. Infant and young child feeding
   23.1 Progress report
   23.2 Draft International Code of Marketing of Breast-milk Substitutes

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1 The agenda was adopted at the third plenary meeting.
2 Item referred to Committee B.
24. Technical activities and questions identified for additional examination during the review of the proposed programme budget and of the Executive Board's report thereon

COMMITTEE B

25. Election of Vice-Chairmen and Rapporteur

26. Review of the financial position of the Organization
   26.1 Interim financial report on the accounts of WHO for 1980 and comments thereon of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Health Assembly
   26.2 Status of collection of assessed contributions and status of advances to the Working Capital Fund
   26.3 Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution
   26.4 Report on casual income and budgetary rate of exchange between the US dollar and the Swiss franc for 1982-1983

27. Reimbursement of travel costs of representatives to regional committees

28. /deleted/

29. Scale of assessments
   29.1 Assessment of new Members and Associate Members
   29.2 Scale of assessments for the financial period 1982-1983

30. Salaries and allowances for ungraded posts and for the Director-General

31. Appointment of External Auditor

32. Real Estate Fund

33. Headquarters accommodation requirements

34. /deleted/

35. Study of the Organization's structures in the light of its functions - implementation of resolution WHA33.17

36. Periodicity and duration of Health Assemblies

37. Transfer of the Regional Office for the Eastern Mediterranean

38. Amendment of the International Health Regulations (1969)

39. Organizational studies by the Executive Board
   39.1 Organizational study on the role of WHO in training in public health and health programme management, including the use of country health programming
   39.2 Future organizational studies

40. Recruitment of international staff in WHO: annual report

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

42. Collaboration with the United Nations system
   42.1 General matters
   42.2 Health care of the elderly (preparations for the World Assembly on Aging, 1982)
   42.3 International Year of Disabled Persons, 1981: WHO's cooperative activities within the United Nations system for disability prevention and rehabilitation
   42.4 Health assistance to refugees and displaced persons in Cyprus
   42.5 Health and medical assistance to Lebanon
   42.6 Cooperation with newly independent and emerging States in Africa: liberation struggle in Southern Africa - assistance to front-line States
   42.7 Cooperation with the Republic of Zimbabwe

43. United Nations Joint Staff Pension Fund
   43.1 Annual report of the United Nations Joint Staff Pension Board for 1979
   43.2 Appointment of representatives to the WHO Staff Pension Committee
1. ADOPTION OF THE AGENDA AND ALLOCATION OF ITEMS TO THE MAIN COMMITTEES (Document A34/1)

The CHAIRMAN reminded the Committee that under its terms of reference, as defined in Rule 33 of the Rules of Procedure of the Health Assembly, it was required to transmit the provisional agenda to the Assembly with its recommendations. Since certain items had been included in the provisional agenda for consideration "if any" to cover eventualities that had not materialized, the Chairman suggested recommending that the Assembly delete those items from its agenda; they were items 11 (Admission of new Members and Associate Members), 28 (Supplementary budget for 1980-1981) and 34 (Working Capital Fund) with its two subitems 34.1 and 34.2. Moreover, in item 26 (Review of the financial position of the Organization) the words "(if any)" following the wording of subitem 26.3 (Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution) should be deleted because that subitem would have to be considered.

It was so agreed.

Referring to subitem 26.4 (Report on casual income) of that same item 26, the CHAIRMAN pointed out that document A34/11 submitted to the Assembly in respect of that subitem dealt not only with casual income but also with the question of the budgetary rate of exchange for 1982-1983; that question had only come to the fore since the January session of the Executive Board, at which the provisional agenda for the present Assembly had been drawn up. The Chairman suggested that, to take this into account, the Committee should recommend to the Assembly that the subitem concerned be re-entitled "Report on casual income and budgetary rate of exchange between the US dollar and the Swiss franc for 1982-1983".

It was so agreed.

Dr ABDULHADI (Libyan Arab Jamahiriya) expressed the wish, before the Committee moved on to the allocation of items to the main committees, to propose to the General Committee the inclusion of a supplementary item in the agenda, if the Rules of Procedure of the Assembly so permitted.

He had in mind a problem which had important repercussions for the health of millions of people all over the world, and which had its origins in the Second World War. That war had left many countries with material sequelae which continued to affect the physical and psychological health of their peoples, some of whom were still living in fear of the possible consequences of those sequelae.
The delegation of the Libyan Arab Jamahiriya felt that the Health Assembly was the appropriate forum to deal with the matter, and wished it to be put on the agenda of the present Assembly. It was not so much a matter of highlighting the responsibilities of certain countries as of drawing the attention of the world as a whole to the continuing nature and severity of the problem.

Dr AL-SAIF (Kuwait) supported Dr Abdulhadi's request.

Professor AUJALEU (France) said that if Dr Abdulhadi wished to propose an additional agenda item he ought to propose a title for the item; he had in fact merely indicated the problem without proposing any wording.

The DIRECTOR-GENERAL suggested that the delegation of the Libyan Arab Jamahiriya might put forward its comments on the problem concerned during the consideration of an item already on the agenda, for example subitem 21.2 (The contribution of health to socioeconomic development and peace). If after that presentation, it felt it necessary to submit more detailed documentation on the subject to the Assembly, it could ask for such documentation to be prepared for a forthcoming Assembly.

Following an exchange of views on the procedure to be followed in the matter, in which Dr REID (United Kingdom of Great Britain and Northern Ireland), Dr GALAHOV (Union of Soviet Socialist Republics), the CHAIRMAN and Dr ABDULHADI (Libyan Arab Jamahiriya) took part, the latter agreed to the Director-General's suggestion: his delegation would present its views on the problem, which it definitely wanted to bring up at the present session, during the consideration of subitem 21.2.

Turning to the allocation of agenda items to Committees A and B, the CHAIRMAN felt that the General Committee would agree to recommend allocating the items as indicated in the provisional agenda drawn up by the Executive Board, on the understanding that if necessary items could subsequently be transferred from one committee to another.

Referring to the preliminary timetable submitted to the General Committee in document A34/GC/1, Dr ABDULHADI (Libyan Arab Jamahiriya) noted that agenda item 37 (Transfer of the Regional Office for the Eastern Mediterranean) was scheduled for consideration in Committee B on Saturday 16 May. Many ministers of health for whom that item was of great importance would have left Geneva by that time and so would not be able to take part in the discussion. He therefore proposed that consideration of that item should be brought forward in the Assembly's timetable.

Dr AL-SAIF (Kuwait) and Mrs DAGHFOUS (Tunisia) supported that proposal in view of the importance of the matter for the countries of the Region they represented.

The CHAIRMAN commented that, while the General Committee allocated agenda items to the main committees, each committee organized its work as it thought fit, and in particular decided on the order in which it would examine the items assigned to it. It was therefore to the Chairman of Committee B that the proposal concerned should be made.

The DIRECTOR-GENERAL, after confirming the Chairman's comments, pointed out that there was nothing to prevent the General Committee from expressing a preference regarding the order of priority for consideration of agenda items.

Dr ABDULHADI (Libyan Arab Jamahiriya) expressed his satisfaction with the explanations given by the Chairman and the Director-General, and agreed that the decision on the date for discussion of the item concerned should be left to Committee B.

In the light of the statements made, the General Committee recommended allocating the agenda items as shown in the provisional agenda.
2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The CHAIRMAN pointed out that the Executive Board had decided at its sixty-seventh session that the Assembly should complete its work by the end of the third week of the session. She also drew the Committee's attention to document A34/CC/1 - already referred to by Dr Abdulhadi - which contained the preliminary daily timetable for the Thirty-fourth World Health Assembly drawn up in accordance with resolution WHA32.36.

Dr BORGOÑO (Chile) expressed the fear that, if the decision contained in that resolution were adhered to, whereby neither of the main committees of the Health Assembly should meet during plenary meetings, the present Assembly would find it impossible to complete its work by 22 May without night meetings. He felt that the General Committee should consider preventive measures and proposed that the Health Assembly should reverse the decision taken two years ago.

The CHAIRMAN reminded the Committee that the decision had been taken mainly because many delegations were not numerous enough to have a member in plenary and in the committees at the same time. For her own part, she intended to appeal to delegates to keep their interventions in plenary short so as to leave more time for the work of the committees. If in the course of the Assembly the shortage of time should become acute, the Health Assembly could discuss the matter in plenary.

The DIRECTOR-GENERAL pointed out that two years ago resolution WHA32.36 had cancelled the provisions of resolution WHA28.69, adopted in 1975, which had provided for plenary meetings and main committee meetings to take place simultaneously. He also drew attention to the fact that the matter was to be reconsidered under agenda item 36 (Periodicity and duration of Health Assemblies). The fact remained that at present resolution WHA32.36 prevented the Assembly from meeting in plenary and in committee at the same time. However, if the General Committee so wished, the Secretariat could study the problem of a change in procedure during the present Assembly.

To help solve the problem Dr ABDULHADI (Libyan Arab Jamahiriya) suggested that the Assembly should not devote the whole of the Friday and the Saturday morning of its first week to the Technical Discussions, in which by no means all delegations took part. That day and a half could more usefully be devoted to continuing the general discussion in plenary.

The CHAIRMAN stated that for the present the Committee had to observe the provisions of the resolutions governing the work of the Assembly. As the Director-General had stated, agenda item 36 would provide an opportunity to reconsider the matter for the future.

Dr BORGOÑO (Chile) agreed that the Assembly could organize its work as in previous years during the first week, but was convinced that the General Committee should already be applying itself to the problem of shortage of time which could be expected to arise during the following two weeks, and should accordingly prepare suitable proposals without delay for the plenary Assembly.

The CHAIRMAN suggested that the Committee should not act so soon and should see how the work of the Assembly proceeded during the first few days before it considered changing the established practice.

The DIRECTOR-GENERAL commented that if circumstances really made it necessary during the session the President could, at the suggestion of the General Committee, request the Assembly in plenary to suspend the relevant provisions of resolution WHA32.36.

At the request of the CHAIRMAN, prior to any detailed examination of the programme of meetings for the forthcoming days, the DIRECTOR-GENERAL informed the Committee of the arrangements made concerning the address to be given in plenary on the following day by Mrs Indira Gandhi, Prime Minister of India, and asked it to approve the time fixed for that address.

The General Committee agreed thereto and then drew up the programme of meetings for the afternoon and for Wednesday, 6 and Thursday, 7 May.
The Committee also approved the Chairman's proposal that suggestions for the election of Members entitled to designate persons to serve on the Executive Board should be submitted by 10h00 at the latest on Monday, 11 May.

The CHAIRMAN announced her intention to close the list of speakers wishing to take part in the general discussion on agenda items 9 and 10 at the end of the afternoon plenary meeting on Wednesday, since there were already 105 delegations on it. She would inform the Assembly in plenary accordingly.

She would also inform the Assembly that, in accordance with the arrangements in force, the Technical Discussions would be held all day on Friday, 8 May, and on the morning of Saturday, 9 May.

Following an exchange of views between the CHAIRMAN, the DIRECTOR-GENERAL and Dr ABDULHADI (Libyan Arab Jamahiriya) regarding the advisability of starting the morning plenary meetings at 9h00 (rather than at 9h30), the Committee agreed, in view of the usefulness of the contacts which could be made in the mornings between delegates and members of the Secretariat, including the Director-General, to fix the hours of work of the Assembly as in the past (apart from exceptional cases): both the plenary meetings and the meetings of the committees would be held from 9h30 to 12h30 and from 14h30 to 17h30, and the General Committee would meet at either 12h30 or 17h30.

The meeting rose at 13h30.

SECOND MEETING

Thursday, 7 May 1981, at 17h45

Chairman: Dr Méropi VIOLAKI-PARASKEVA (Greece), President of the Health Assembly

PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

After hearing Dr BRAGA (Brazil), Chairman of Committee A, and Dr DLAMINI (Swaziland), Chairman of Committee B, report on the first brief meetings that their committees had just held, the General Committee drew up the programme of meetings for Monday, 11 and Tuesday, 12 May, fixing its next meeting for Monday, 11 May, at 12 noon.

The meeting rose at 17h50.

THIRD MEETING

Monday, 11 May 1981, at 12h00

Chairman: Dr Méropi VIOLAKI-PARASKEVA (Greece), President of the Health Assembly

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

The CHAIRMAN pointed out that the procedure for drawing up the General Committee's proposals for the election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and by Rule 102 of the Assembly's Rules.
of Procedure, and drew the attention of the members of the Committee to the documents provided, namely:

(a) a table showing the geographical distribution of seats on the Executive Board by region;
(b) a regional list of the Members of the Organization which were, or had been, entitled to designate persons to serve on the Executive Board;
(c) a list, in alphabetical order by region, of Members the names of which had been suggested following the announcement made by the President of the Assembly in the plenary meeting under Rule 101 of the Assembly's Rules of Procedure;
(d) lastly, a table showing the present composition of the Executive Board, with the names underlined of those of the Members that had designated a person to serve on the Board whose term would expire at the end of the Thirty-fourth World Health Assembly and who would have to be replaced; for the African Region, Burundi, Cape Verde, the Comoros and Chad; for the Region of the Americas, Mexico; for the South-East Asia Region, Burma; for the European Region, France and the Union of Soviet Socialist Republics; for the Eastern Mediterranean Region, Bahrain; and, finally, for the Western Pacific Region, China.

At the request of the Chairman, Mr VIGNES (Legal Adviser) explained the procedure usually followed by the General Committee in submitting its proposals to the Assembly. The General Committee could, if it so desired, engage in a general discussion during which they could propose by word of mouth the names of countries other than those whose names had already been suggested in writing. The first operation would then consist in drawing up, by secret ballot, a list of candidatures in which the members of the Committee could include all the countries they wished to have taken into consideration. The Committee would then proceed to the vote proper, again by secret ballot, drawing up on the basis of the list of candidatures thus established a list of not more than fifteen and not less than ten Members; finally if necessary, the Committee would recommend the names of ten Members selected obligatorily from the previous list. Of course, if the list of candidatures established by secret ballot included only ten names it would be needless for the Committee to go through the successive stages that had just been mentioned.

The CHAIRMAN first asked the members of the General Committee if they wished to hold a general discussion. As this was not the case, she wondered, since the list of Members submitted in writing to the Committee included only ten names and the countries concerned satisfied the criterion of geographical distribution, whether it would be necessary for the General Committee to go through the intermediate procedural steps enumerated by the Legal Adviser.

Mr VIGNES (Legal Adviser) pointed out that the General Committee was obliged at least to draw up by secret ballot the list of candidatures which he had mentioned, so that its members would have the possibility of including in the list the names of all the countries they wished to be considered as candidates.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) agreed with the Legal Adviser that, satisfactory though the agreement between the countries of the different regions might be, which had led to the drawing up of a preliminary list of ten Members ensuring a balanced geographical distribution, the Committee could not dispense with the establishment of a list of candidatures by secret ballot. It was only then that the Committee could, if necessary, pass on to drawing up the maximum and minimum lists provided for under the relevant provisions of the Rules of Procedure.

Dr BORGOÑO (Chile) did not see why the General Committee had to go through all the steps in the procedure outlined, since the list submitted to it included only the names of ten Members and he therefore proposed approval by acclamation of the list of those ten Members for transmission to the Health Assembly.

The CHAIRMAN, after having consulted the Legal Adviser, stated that such a vote by acclamation was not possible. The General Committee would therefore have to follow the voting procedure laid down, and she asked Dr Marranghelli (Costa Rica) and Dr Reid (United
Kingdom of Great Britain and Northern Ireland) to act as tellers for counting the votes that would be cast.

Mr VIGNES (Legal Adviser) reminded the Committee that before it could go on to the official vote for drawing up by secret ballot a list of not more than fifteen and not less than ten Members it must first proceed, also by secret ballot, to draw up the list of candidatures.

The CHAIRMAN pointed out that the General Committee had not deemed it necessary to hold a preliminary discussion with a view to the addition of the names of other countries to those on the list which had been submitted to it. She herself had thought that the agreement reached between the Member States of the different regions and which had resulted in the drawing up of that list - the agreement to which Dr Venediktov had referred - could dispense the Committee from having to go through all the steps of the procedure described by the Legal Adviser.

Dr ABDULHADI (Libyan Arab Jamahiriya) felt that the statutory provisions in force should be strictly respected. Even if the list of ten Member States submitted in writing to the General Committee resulted from an agreement between Member States of different regions, none the less the members of the General Committee must be given the possibility of adding the names of such countries as they deemed desirable to those of the ten countries in question. For the Committee should avoid creating a precedent by not strictly following the provisions of the Rules of Procedure.

Professor AUJALEU (France) stated that the list of candidatures could include a number of names considerably greater - 20 or 30 or even more - than that of the first official list mentioned in Rule 102 of the Rules of Procedure.

The General Committee took a vote by secret ballot to draw up the list of candidatures.

The CHAIRMAN communicated to the General Committee the results of the ballot in which 15 countries received votes.

In response to a request by the Chairman for fuller information, Mr VIGNES (Legal Adviser) pointed out that the vote which had just been taken was not a formal vote but had only an indicative value and aimed only at drawing up a list of candidatures on the basis of which it now remained for the General Committee to proceed to the vote proper. Consequently the Committee now had to draw up by means of a vote by secret ballot, a list of at least ten and at most fifteen Members.

Dr GURMUH SINGH (Malaysia) informed the Committee that his country, whose name appeared on the list of candidatures, wished to withdraw in favour of Japan which belonged to the same region.

In response to further requests for clarification from the Chairman, Mr VIGNES (Legal Adviser) explained that the Committee could not skip a step in the procedure by failing to draw up the list of not more than fifteen and not less than ten Members, since the provisions of Rule 102 of the Rules of Procedure imposed on the General Committee the obligation to transmit that list to the Health Assembly with, if necessary, its recommendations concerning the ten Members who would provide if elected, a balanced distribution of the Board as a whole.

Professor AUJALEU (France) supported the Legal Adviser's interpretation. In his view the General Committee had to have the possibility of transmitting a list containing more than ten Members to the Health Assembly.

The DIRECTOR-GENERAL stated that the members of the General Committee were not obliged to enter more than ten names on their ballot papers for drawing up the list in question but that they were entitled to do so, provided that the names in question were those appearing on the list of candidatures.

The General Committee then took a vote by secret ballot to draw up a list of not less than ten and not more than fifteen Members selected from the list of candidatures, which would be transmitted to the Health Assembly.
The CHAIRMAN then read out the names of the countries which had obtained the necessary majority: Bulgaria, Maldives, Mozambique, Japan, Sao Tome and Principe, Seychelles, Spain, Guinea-Bissau, United Arab Emirates, and United States of America. She also gave the names of the countries that had not obtained that majority: Mauritania, Bangladesh, Cuba, Malaysia, and Niger.

As the result of the ballot which had just taken place was that only ten Members obtained the necessary majority, the Chairman stated that she considered there was therefore no need to proceed to a further ballot and that only the names of the ten countries that had obtained the necessary majority would be transmitted to the Health Assembly, in accordance with the provisions of the Rules of Procedure, with a view to the annual election of ten Members to be entitled to designate a person to serve on the Board.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) said that he agreed with the Chairman's suggestion.

Since there were no other comments the CHAIRMAN announced that the procedure that she had indicated would be followed.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The General Committee confirmed the programme of work already planned for Tuesday, 12 May, and drew up the programme for Wednesday, 13 May.

The meeting rose at 13h45.

FOURTH MEETING

Wednesday, 13 May 1981, at 17h40

Chairman: Dr Méropi VIOLAKI-PARASKEVA (Greece), President of the Health Assembly

PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

After hearing reports by Dr DLAMI N (Swaziland), Chairman of Committee B, and by Dr BRAGA (Brazil), Chairman of Committee A, on the progress of the work of their committees, the General Committee drew up the programme of work of the Assembly for Thursday 14, Friday 15 and Saturday 16 May. On the Saturday the main committees would meet from 09h00 to 13h00.

The meeting rose at 17h50.

FIFTH MEETING

Friday, 15 May 1981, at 17h40

Chairman: Dr Méropi VIOLAKI-PARASKEVA (Greece), President of the Health Assembly

PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

After Dr BRAGA (Brazil), Chairman of Committee A, had reported on the progress of the work of that Committee, the CHAIRMAN expressed her anxiety at the slow progress of its work and the hope that the pace could be speeded up so as to avoid having to consider night meetings.
Dr DLAMINI (Swaziland), Chairman of Committee B, reported in turn on the progress of the work of that Committee.

Following an exchange of views on ways of avoiding the need for night meetings during the final week of the Assembly, in which Dr BORGONO (Chile), Dr ABDULHADI (Libyan Arab Jamahiriya), Dr HARRIS (United Kingdom of Great Britain and Northern Ireland), Dr DLAMINI (Swaziland), Chairman of Committee B, and the CHAIRMAN took part, the General Committee agreed to extend the hours of work of the Assembly for the first few days of the following week.

Accordingly it drew up the programme of work of the Assembly for Monday 18 and Tuesday 19 May, fixing the starting time of the morning meetings (both plenary and main committee meetings) at 09h00 (instead of 09h30) and the closing time for the afternoon meetings at 18h00 (instead of 17h30). The General Committee would hold its next meeting on Monday 18 May at 12h30 and, subject to confirmation at that meeting, would hold its subsequent meeting on Tuesday 19 May at 18h00.

The meeting rose at 17h55.

SIXTH MEETING

Monday, 18 May 1981, at 12h40

Chairman: Dr Méropi VIOLAKI-PARASKEVA (Greece), President of the Health Assembly

1. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

Dr DLAMINI (Swaziland), Chairman of Committee B, and Dr BRAGA (Brazil), Chairman of Committee A, reported on the progress of the work of their committees. The latter reported that, in order to make up some of its arrears of work, Committee A had agreed to extend its meeting that same afternoon, Monday 18 May, until 19h30; it had also decided to move on to agenda item 23 (Infant and young child feeding) as soon as it had completed its consideration of item 19 (Programme budget for the financial period 1982-1983).

At the suggestion of the CHAIRMAN and in agreement with Dr DLAMINI (Swaziland), Chairman of Committee B, it was agreed that Committee B would also continue its work that afternoon until 19h30.

Turning to consider the programme of meetings already arranged for the following day, the General Committee agreed, in view of the heavy workload still facing the two main committees, and taking into account comments by Dr ABDULHADI (Libyan Arab Jamahiriya) regarding the traditionally poor attendance at night meetings of the Assembly, to extend the day meetings of the main committees on Tuesday 19 May as follows: from 8h30 to 13h00 and from 14h30 to 20h00.

The CHAIRMAN reminded the Committee that in accordance with resolution WHA31.1 Committee B would not meet while Committee A was engaged in recommending the budget level and Appropriation Resolution for the financial period 1982-1983 and in considering the tentative budgetary projections for the ensuing biennium.

The General Committee drew up the programme of work of the Assembly for Wednesday 20 May; for the same reasons which had led it to change the hours of work for the preceding day, it fixed the timetable of meetings for Wednesday 20 May as follows: meetings of the main committees from 8h30 to 12h30 and from 14h30 to 18h00, plenary meeting at 12h30, and meeting of the General Committee at 13h00.
2. DATE OF CLOSURE OF THE HEALTH ASSEMBLY

The General Committee agreed to fix the date of closure of the session at its meeting on the day after next, Wednesday 20 May.

3. ALLOCATION OF AGENDA ITEMS TO THE MAIN COMMITTEES: TRANSFER OF ITEMS

Drawing attention to the short time remaining until the end of the Assembly and stressing the extreme importance of agenda item 21 (Health for all by the year 2000), Dr BORGONO (Chile) urged that the item - which was to be considered by Committee A - should not be dealt with in haste right at the end of the session. If necessary it could be transferred to Committee B, which seemed to be less pressed for time than Committee A.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) was also convinced of the cardinal importance of that agenda item but took the view that, since it concerned a matter essential to the Organization's programme, it was most desirable that Committee A - which dealt primarily with programme matters - should consider it. To lighten the load on that Committee it would be possible to transfer another agenda item to Committee B, for example item 23 (Infant and young child feeding), in which subitem 23.2 (Draft International Code of Marketing of Breast-milk Substitutes) was concerned more with establishing regulations.

Following a discussion concerning both the appropriateness and merits of transferring one or the other of the items in question from Committee A to Committee B and the authority to decide on such a transfer, in which Dr BRAGA (Brazil), Chairman of Committee A, Dr HARRIS (United Kingdom of Great Britain and Northern Ireland), the CHAIRMAN, Dr BORGONO (Chile), Dr VENEDIKTOV (Union of Soviet Socialist Republics), and Dr DLAMINI (Swaziland), Chairman of Committee B, took part, and during which the DIRECTOR-GENERAL insisted that the subject of breast-feeding covered by agenda item 23 was also unquestionably a programme matter and not an administrative matter, the General Committee agreed as follows:

The Chairman of Committee A would request that Committee at its next meeting to make a final decision on the transfer to Committee B of either item 21, with its two subitems, or item 23, also with its two subitems; he would officially announce that transfer, to which the General Committee agreed in advance.

The meeting rose at 13h15.

SEVENTH MEETING

Wednesday, 20 May 1981, at 13h15

Chairman: Dr Méropi VIOLAKI-PARASKEVA (Greece), President of the World Health Assembly

1. PROGRAMME OF WORK AND DATE OF CLOSURE OF THE HEALTH ASSEMBLY

After Dr BRAGA (Brazil), Chairman of Committee A, and Dr HASSOUN (Iraq) Vice-Chairman of Committee B, had reported on the progress of the work of those committees, the General Committee drew up the programme of work of the Assembly for Thursday, 21 May. As the two main Committees still had a heavy agenda it was agreed that they should meet in the morning, from 8h30 to 13h00, and that they would continue their afternoon sessions, which would immediately follow a plenary meeting fixed for 14h30, after 17h30 if necessary.

The CHAIRMAN again pointed out that Committee B would not meet during the consideration by Committee A of item 20 of the agenda (Tentative budgetary projections for the financial period 1984-1985).
The General Committee then decided that the closure of the Assembly should take place on Friday, 22 May, and drew up the programme of meetings for the last day of the session: the main committees would meet from 09h00 to 12h30, and in the afternoon a plenary meeting would be held at 14h30 and would be followed at 15h00 by the closing meeting of the Assembly.

2. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee at an end.

The meeting rose at 13h25.
COMMITTEE A

FIRST MEETING

Thursday, 7 May 1981, at 17h00

Chairman: Dr E. P. F. BRAGA (Brazil)

1. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 18 of the Agenda (Document A34/28)

The CHAIRMAN expressed gratitude for his election. He particularly appreciated the opportunity to continue his country's long association with WHO. He recalled that Brazil had been one of the founder Members of the Organization, evoked the earlier role of another member of the Brazilian delegation, Dr Candau, as Director-General, and referred to his own close association with WHO since 1951.

He drew attention to the third report of the Committee on Nominations, nominating Dr T. Szelachowski (Poland) and Dr A. A. K. Al-Ghassany (Oman) for the offices of Vice-Chairmen of Committee A, and Dr J. M. Kasonde (Zambia) for that of Rapporteur. Dr Szelachowski, however, had to return to Poland unexpectedly, and he therefore called for nominations for a candidate to replace him.

Mr SOÓS (Hungary), supported by Professor SENAULT (France) and Dr ODDO (Italy), proposed Dr J. Rogowski, also of the Polish delegation.

Decision: Committee A elected the following officers: Vice-Chairmen, Dr J. Rogowski (Poland) and Dr A. A. K. Al-Ghassany (Oman); Rapporteur, Dr J. M. Kasonde (Zambia).

2. ORGANIZATION OF WORK

The CHAIRMAN drew attention to the Committee's heavy agenda, including review of the proposed programme budget for 1982-1983 and consideration of the global strategy for health for all. The daily programmes of work would be announced in the Journal; he suggested that the Committee should normally work from 9h30 to 12h30 and from 14h30 to 17h30.

It was so agreed.

The meeting rose at 17h30.

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1 See document WHA34/1981/REC/2.
SECOND MEETING
Tuesday, 12 May 1981, at 9h30

Chairman: Dr E. P. F. BRAGA (Brazil)

PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA33.17, para. 4(1), and WHA33.24, para. 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOCS./2)

The CHAIRMAN, introducing the agenda item, said that the proposed programme budget was the second biennial budget to be considered by the Health Assembly and the first to be developed entirely after the International Conference on Primary Health Care, Alma-Ata, 1978. It had been examined in great detail by the Executive Board at its sixty-seventh session in January of the current year. The proposed programme budget for 1982-1983 (document PB/82-83) and the report of the Executive Board thereon (document EB67/1981/REC/3) would be the Committee's main working documents; the other documents listed provided further detailed information.

The Committee would first discuss the policy issues referred to in the Introduction to the proposed programme budget and in the relevant paragraphs of the Executive Board's report. He invited the Chairman of the Executive Board to present the Executive Board's general view of the overall policy issues.

Dr BARAKAMFITIYE (representative of the Executive Board) said that the Committee was about to consider one of the major issues before the Thirty-Fourth World Health Assembly, since its deliberations would be of vital importance for WHO's work in 1982-1983. The Executive Board had taken considerable pains to make a detailed examination of the proposals submitted to it by the Director-General.

In his Introduction (paragraph 12), the Director-General had pointed out that the programme budget proposals for 1982-1983 aimed at achieving an impact on countries in four interlinked ways by bringing about the individual and collective action of Member States to give effect to the global strategy for health for all; by providing valid information on health systems, infrastructures and technology, obtained both from existing knowledge and experience and from the promotion and application of research; by improving the capacity of countries to absorb that knowledge and adapt it to their health and socioeconomic situation; and by mobilizing massive national and international resources in support of the endeavours of developing countries to implement their strategies for health for all.

The Board had kept those objectives in mind when considering the Director-General's proposals and had stressed that WHO's work should, both directly and indirectly, support national strategies for attaining health for all. That was a major criterion for evaluating the pertinence of the various programme activities proposed.

In order to strengthen further what was being done within countries, the Board had considered what was the best way to use WHO resources at country level. It had concluded that, despite the progress that had already been made, much still remained to be done in that field. The Committee would also have noted that the Director-General had himself mentioned that point in his address to the plenary meeting.

Another crucial point discussed by the Board was how to use the programme budget to facilitate technical cooperation among Member States. Such an approach called for a different way of using the Organization from that in practice when WHO was executing or financing technical assistance projects in those countries. Comments by members of the Committee on that point were eagerly awaited, as they would allow an assessment to be made of the extent to which the proposals actually met the programme budget objectives he had mentioned.

In considering to what extent all the programmes together supported one another and formed a coherent pattern of activities that countries would find easy to use to develop and implement their health strategies, the Board had stressed that the best way to make use of WHO was for countries to put to work the knowledge and experience their joint efforts had accumulated.
within the Organization. That meant that countries must use that knowledge on an individual basis, but must also work together within the governing bodies to ensure that that knowledge and the other resources of the Organization were put to the best possible use in order to promote strategies for the development of health systems based on primary health care, in accordance with the Declaration of Alma-Ata.

When considering whether it was possible for the Organization to carry out its ambitious programme within a budget framework of reasonable size, the Executive Board had greatly appreciated the fact that the Director-General, although authorized by the Health Assembly to make proposals up to a ceiling representing a real increase of 4%, had taken the world economic situation into account and had made proposals not exceeding a real increase of 2.25%.

The Committee's comments on that "progressive programming and conservative budgeting" would be of vital importance. He suggested, however, that those comments should be made in connexion with agenda item 19.2 - Budget level and Appropriation Resolution for the financial period 1982-1983; they would not only determine the budget ceiling for 1982-1983, but would also have an impact on budget ceilings for the years to come.

It should be recalled that the funds available to the Organization for implementing its programmes were of two kinds: those included in the regular budget, of which he had just spoken, and those from extrabudgetary sources. Nearly 50% of the proposed programme budget would be met from extrabudgetary funds. That showed the considerable interest being taken in WHO's work. While noting that trend with satisfaction, the Board had once again stressed that all funds, whatever their source, should be used to support policies and strategies that had been defined by the governing bodies of the Organization.

It was incumbent on all to make sure that the activities contained in the programme budget contributed effectively to the implementation of the health policies that had been defined. In particular, it was essential to ensure that the programme budget effectively supported the efforts being made by Member States to attain the highest possible level of health for all their peoples compatible with their socioeconomic situation, whether those efforts were individual ones or formed part of cooperation among countries and with WHO.

The CHAIRMAN said that he hoped that members of the Committee would, in their comments, bear in mind the criteria for reviewing the budget proposals which Dr Barakamfiteyi had mentioned: for example, their relevance to the efforts of Member States in developing and implementing their health strategies, the way in which those activities could help Member States to cooperate with one another, how the activities were being coordinated among themselves so that Member States could make the best possible use of them, and how the Organization could undertake all those activities with the funds available.

He reminded delegates that they would have the opportunity of discussing matters of a technical nature that might go beyond the policy issues and programme proposals under agenda item 24 (Technical activities and questions identified for additional examination during the review of the proposed programme budget and of the Executive Board's report thereon), which had been placed on the agenda specifically for that purpose. If, therefore, delegates had specific technical issues that they would like discussed they should raise them during the discussion on the programme concerned, and he would see that they were taken up in more detail under agenda item 24. In the meantime, they should focus their observations on the broader programme issues.

Professor LISICYN (Union of Soviet Socialist Republics) asked whether at that early stage of the discussions, comments on the Introduction to document PB/82-83 should be limited to general remarks, or whether more detailed comments could be made on individual programmes.

Dr FRESTA (Angola) congratulated the Secretariat and the Executive Board for their work on the programme budget, which would serve to encourage countries to develop their health programmes. Angola was making great efforts in that field and was devoting some 10% of its budget to health programmes. However, the war being waged was hindering the implementation of the programmes and dissipating resources.

Dr EL GAMAL (Egypt) said that, while agreeing that comments should be limited to general observations on policy and that details should be considered under agenda item 24, he wondered what would be the situation if, under agenda item 24, it was decided to cancel some part of the programme after the programme budget had already been approved.
The CHAIRMAN said that, even if it was felt that detailed attention should be given to a topic under agenda item 24, it would nevertheless be possible to discuss it during examination of the programme budget.

In reply to the question raised by Professor Lisicyn, he confirmed that he would first like to hear general comments on the Introduction to the programme budget, and that the Committee would subsequently consider the document section by section.

Professor LISICYN (Union of Soviet Socialist Republics) said that his delegation considered the proposed programme budget to be one of the most important questions before the Health Assembly relating to the practical steps being taken by the Organization towards achieving health for all by the year 2000. He congratulated the Director-General on his attempt to orient the programme budget towards the Global Strategy. Nevertheless, after careful study of the document, his delegation considered that it revealed a certain failure to concentrate programmes and the corresponding allocations around the basic nucleus of the strategy, namely primary health care, as adopted in 1977. Insufficient stress had been laid on primary health care as an integral part of all health services and of all activities in the health field.

His delegation was pleased to note, however, how WHO, in accordance with previous resolutions of the Health Assembly, had introduced changes in certain structural elements and in the relationship between the central, regional and local levels of health care delivery. It noted also that there was a certain trend towards a weakening of central control over WHO programmes being implemented in the field, which had led the Director-General to suggest setting up a core group to study the coordination of technical inputs at the three levels, and to report directly to him. Yet it was to be feared that such an approach might hamper the implementation of a unified programme of strategies.

His delegation also noted, as the Director-General had stressed in his Introduction, that insufficient efforts had been deployed towards achieving genuine technical cooperation rather than technical assistance, and considered that more needed to be done to remedy this shortcoming.

Insufficient stress had also been given to scientific research, which was a basic element for solving the problems of the strategy for achieving health for all.

As regards the real increase in the programme budget of 2.25%, to which reference had been made, it should be remembered that that increase was in addition to the allowance of 10-11% for inflation. Thus, the programme budget was not being reduced, but was in fact increasing, and that increase was not necessarily justified as regards every item; and yet the whole of WHO's biennial budget of about US$ 500 million represented only about 1% of total world expenditure on health. The Health Assembly should therefore make every effort to see whether certain parts of the programme budget could be deleted, so that allocations could be concentrated on the key components of the Global Strategy. Moreover, although it was pleasing to read, at the beginning of the Introduction to the budget document, of the warm atmosphere within the Organization, a more realistic approach should be adopted, taking into account the realities and needs of the cold climate in the world at large, in which health policies had to be implemented.

Dr QUAMINA (Trinidad and Tobago) stressed the need to build up national infrastructures, as mentioned in the Introduction to the proposed programme budget; many countries adopted programmes and were then unable to implement them because such infrastructures were lacking. She welcomed the Director-General's initiative in trying to channel extrabudgetary funds and to rationalize the process of obtaining and spending funds, but warned against the setting-up of a new bureaucracy for the purpose, which would lead to undue delays. Her delegation approved the modest real increase of 2.25% in the budget, and was pleased that 80% of that increase was devoted to country, regional and interregional programmes.

Professor JAKOVLJEVIĆ (Yugoslavia) said that the representative of the Executive Board had requested that the programme budget should be discussed in the light of the principles defined in paragraph 12 of the Introduction to document PB/82-83. His delegation had studied that document with a view to determining the extent to which the proposals in it were related to those principles. Of those principles, one of the most important was bringing about the individual and collective action of Member States to give effect to the Global Strategy for health for all. It was not an easy task to reflect that principle completely, particularly as a comparatively short time had elapsed since the Alma-Ata
Conference and the important decisions by the Health Assembly which had completely changed WHO's policy. The programme budget was a very serious attempt to implement that policy and to stimulate countries and regions to fulfill their various tasks, but it would be difficult to say that it was totally based on, and adapted to, that policy. Nevertheless, his delegation supported the programme budget, because it was clear that a major effort had been made in that direction, especially in view of the great difficulty of the task.

Dr BORGÔNO (Chile) said that the real increase of 2.25% in the budget level, over and above the 11% allowance for inflation, was an appropriate figure. The strengthening of national capabilities was essential if primary health care was to achieve its maximum effect in terms of preventive medicine and health promotion. The infrastructure should be strengthened in such a way as to produce an integrated system; all levels, not merely the base, were essential in achieving health for all by the year 2000. Finally, he stressed the importance of research, already mentioned by the delegate of the Soviet Union, and the exchange of information on the results of such research. His delegation was in complete agreement with the principles laid down in the Introduction to the budget document.

Dr EL GAMAL (Egypt) referred to paragraph 21 of the Introduction and to the firmer control to be exercised by the Director-General over the coordination of programme activities. In that connexion, he drew attention to major programme 2.5 on page 89 of the budget document, under which US$ 4.6 million was allocated to the Director-General's Development Programme. No details were given, although the amount involved was greater than for many other programmes and exceeded, in particular, the total figure of US$ 3.18 million for the Regional Directors' Development Programmes.

Dr RINCHINDORJ (Mongolia) found the programme budget an improvement on what had been presented in previous years. It was the first to be prepared after the general acceptance of health for all by the year 2000 as WHO's objective and after the Alma-Ata Declaration. The key question for WHO was therefore that of the Global Strategy for achieving that objective; nevertheless, all WHO's work should be directed towards supporting national health strategies, since its activities were evaluated mainly in terms of their impact on the development of health in the Member States. In formulating the programme budget, therefore, and in implementing it, projects for cooperation in line with the needs of national health services were of central importance.

He noted with satisfaction that the programme budget reflected the changes that had taken place in the international social, economic and political climate in accordance with the principles of the New International Economic Order and the New International Development Strategy, and with United Nations General Assembly resolution 34/58 on health as an integral part of socioeconomic development. He was fully in agreement with the principles laid down in paragraph 12 of the Introduction to the budget document, which were in line with the Global Strategy for health for all by the year 2000. In the application of those principles, although priority had been given to certain important programmes, an attempt had also been made to ensure that support was given in a balanced way to all programmes.

Examination of the programme budget showed that practically all projects were linked with primary health care; that was fully justified, since the key to the achievement of health for all was the development and strengthening of such care. It was not always clear, however, how separate primary health services were to be linked with the higher levels of public health; that applied particularly where small-scale primary health services had been started in countries. He therefore stressed the importance of a systems approach in both the establishment and the management of primary health services.

For obvious reasons, different countries had begun to develop the structure of primary health care in different ways, as mentioned in the report of the Executive Board on the proposed programme budget for 1982-1983. In that report, the Board had drawn attention to the problem of providing expertise in the strengthening of national capabilities for health development. Great progress would be made towards achieving the goal of health for all if the majority of Member States were really committed to health work in line with progressive principles of health.

The programme budget for 1982-1983 showed some increase over the previous one in real terms, after an allowance of 11% for inflation had been made. That showed, he was sorry to see, that WHO was still affected by inflation. He hoped that the present and future programme budgets would be both rational and effective.

Dr BRYANT (United States of America) said that WHO's programmes were highly complex, especially because of the need to integrate them within the single theme of health for all.
by the year 2000. His delegation, in previous years, had urged the Secretariat to work towards that end, and it was clear that a substantial and successful effort had been made to relate the major programmes to one another and to that goal; the budgetary implications of those programmes were also given. In addition, the problems and difficulties of proceeding from theoretical descriptions to concrete programmes had been faced.

Major milestones in the development of WHO’s capability to achieve the objective of health for all by the year 2000 included the study of the Organization’s structures in the light of its functions, and the Seventh General Programme of Work - an opportunity for WHO to specify how various individual programmes would be related to the goal. The foregoing represented a brilliant, systematic and logical treatment of highly complex subjects, but the question remained whether it was enough. The answer given in document PB/82-83 was that it was not.

Most of the managerial attention and most of the programme budget were focused on the headquarters and regional levels, whereas health for all had meaning ultimately at the country level. The current stages in the conceptualization and management of health for all were therefore only preparatory to developments at national level. WHO would have to link headquarters and regional ideas, expertise and resources with country needs, desires and capacities. The brilliance of the global ideas did not mean that they would necessarily penetrate to the countries and communities where they were most needed.

Efforts would have to be made within a framework of budgetary constraints at all levels; that was all the more reason for focusing on priority areas, especially at country level. The Director-General had referred to the need for effective management of efforts at the global level, and had spoken of the establishment of a small staff group reporting directly to him, specifically with the aim of developing more effective links between headquarters and countries; that was his prerogative, and the United States delegation would encourage him to proceed. He had also spoken of developing a mechanism for rationalizing the flow of funds internationally, whatever their source or destination, so that they could be related effectively to health for all. The United States delegation also supported the development of such a mechanism, appropriately related to and supportive of WHO’s existing governing bodies, structures and functions.

The task ahead was an immense one, and there should be no drawing back from considering the changes proposed by the Director-General.

In concluding he commended the Director-General and the Secretariat for the programme budget they rightly characterized as being "progressive programming and conservative budgeting".

Professor SHEHU (Nigeria) said that he had no doubt that the principles enunciated by the Executive Board and the Director-General were sound; there was a shift towards a more realistic budget designed to support activities in Member States aimed at attaining the goal of health for all by the year 2000. He referred to the statement contained in paragraph 7 of the Executive Board’s report to the effect that WHO’s activities had to be developed in the light of, and in support of, national strategies for the attainment of health for all within countries. He could not see anywhere in the budget document, however, how it was proposed to ensure that the Organization’s management structure would be modified so as to strengthen WHO’s role at the country level. There was a lack of proper delegation of authority to programme coordinators in the Member States, yet he saw no other way of producing maximum impact at that level. He was not saying that because he was himself a programme coordinator; he had expressed the same view long before he had begun to play that role. A more aggressive approach by WHO at the country level was definitely needed.

According to paragraph 17 of the Executive Board’s report, some US$ 2000-3000 million was being transferred for health work each year to developing countries. It was to be hoped that those huge sums would be used in accordance with the principles set out in the budget document.

Professor LU Ruslan (China) said that he had carefully studied the programme budget; it was a well-presented document which was in line with the general aims of health for all by the year 2000. It was appropriate that emphasis should be given to expenditure on health care in Third World countries and to the prevention and treatment of communicable diseases. His delegation approved the programme budget, but would have comments to make later on specific items.

Dr ABDULHADI (Libyan Arab Jamahiriya) said that preparation of the programme budget consisted of a number of different stages at the regional and international levels, with a view to ensuring harmonious and coherent policies, and the integration and coordination of programmes between countries and regions. He pointed out, however, that there was a lack of
representation in the Eastern Mediterranean Region, since Subcommittee A and other bodies had been unable to obtain the views of countries as a result of the difficult situation prevailing there. His delegation would therefore find it difficult to discuss the programme budget, and would state its position only when it was put to the vote in the plenary.

Professor VON MANGER-KOENTIG (Federal Republic of Germany) congratulated the Director-General and the Secretariat on the well-presented proposed budget for 1982-1983 and thanked the Chairman of the Executive Board for his clear comments, which would considerably facilitate assessment and analysis of the budget. His delegation fully supported the general policy and principles, including those set out in paragraph 12 of the Introduction to the budget document.

None the less, his delegation had certain reservations as to various financial aspects. A real increase of 2.25% was considerably higher than what his country could afford in its national budget. There, in the light of the financial constraints that also affected other countries, the idea of real growth had had to be abandoned. The budgetary policies of international organizations should likewise take account of the economic situation and limited resources of the contributing Member States. Both the international organizations and Member States were being called upon to keep any budgetary increase under the most careful scrutiny, with a minimum growth and as much absorption as possible of additional costs resulting from exchange rate fluctuations and inflation, through savings. That applied particularly when drawing up new programme budgets, which afforded an opportunity to examine carefully all existing programmes and administrative areas, to decide to what extent they tallied with priorities; all measures and projects over which there hung any doubt could then be reduced or dropped, thus paving the way for new growth.

Dr TOURE (Senegal) congratulated the Director-General on the proposed programme budget.

The preconditions for optimizing the programme were peace and the New International Economic Order. It was however essential to reach a definition of health with the most disadvantaged populations in mind. The transfer of technology, while excellent in its way, should not be allowed to eclipse the development of appropriate local technology; milk substitutes, for example, had their part to play, but it was breast-feeding that should be particularly encouraged in developing countries.

Regarding international cooperation, he stressed the need for coordination. The strengthening of countries' individual capacities was not at variance with the spirit of TCDC; on the contrary, it was complementary.

He supported the principles for 1982-1983 (paragraph 12 of the Introduction); regarding their application, his delegation would comment later in greater detail on certain specific aspects.

He stressed the need to protect the budget against currency fluctuations; he was convinced that, given the right strategies, a rigorous management of health programmes and the will to succeed - both at the national and international levels - the Director-General's proposals for "progressive programming and conservative budgeting" would be successful.

Dr MUEKE (Kenya) said that both the programme budget and the report of the Executive Board highlighted a number of major issues and clearly represented a considerable amount of work. His delegation had noted that the main theme was the Global Strategy for achieving health for all through primary health care, and wished to associate itself with that approach. It particularly appreciated the references to the promotion of technical cooperation among countries, and would like to see it strengthened particularly in the fields of research training, the control of communicable diseases, and the exchange of technology.

Mrs BROWN (Bahamas) congratulated the Director-General on the proposed programme budget for 1982-1983 and expressed her delegation's appreciation of his efforts to improve the monitoring of developments at a time of unavoidable constraints. At the same time, she put in a plea for more effective action to foster technical cooperation - which, in her view was the key to the achievement of health for all by the year 2000. To that end, the country management components should be improved, and the establishment of country programme posts to facilitate that mechanism should be supported. Her delegation would accordingly support that component of the budget.
Dr KLIBAROVÁ (Czechoslovakia) said that the general discussion in plenary on the Director-General’s report and the reports of the Executive Board had left the impression that attention was almost entirely concentrated on solving problems related to primary health care at regional and country level. Very little appeared to have been said, however, on how to work for health for all at the global level. Moreover, the headquarters budget allocation appeared to be reduced to an extent which left her delegation wondering whether problems which should be solved at the highest scientific level were instead being decided at secondary level, and whether the coordinating role of WHO headquarters was not being reduced.

She asked, further, whether programmes in which WHO played an important part in conjunction with other agencies, such as UNDP and voluntary bodies, were conducted in accordance with the same basic guidelines as WHO programmes.

Dr OLDFIELD (Gambia), commenting on the proposed programme budget from the viewpoint of a small developing country which had great difficulty in finding funds for its health programmes, spoke of the strenuous efforts being made by the developing countries for the first time in history to re-order their priorities, the better to serve the needs of health for all by the year 2000. His delegation was accordingly concerned at the suggestion that WHO should budget for zero growth, a policy which was not even being adopted in his own very poor country. There was a very great deal to be done, and the Director-General was to be congratulated on his success in budgeting for a 2% real growth. His delegation fully supported that policy.

The DEPUTY DIRECTOR-GENERAL, replying to some of the comments made in the course of the overall debate, observed that some of them had touched on the very principles behind the programme budget and on general trends within the Organization endorsed by the Assembly and by the Executive Board. The point at issue was where the major thrust of the Organization’s programme should lie.

The delegate of Czechoslovakia had raised a most critical issue of principle by suggesting that there was a need to strengthen the Organization’s global capacity and to provide for the taking of decisions on some major programmes at global level. He had also understood her to equate global level with the highest scientific level, and to characterize as a "secondary level" the level at which some major decisions with respect to programme budgeting were being taken. All those suggestions held controversial implications for the general principles which had been endorsed by the Organization in recent years. Every other speaker except the delegate of Czechoslovakia had stressed that national managerial skills and infrastructures needed strengthening, in a move away from a situation in which most of the Organization’s energy and strength was concentrated at global level and very little happened at national and regional levels. In recent years, efforts had been made to decentralize and give a more liberal approach and interpretation to the Organization’s programmes.

The delegate of Czechoslovakia had further asked whether other agencies and programmes in which WHO had an interest operated in the same way as did WHO. The answer to that was a clear "no". While there were similarities in operation between agencies and programmes, individual styles were more important, and WHO in particular had its own traditions. If the Assembly felt that WHO should operate in the same way as UNICEF or some other United Nations agency, the Constitution would require amendment to make such a shift in control possible. Nevertheless programmes financed from extrabudgetary resources were fully compatible with and complementary to the regular budget aims and programmes.

The delegate of the United States of America had mentioned the need to strengthen national capabilities to ensure that the main thrust of the Organization’s program was felt at country level. In that respect, it seemed to him that the programme budget for 1982-1983 was more integrated, more rationalized, better articulated and certainly more effectively broken down than in any other year, and he was delighted at the reference to progressive programming and conservative budgeting; it was heartening that the United States delegation should see the programme budget in that light.

He was happy to reassure the delegate of the Federal Republic of Germany, who had expressed some anxiety regarding the need for critical examination of projects and effective pruning, that at regional, national and global levels the viability of technical programmes was being constantly and critically reviewed by means of a wide variety of mechanisms. The programme budget which had emerged was as effective a rationalization as possible.

A preoccupation alluded to by the delegate of Trinidad and Tobago related to the existence of an obstructive bureaucracy within the Organization. He agreed that
bureaucracy had at one time been a problem, but he was certain that it had now all but disappeared at global level, and that the newer mechanisms introduced to control management and the mobilization of resources were notable for their great flexibility, which enabled constant and immediate action to be taken by officers fully aware of the need not to allow themselves to be tied up in bureaucratic knots. He suggested that it was rather in some ministries of health that bureaucracies were entrenched.

Replying to the question from the delegate of Egypt regarding the Director-General’s Development Programme, he said it might well be desirable for the Organization to have firm global control of the fund and be in a position to overview its activities. In the existing constitutional situation, however, such was not the case, as he had already pointed out. When that item of the budget was reached, further details would be given as to how the fund was managed, but, for the benefit of delegates who might not be conversant with its history, he would mention the following activities financed in 1980-1981 from the Director-General’s Development Programme: the action programme on essential drugs, the programme on traditional medicine and essential surgery, health services in Zimbabwe, primary health care in Africa, malaria and parasitic disease programmes in the Gambia, and training courses in the Expanded Programme on Immunization; all of these were examples of the use of a flexible fund that could be used quickly in emergency situations in a way not possible in the past.

It was for the Assembly itself to decide how it wished the Global Strategy for health for all by the year 2000 to be implemented. There was everything to be said for implementation that was quick, rational and unimpeded. Particularly at national level, there might be a variety of political, administrative and bureaucratic constraints which it was essential to identify and deal with if they were not to undermine and nullify efforts to achieve health for all by the year 2000 at all levels.

POLICY ORGANS (Appropriation Section I; Documents PB/82-83, pages 61-64 and EB67/1981/REC/3, paras 19-25)

The CHAIRMAN proposed that, in view of the close relationship between the three main items in Appropriation Section I, the Committee should consider all three items at the same time.

It was so agreed.

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board) said that the Board had attached considerable importance to the Organization’s policy organs.

The study of WHO’s structures in the light of its functions, culminating in resolution WHA33.17, had emphasized the importance of the policy organs, and the proposed programme budget for 1982-1983 envisaged closer correlation in their activities, with a view to maintaining the unity of the Organization, harmonizing policy and practice, and striking the right balance between centralised and decentralized activities.

The Board had noted that, whereas there was a reduction in the allocations for the Health Assembly and the Board - due largely to changes in the exchange rate - there was a considerable increase in the allocations for regional committees (US$ 360 800 for real increases and a further US$ 349 900 for cost increases). That reflected the increasing participation of regional committees in the work of the Organization. The regional committees had, for example, set up a number of subcommittees and advisory groups on important subjects such as the strategy for health for all, the implementation of the recommendations of the study of WHO’s structures in the light of its functions, the Seventh General Programme of Work, technical cooperation among the countries of the region, and the preparation of the programme budget. The Board had considered ways of harmonizing the work of the regional committees and the related budgetary provisions - such as annual reviews of regional activities by the Board and the Health Assembly, and the work of the Global Programme Committee, providing regional committees with a worldwide spectrum of relevant information. The Board recognized at the same time the constitutional right of regional committees to organize their activities as they deemed necessary to discharge their responsibilities.

The Board had also considered the possible budgetary implications of changes in the periodicity and duration of Health Assemblies (to be considered by Committee B under agenda item 36). Any decision to hold a biennial Health Assembly would in any case have no budgetary implications for the 1982-1983 budget, but certain savings could be made as a result of a decision to hold shorter Health Assemblies.
In connexion with the reimbursement of travel costs of representatives to regional committees (agenda item 27), the Board had felt that consideration should also be given to reviewing the reimbursement of travel costs to delegates to the Health Assembly. Any such decision would not, however, apply to the Executive Board, since members served on the Board in their personal capacities.

The attention which the Board had devoted to policy organs was a welcome portent for the future, since the best possible contribution which governing bodies could make to efficiency was to ensure that they themselves were functioning as efficiently as possible.

Dr BORGOÑO (Chile) suggested that, since the periodicity of Health Assemblies and the reimbursement of travel costs of representatives to regional committees were to be considered by Committee B, it might be preferable to await the results of the deliberations in Committee B before considering those matters further.

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board) explained that his only reason for referring to those two agenda items had been to make it clear that any decision that might be taken would have no implications for the programme budget for 1982-1983.

Mr PAGÉS PIÑEIRO (Cuba) expressed concern at the increase in the budget allocation for regional committees by almost 60% over the previous biennium, and suggested that it would be desirable to find other sources for financing the activities of regional committees. He pointed out that in the Region of the Americas the costs of regional subcommittees and subgroups were borne by the countries concerned. He suggested that in future there should be a closer correlation between the activities of regional committees and the budgetary allocations to them. If certain groups of countries were faced with specific problems in view of their geographical situation, state of development, etc., it was of course perfectly natural that they should wish to consider those problems in regional subgroups.

GENERAL PROGRAMME DEVELOPMENT, MANAGEMENT AND COORDINATION (Appropriation Section 2; Resolution EB67.R11; Documents PB/82-83, pages 65-89, and EB67/1981/REC/3, paras 26-30)

Executive management (major programme 2.1)

Dr BARAKAMPITIE (representative of the Executive Board) said that Member States were in the final instance responsible for the direction of WHO activities through its executive organs, but those organs could only perform their tasks properly if they received the necessary information and support. It was the function of executive management to provide this, as well as adequate support for individual governments and for cooperative activities between governments. That function was performed not only by the formal managerial machinery at headquarters and in the regions, but also by consultative and coordinating bodies such as the Headquarters Programme Committee and regional programme committees. The latter bodies, which represented only a modest additional expense, provided, in conjunction with the formal machinery, coherent managerial control systems covering the Organization as a whole. Proper managerial control was vital at a time when the Organization was dealing with so many new issues and trying out so many new ideas, with consequent increases in the regular budget and in extrabudgetary expenditure.

The Board had noted a cost increase of about 11% in this programme and a real increase of about 7%, largely accounted for by the creation of a new post of Assistant Director-General, together with supporting staff, which the Board had endorsed. The Board had been given comparative information on the top management establishment of other United Nations agencies, details of which would be found in the summary records of the Executive Board’s sixty-seventh session (document EB67/1981/REC/2, pages 53-54).

Mr PAGÉS PIÑEIRO (Cuba) asked for information on the reasons for creating a new post of Assistant Director-General, the additional functions to be performed, and the budgetary implications.

Mr WEITZEL (Federal Republic of Germany) recalled that attention had been drawn earlier to increasing bureaucratization and, in that connexion, he too would like further information on the need for a new post of Assistant Director-General.
The DEPUTY DIRECTOR-GENERAL said that the relevant details had been given to the Executive Board by the Director-General, and were contained in the extract from the summary records referred to by the representative of the Board.

General programme development and management (major programme 2.2)

Dr BARAKAMFITIYE (representative of the Executive Board) said that the proposed programme budget now under review was based on the more detailed medium-term programmes derived from the Sixth General Programme of Work covering the period 1978-1983. The Director-General had illustrated very well the aspects of continuity in his Introduction to the proposed programme budget, by evaluating first of all the achievements of the programme budget for 1980-1981. That was a good example of what should be done for all programmes, and one of the functions of the major programme now under consideration was to help in so doing. All the listed activities, if they were to be properly performed, depended on the availability of relevant and valid information, and the programme was designed to ensure that those responsible for planning and managing WHO activities had access to such information. The Board had therefore examined carefully the measures aimed at perfecting the managerial process for WHO's programme development, and taken note of the efforts made to ensure coordinated programme development at all levels. It had also confirmed the value of detailed medium-term programmes as a stepping-stone between the General Programme of Work and the WHO programme budgets.

The Board had raised the question of the resources required for the further development of indicators to monitor progress towards health for all, and had received assurances that adequate resources would be available. It had noted that WHO's information programme would continue to provide methodological and technical support for the further development of management and information systems, especially in the regions, in order to promote as far as possible the decentralization of management to regions and the setting-up of information processing services within the countries concerned. The Director-General had undertaken to carry out cost-benefit analysis both of the information system as a whole and of its individual activities. Planning and high quality management were no less important at country level than at headquarters, especially in connexion with the efforts being made to draw up and implement health for all strategies. The Board had noted with interest the efforts made not only to provide Member States with guiding principles for the managerial process for national health development, including of course country health programming, but also to provide support for countries to introduce and operate their own managerial processes based on those principles.

Professor LISICYN (Union of Soviet Socialist Republics), referring to the information systems programme (2.2.3), said that great emphasis had been placed on the need for information systems, but few details had been given on what the Organization was doing to satisfy that need. At the same time, there had been a tendency to cut budgetary allocations for information services, both in the field of health statistics and in medical research. He also asked for information on the joint UNICEF/WHO studies to which more than US$ 63 000 had been allocated (page 79 of the programme budget).

The meeting rose at 12h30.
THIRD MEETING

Tuesday, 12 May 1981, at 14h30

Chairman: Dr E. P. F. BRAGA (Brazil)

PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA33.17, para. 4(1), and WHA33.24, para. 3; Documents PB/82-82, EB67/1981/REC/3, Chapters I and II, and A34/INF./DOC./2) (continued)

GENERAL PROGRAMME DEVELOPMENT, MANAGEMENT AND COORDINATION (Appropriation Section 2; Resolution EB67.R11; Documents PB/82-83, pages 65-83 and 89, and EB67/1981/REC/3, paras 27-39 and 53-54)

General programme development and management (major programme 2.2) (continued)

The DEPUTY DIRECTOR-GENERAL, replying to questions raised, said that the sum of US$ 63 000 mentioned by the delegate of the Union of Soviet Socialist Republics at the previous meeting represented WHO's share of the costs of the studies undertaken jointly with UNICEF and of the UNICEF/WHO Joint Committee on Health Policy, composed of members of the Executive Boards of the two organizations, that reviewed them at its biennial session.

The additional post at the Assistant Director-General level was proposed because of the importance of regional representation at top management level. In that connexion it should be borne in mind that the number of six Assistant Directors-General was low in relation to the size of the Organization, as was clear from a comparison with the arrangements at ILO, UNESCO and FAO. The information requested by the Cuban delegate at the previous meeting was to be found in the summary records of the sixty-seventh session of the Executive Board (document EB67/1981/REC/2, pages 53-54).

Dr KO KO (Regional Director for South-East Asia) explained that the reduction in the amount allocated for the South-East Asia Region in programme 2.2.3 (Information systems programme) was not due to any lack of interest in the subject but to the fact that the countries of the Region had thought it better that information should be considered in the broad context of overall planning. Thus most information activities had been incorporated in country health programming (programme 2.2.2) or had been transferred to major programme 7.1 (Health information).

Dr KLIVAROVÁ (Czechoslovakia), referring to the directors of programme management mentioned in paragraph 11 of the narrative for general programme development (programme 2.2.1), asked how many directors of programme management there were in all and how many in each regional office.

Dr BARAKAMFITIYE (representative of the Executive Board) replied that there was one such officer per region.

Dr KAPRIO (Regional Director for Europe) explained that there had been a change in nomenclature and that the posts concerned had formerly been called "directors of health services", who were responsible for the total programme management under the regional director. There was only one director of programme management in each region. Under the director of programme management there might be several other directors responsible for more specific services. The group of directors of programme management formed, at the global level, a consultative body to help with the coordination of global programmes under the Global Programme Committee. The Region of the Americas had, however, a different nomenclature.

Mr PAGÉS PIÑEIRO (Cuba) said that, the socioeconomic inequalities existing between countries as a result of the unjust relations of the present international economic order
constituted a major obstacle to the attainment of the goal of health for all by the year 2000. His country therefore strongly supported the efforts being made by WHO, within the United Nations system, to achieve a New International Economic Order and a New International Development Strategy. It also agreed with the policy of promoting country health programming (programme 2.2.2) and endorsed the Executive Board's view that experience in health planning varied considerable from country to country, as well as its recommendation, in paragraph 28 of its report on the proposed programme budget (document EB67/1981/REC/3), that selective examples of such experience should be presented in a form suitable for training, adaptation and use by other countries. Cuba was willing to have the modest experience in health planning, which it had accumulated in the 22 years since the revolution, analysed and studied so that it could be of value to other interested countries and thereby contribute to improved cooperation among developing countries.

Dr LOCNO (Niger) said that nearly all countries, particularly in the African Region, recognized the great importance of country health programming as a systematic and continuous planning and programming process at the national level. The budgetary effort proposed in that connexion was therefore to be commended, and stress should be laid on the vital role to be played by the WHO national programme coordinators, whose authority should be strengthened, as the delegate of Nigeria had rightly suggested at the previous meeting. His delegation was satisfied with programme 2.2.3 (Information systems programme) and welcomed the proposal that training and practical seminars for national personnel should be intensified during the 1982-1983 biennium.

Professor LU Rushan (China) emphasized the importance of programme 2.2.2 (Country health programming) as a managerial process for national health development with a view to attaining the goal of health for all by the year 2000. Consequently, all programmes should be formulated in the light of real situations, and management should be strengthened; in that connexion WHO had an important coordinating task to perform. To that end it should cooperate with Member States, particularly with developing countries, in order to ensure managerial efficiency in the elaboration, formulation, implementation, monitoring and continuous evaluation of national health programme development. At the same time it should support training schemes for health development managerial staff. Particular attention should be paid to training material, which ought to cover all aspects of the managerial process.

Dr OSMAN (Sudan) said that the programme 2.2.2 was of fundamental value because the national experience acquired under it could be considered a most important indicator for training. Health programming was a corner-stone of health development in his country, and to promote it a committee of nationals had been established in 1974 with the cooperation of the Regional Office for the Eastern Mediterranean.

Speaking as representative of the World Federation of Public Health Associations at the invitation of the Chairman, he informed the Committee that the World Federation had cooperated closely with WHO in elaborating programmes designed to intensify national programmes, with particular emphasis on country health programming. The Federation had produced a document on both national and international cooperation in that field. The Federation, which felt that social aspects reinforced the health aspects, had further plans to consolidate the programme in cooperation with WHO and with Member States.

Dr BULLA (Romania), referring to the critical voices which had been raised to question the feasibility of the strategy for health for all at all levels, particularly the peripheral level, said that the only answer was to measure progress by means of health indicators. His delegation was therefore glad to note that there was to be an increase of US$ 2.4 million in the sum allocated to programme 2.2.1 (General programme development). However, within that overall increase the modest increase of US$ 19 200 allocated to research on the development of health indicators was disappointing. An explanation would therefore be most welcome. If further funds for research on health indicators were provided, though not explicitly, under other appropriation sections, the Secretariat might wish to supply some further information.

The CHAIRMAN pointed out that the subject of health indicators was due to be discussed in a broader context later in the session. Nevertheless, it would be helpful if Dr Barakamfityiye could provide some information on why such a low sum had been allocated to research on them.
Dr BARAKAMFITIYE (representative of the Executive Board) added that the whole problem of indicators would be taken up when the Committee came to discuss the Global Strategy for health for all by the year 2000 (agenda item 21.1). The Executive Board had discussed the development of indicators and the monitoring of progress and had been assured that the necessary resources would be provided, particularly for research programmes.

External coordination for health and socioeconomic development (major programme 2.3)

The CHAIRMAN suggested that the Committee might wish to take up the draft resolution contained in resolution EB67.R11 under agenda item 24.

It was so agreed.

Dr BARAKAMFITIYE (representative of the Executive Board) said that the Board had been informed that, pursuant to United Nations General Assembly resolution 32/197, the resident coordinators of the United Nations would henceforth assume overall responsibility for the support given at country level to operational activities for development by the United Nations system as a whole. That new approach would facilitate the integration of the health community with other social and economic sectors.

Several members of the Board had mentioned programme 2.3.3 (Emergency relief operations), which was designed to improve the preparedness of countries in disaster-prone regions. The Board had been informed that action was being taken to prepare national personnel to take the necessary action in disaster situations and that information was being collected on health requirements in such situations. The Board had also been informed that WHO was participating in a study being made of the capacity of the United Nations system to respond to disaster situations. Information had also been given on the financing of the programme.

The Executive Board had seen fit to adopt resolution EB67.R11, on the promotion of prevention of adverse health effects of disasters and emergencies through preparedness, which contained the draft resolution that the Committee had just agreed to take up later.

Dr BORGONIO (Chile) stressed the importance of coordination with other agencies within the United Nations system in order to secure an adequate participation of the health sector in multisectoral projects, in which the health sector was sometimes under-represented. Unfortunately, the voluntary agencies were undergoing a financial crisis which often made it difficult for them to participate.

The Region of the Americas was subject to all kinds of natural disaster, and it would be appreciated if an explanation could be given as to why the provision proposed for emergency relief operations in respect of that Region showed a decrease by comparison with the current financial period.

Mr PAGÉS PIÑEIRO (Cuba), referring to the programme on emergency relief operations, pointed out that his country was in the middle of a geographical area frequently devastated by hurricanes. Experience clearly showed that the preparation of the health sector, in coordination with other interested bodies and sectors, to meet the emergency situations caused by such disasters contributed very significantly to a reduction in the loss of life and in the outbreak of epidemics, as well as to the early recovery of the areas affected. His country therefore supported the proposed programme but considered that the sum allocated to it was too small. He wondered whether WHO should not pay greater attention to emergency situations confronting communities devastated by acts of war and whether these situations ranked as emergency situations for the purposes of programme 2.3.3. In any case the astronomical sums being spent on the production of lethal weapons led to non-natural disasters and could be better utilized to counter the effects of natural disasters.

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1 Agenda item subsequently transferred to the agenda of Committee B; see summary record of the fourteenth meeting of Committee B, section 3; fifteenth meeting, section 2; sixteenth meeting, section 1, and seventeenth meeting, section 3.

2 See p. 220.
Professor JAKOVLEVIĆ (Yugoslavia), noting that there was a constitutional obligation to devote resources to emergency situations arising out of natural and other disasters, said that it was the least developed countries which were in greatest need of support. The total sum allocated under programme 2.3.3 was therefore purely symbolic, and further financing should be sought from other sources. International solidarity was always present, but WHO should play a more important role.

Dr BAJAJ (India), noted that no allocation was shown for the European, Eastern Mediterranean and Western Pacific Regions in the table for programme 2.3.1 (Collaboration with the United Nations system and other organizations). He inquired whether that meant that no provision had in fact been made.

Dr DEL CID (Assistant Director, Regional Office for the Americas), replying to questions raised by the delegates of Chile and Cuba, said that the programme on emergency relief operations in the Americas related solely to natural disasters and to preparedness for such disasters rather than to immediate action. That situation was due to the lack of resources. The budgetary allocation had apparently diminished, but income from extrabudgetary sources was available.

The programme basically trained national staff and coordinated disaster relief operations among countries, with special emphasis on international cooperation for the training of human resources. Preparation for actually meeting disaster situations had been scant, and the Regional Office had tried to apply the concept of technical cooperation among developing countries. The experience of some countries such as Cuba had been quite rich, and an attempt had therefore been made to obtain, within countries, the necessary experience to secure both national and international coordination. The actual funds available were greater than those shown in the proposed programme budget, especially if extrabudgetary sources were taken into account.

Dr KAPRIO (Regional Director for Europe) said that in his Region financing for emergency relief operations was available from the Regional Director's Development Programme and had been used on a small scale to play a catalytic role in the attraction of other funds for disaster situations in both Algeria and Italy. There was also increasing interest in developing preparedness for more systematic preventive action to deal with disasters, especially earthquakes. In the European Region a number of governments had been invited to a workshop on preparedness to be held later in 1981 in the context of the increasing awareness of the importance of disaster relief operations.

Dr NAKAJIMA (Regional Director for the Western Pacific) said that in his Region collaboration with the United Nations system in respect of activities relating to emergency relief operations was made more difficult by the fact that no official United Nations agency was located in that Region, most of them being located in Bangkok, which was in WHO's South-East Asia Region. In the Western Pacific Region collaboration was mainly with the regional bank and with regional and subregional multilateral and bilateral organizations. The Regional Office was playing a mainly coordinating and technical advisory role with regard to emergency relief operations. Financing was quickly mobilized from other multilateral and bilateral sources, such as UNICEF and the Red Cross, or several industrialized countries within and/or outside the Region.

Professor SENAULT (France) said that no country was safe from natural disasters, and therefore all countries should have a disaster preparedness programme. The discussion on the subject in the Executive Board had underlined the special role of WHO in that field in terms of studies and information. Despite the goodwill always shown by the international community at times of natural disaster, there was undoubtedly a lack of the coordination that was so essential. WHO could play a special role in helping countries to prepare for natural disasters. Such disasters could not be forecast, but measures must be taken against the day when they might occur. He had intended to ask why no provision in that sphere had been made for Europe, since Europe was not free from all natural disasters, but Dr Kaprio had anticipated that question.

Professor GIANNICO (Italy), referring to the tragic results of the major earthquake in Italy in November 1980, when 3000 people had died, conveyed to the Committee his country's great appreciation of the immediate and effective aid WHO had furnished at that time. The
help received from so many quarters had demonstrated the spirit of international solidarity that was shown when a country was the victim of a natural disaster. Italy fully supported programme 2.3.3 (Emergency relief operations).

Dr BARAKAFITIYE (representative of the Executive Board) said that the Executive Board had sought mainly to see how a number of procedures could be established in preparation for a possible natural disaster. Such disasters could not be foreseen or prevented, but procedures could be prepared for use when disaster struck. Panic was all too likely at such times, with an attendant delay before action could be taken to protect the population against disease and other dangers. The need was for trained personnel with equipment and supplies and a certain organizational preparedness, to take immediate measures. That had been the main emphasis during the Executive Board’s discussion.

Professor HALTER (Belgium) invited the Committee’s attention to a special part of WHO’s work which was being done in Belgium. Under the guidance of Professor Lechat a centre specializing in disaster studies had been established at the Catholic University of Louvain. Disasters had an immediate impact on the health of the population, and he accordingly hoped that WHO would energetically pursue disaster preparedness activities. No other United Nations agency was as well equipped as WHO to deal with the many physical, social and mental health aspects of disasters. He thanked WHO for its cooperation in establishing the centre, which received visitors from all over the world who wished to study disaster problems.

Dr BAJAJ (India) expressed his country’s thanks for WHO’s help during the outbreaks of Japanese encephalitis and kala-azar in India, when vaccine and pentamidine had been supplied immediately.

Dr ADANDÉ MENEST (Gabon) referred to disasters that were due not to natural conditions, but to consequences of scientific and technological advances, such as bursting dams or oil spills. A country might be overtaken by such a disaster because of the actions of another, and be quite unprepared to deal with it. WHO should consider measures to deal with such events, with the help of international aid.

The DEPUTY DIRECTOR-GENERAL said that WHO had established a network of operations of which it could be proud and which compared well with the activities of other organizations. Dr Gunn would give further details of the fundamental activities, including training programmes to enable countries to respond urgently to emergencies.

Dr GUNN (Emergency Relief Operations) said that, as the Chilean delegate had pointed out, the Americas suffered severely from natural disasters. Indeed 93 of WHO’s 156 Member States were exposed to the risk of cyclically recurring natural disasters.

In the Americas, the Caribbean countries particularly were subject to hurricanes and the central and northern parts of South America to earthquakes. Cuba also had a severe disaster problem, and its programmes had greatly helped WHO as models for the establishment of preparedness and preventive measures. The Region had a good programme of preparedness for non-preventable disasters.

As for whether or not the funds available were sufficient, they seemed little more than symbolic. He could only say that he would do all he could to increase the extrabudgetary funds. When disaster struck, the raising of such funds presented no problem; and he paid tribute to the spirit of international solidarity shown at such times and to all the countries that gave direct or indirect help. But it was less easy to raise such funds for programme activities, even those for disaster preparedness. However, he believed that before long the same spirit would be shown in support of those programmes.

In reply to the delegate of Cuba, he confirmed that programme 2.3.3 covered disaster problems due to strife: it dealt with all disasters, whether natural or man-made. In fact a recent prospective study had singled out strife and man-made, including technological, disasters as a major problem of the 1980s. WHO was currently involved in disaster problems due to strife, as in the Lebanon; it was concerned also with national liberation movements and, in cooperation with the Office of the United Nations High Commissioner, with refugees. Technological disasters, to which the delegate of Gabon had referred, were also the special responsibility of the United Nations Environment Programme, with which WHO kept in close touch.
The delegate of Yugoslavia was entitled by his country's direct experience especially to speak on the subject. Though much to be regretted, that experience had proved valuable to WHO with respect to the organization of health services and methods of rapidly restoring normal life when disaster struck. WHO provided advice, both from headquarters and in the regions, on supplies and methods of supply, on guarding against duplication, and on dealing with panic. Cool-headed coordination was vital and difficult to organize from a distance. Foci of expertise in disaster management were therefore needed within the countries themselves. They should be established preferably in the ministries of health but, if that were not possible, in the ministries of housing or social affairs of the various disaster-prone countries where the need was greatest, although no country could be regarded as exempt from disaster in the modern technological age. One important aspect of disaster management was the task of assessing the health, social and economic effects. The problem was interdisciplinary and foci of expertise manned by trained staff were needed to deal with it. In cooperation with the centre already mentioned and with other university centres in process of establishment in the developing countries, WHO had set up courses to train personnel in disaster management; the courses had been tested in the field and were about to be transferred to the regions and countries with a view to promoting their self-sufficiency.

He thanked the Belgian Government for having virtually pioneered the specialty of disaster studies.

During 1980 major disasters had occurred in both Italy and Algeria, two of the 52 events - averaging one every week - for which the Organization had provided assistance. Endeavours to meet the expectations of the Executive Board and Member States would continue and it was hoped that the programme would have the wherewithal to do so.

At the suggestion of the CHAIRMAN, it was agreed that discussion of major programme 2.4 (Research promotion and development) would be postponed until the Chairman of the global Advisory Committee on Medical Research could be present (see page 63).

Director-General's and Regional Directors' development programmes (major programme 2.5)

Dr BARAKAMFITIYE (representative of the Executive Board) said that programme funds had been set aside to give the Director-General and Regional Directors some flexibility in the promotion and support of technical cooperation programmes for which no, or insufficient, funds had been made available in the individual programmes when the programme budget had been prepared. The Board, at previous sessions, had discussed the purpose of such funds in detail and it had been agreed that they should continue to be used to give impetus to existing programmes, to promote new programmes, to attract extrabudgetary resources and to deal with unforeseen situations, particularly at country level, in order to tackle the resulting urgent health problems.

Dr BAJAJ (India) wondered whether an example could be given of the use that might be made of such funds in an emergency.

Mrs BROWN (Bahamas) noted that, according to paragraph 54 of the Executive Board's report on the proposed programme budget (document EB67/1981/REC/3), the Region of the Americas had no provision under the Regional Director's Development Programme as such, since the Regional Committee had made a practice of allocating all available funds directly to specific programmes. She wondered, therefore whether funds, although not specifically earmarked for the Americas, were provided elsewhere in the budget for that Region.

Dr EL GAMAL (Egypt), recalling his remarks at the previous meeting, wondered why the item had not been termed a contingency fund or reserve.

The DEPUTY DIRECTOR-GENERAL, replying to the delegate of India, said that the Director-General's Development Programme funds were used to support programmes essentially of a technical cooperation nature, at regional, global and other levels; he recalled the examples he had mentioned at the previous meeting, such as programmes on traditional medicine and essential surgery, and programmes to strengthen the health services in Zimbabwe.

Replying to the delegate of Egypt, he said that the essential feature of the programme was that its funds should act as a catalyst for new projects which in normal situations would not have been catered for. It therefore provided the Director-General with some degree of flexibility to meet unforeseeable programme needs or activities. It would not be appropriate to regard its funds solely as of a contingency or emergency nature.
Dr KO KO (Regional Director for South-East Asia), referring to the question raised by the delegate of India, said that in South-East Asia some emergencies could be covered, though the main aims of the Regional Director's programme were to collaborate with Member States in meeting specific needs in areas not covered by specific programme activities, especially areas of potential further development. Thus, assistance was given for activities not covered by other programmes; for example, the programme for the elderly, accident prevention and women's health, and so on. South-East Asia had developed research and prevention of blindness programmes in that way. In addition funds were used for overall coordination and interim assistance in cases of disaster. It should be noted that situations covered by programme 2.3.3 were not budgeted for in South-East Asia.

Dr VAN WEST CHARLES (Guyana) expressed concern that no provision had been shown for the Region of the Americas.

Dr DEL CID (Assistant Director, Regional Office for the Americas) said that the use of funds in the coming years would depend on the Director-General's decisions. Funds provided by the Director-General and PAHO, however - for example, for vaccination and primary health care programmes - would be allocated by joint decisions.

DEVELOPMENT OF COMPREHENSIVE HEALTH SERVICES (Appropriation Section 3; Documents PB/82-83 pages 90-99, and EB67/1981/REC/3, paras 55-73)

Health services development (major programme 3.1)

The CHAIRMAN suggested, in order to facilitate discussions, programmes 3.1.1 and 3.1.2 should be considered together, followed by programmes 3.1.4 and 3.1.5 together, and that programme 3.1.3 should be the subject of a special debate.

It was so agreed.

Health services planning and management (programme 3.1.1)

Primary health care (programme 3.1.2)

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board) outlined the Executive Board's discussions on the major programme on health services development and its six subprogrammes.

The Board had emphasized the importance of the major programme of health services development and found that its objectives were crucial for the overall concept of health development; for example, the strengthening of national health infrastructures was essential for the achievement of the social goal of health for all by the year 2000.

During the consideration of programme 3.1.1 (Health services planning and management), an important discussion had taken place on the concept of national health development networks. It was recognized that to achieve health for all by the year 2000 through primary health care would require the mobilization of various skills within and among countries. An important aspect of network-strengthening was the overall improvement in health management capabilities that would accrete. Few medical schools provided the courses needed to prepare future doctors in understanding the managerial processes for health development.

In its discussion of programme 3.1.2 (Primary health care), the Board had emphasized that the primary health care concept was the corner-stone for the achievement of health for all, and that it was the recurring theme in practically all programmes in the proposed programme budget under review. Implementation of the concept would require a high degree of commitment, since it represented a political, social and technological challenge.

The concept of primary health care was understood to include what individuals and communities did for themselves and what was done for them at the first contact point with the health system. The supporting role of health units, especially front-line hospitals, had been stressed. The situation varied from country to country, but in most developing countries care provided in the health system up to the first-level hospital was considered as part of primary health care.

The improved wellbeing and quality of life associated with primary health care could be achieved only if the whole health system was developed in unison. Careful evaluation of
progress became an imperative, especially of those national efforts that aimed at health development as an integral part of overall socioeconomic development.

The Board had stressed the importance of WHO collaborating centres for primary health care. They provided opportunities for obtaining a better understanding of the functioning of health systems and for exchange of experience among countries.

The inclusion of traditional medicine in the health system was an important and realistic policy for health development in the health systems of countries where such medicine played an important role. It was important to identify, through scientific study, the beneficial aspects of traditional medicine as practised in different parts of the world. In view of the many and varied forms encountered, the programme would be developed in a decentralized way, with regional offices taking on increasing programme responsibilities. The Board had welcomed those developments.

The major thrust of programme 3.1.3 (Workers' health) in 1982-1983 would be in the identification and control of major occupational health problems of inadequately served working populations, which had not so far been given attention, and in the development of the infrastructure of health services to workers. Emphasis would also be given to the formulation of policies, strategies and guiding principles for disease prevention and control at work through the primary health care approach. So far, the historical institutional arrangement for occupational health in many countries had left national health services with an ill-defined role in that field, and the place of occupational health in primary health care had not been identified. To reach the target of providing workers with adequate primary health care by 1990, intensive efforts should be made to carry out cross-sectional studies on occupational health problems in countries together with guidelines on appropriate preventive measures, occupational hygiene methods and standards.

At its sixty-seventh session, the Executive Board had highlighted those needs and had urged WHO to intensify its efforts in coordinating international work in occupational health with other United Nations agencies, particularly ILO, UNIDO and UNEP.

With regard to programme 3.1.4 (Care of the aged, disability prevention and rehabilitation), the subject of disability prevention and rehabilitation had been mainly discussed in connexion with the International Year of Disabled Persons, 1981, and would be so discussed again in Committee B, under agenda item 42.3,1 as would care of the aged, under agenda item 42.2, in preparation for the 1982 United Nations World Assembly on Aging.2

The Board had been informed that the Regional Office for Europe had been assigned global responsibility for the programmes on care of the aged and prevention of road traffic accidents. That attempt to decentralize specific global responsibilities had proved satisfactory. A network of programmes involving all the regions was emerging, so that there was a sharing of responsibilities and activities.

The focus of the 1982-1983 programme for the prevention of road traffic accidents was multisectoral collaboration in the development of national programmes designed to reduce traffic accidents and minimize their consequences. The psychological and environmental aspects of road traffic accidents would be the subject of national seminars bringing together scientists and decision-makers with a view to facilitating the formulation of appropriate legislation.

The Board thought that WHO was likely to be increasingly concerned with traffic accidents in the future. In that connexion, the rapid growth of road traffic accidents in the developing world had been cited as a reason for giving some priority to the programme. The information that the programme might be expanded in scope to include all forms of accidents in 1984 had been welcomed by the Board.

With regard to the programme on care of the aged, it had been stated that insufficient attention had been given at national policy level to the health status of the aged. The situation was made worse by inadequate social research on the aged, and the lack of coordination of research activities. There was also the risk that the value of traditional family support systems might be overlooked, and that those systems might be undermined as a result of the development of incompatible approaches to the care of the aged.

It was noted that the budget proposals for the programmes on care of the aged and prevention of road traffic accidents would provide a more regular and stable budget situation

1 See summary records of the twelfth meeting of Committee B, section 2; thirteenth meeting, section 3, and sixteenth meeting, section 3.

2 See summary record of the twelfth meeting of Committee B, section 2.
for those recently developed programmes. Developed and developing countries alike with problems in those areas would thus be able to utilize WHO more effectively.

The Board had considered programme 3.1.5 (Appropriate technology for health) to be of great significance, especially with regard to the essential methods and technologies needed at all levels of a health system for achieving an equitable distribution of efficient and effective health care. Those methods and technologies often required extensive scientific study, and their development could not be considered simple.

The Board had noted the importance of cost-effective local production of basic reagents and equipment in the area of health laboratory services. High priority was being given to the local production of equipment able to withstand difficult environmental conditions and, at the same time, easy to maintain; similar concerns were guiding the development of the basic radiological services programme.

The Board had also been informed that solar-energy-powered refrigerators could become a practical reality within two to five years.

It had been noted that activities for radiological technology concentrated mainly on the improvement of population coverage by radiodiagnosis, on radiotherapy, radiation protection and equipment maintenance services, principally with a view to providing support facilities for front-line health care. They also aimed at improving the quality of such technology by the introduction of quality assurance methods, and at optimizing procedures and utilization in order to keep costs as low as possible.

It was expected that during the planned biennium the basic radiological services programme would be expanded to a large number of countries.

The Board had reviewed programme 3.1.6 (Health services research) and appreciated the increasing importance of the proposed health services research activities as a component of the WHO effort in research and of programmes for the development of comprehensive health services at all levels. The main emphasis of programme 3.1.6 would be on the strengthening of national capabilities for health services research in all its different aspects such as orientation and training, dissemination of information, technical collaboration and the strengthening of national institutions and networks. The Board had emphasized the multi-sectoral and multidisciplinary nature of health services research, the need to attract more young people to undertake it and to facilitate their careers as research workers, and the importance of reorienting health services research work to support the practical needs of managers and political leaders. Despite the efforts made, those were still distant targets in most countries regardless of their level of development. The Board had appreciated the emphasis placed on national activities, the efforts to provide direct advisory services on matters of moment such as the identification of social indicators, and the contributions made to the development of health services research methodology and the dissemination of relevant information.

The Board had been apprised of the activities of the Subcommittee on Health Services Research, set up by the global Advisory Committee on Medical Research in 1978.

Professor JAKOVLJEVIC (Yugoslavia) thought that the separate programmes had successfully reflected the important principles of the major programme as a whole. With regard to objectives, it was important to adopt a realistic approach to the role of traditional medicine, bearing in mind the aim of health for all by the year 2000. Indeed, the importance attached to traditional medicine fully reflected the policy established by WHO a few years ago.

The plan of action in regard to community involvement in primary health care (paragraph 9 of the narrative for programme 3.1.2) was well defined. In his delegation's view, however, the aim should be to go beyond the theory of community involvement to actual international cooperation, by such means as the intercountry workshops for exchange of experience - a matter on which his delegation shared the views already expressed.

The CHAIRMAN, answering Dr BAJAJ (India) said that his question regarding the role of hospitals in the various levels of health care, particularly on the periphery, would be taken care of.

Dr WILLIAMS (Sierra Leone) said that traditional birth attendants were recognized in Sierra Leone as members of the health team. In general, there was growing pressure for official recognition from other traditional healers and herbalists and for permission to practise in hospitals. Her delegation would welcome suggestions on how to recognize such important groups.

In the area of first-referral hospitals, help was needed in order to make them more functional in the supply of support services; but funding agencies were reluctant to give aid for hospitals and always preferred to emphasize village work.
Dr TOURÉ (Senegal), referring to community involvement, recalled that the constraints on primary health care had been fully dealt with during the Technical Discussions. He thought it essential that financial participation should not be deemed the corner-stone of the system. Community involvement would entail legislative reforms, not only to promote the social control mentioned by the Director-General, but also to provide the legal recognition needed to permit certain new categories of personnel, including community health workers, to participate in the promotion of community health. It was necessary to redefine the responsibilities of the various members of the health team within the context of the development of basic health services.

Professor SPIES (German Democratic Republic) agreed with the delegate of Yugoslavia about the important developments in the field of primary health care. Discussion on the subject, however, would occupy many more years because new aspects and priorities were bound to continue appearing. The delegate of India had mentioned the question of a more important role for hospitals in primary health care; in his own view, the development of all aspects of primary health care was a prerequisite to an efficient health care system. Even standards of surgery and hospital treatment depended on the situation at primary health care level, and to begin at that level was surely the best way to proceed.

There had clearly been much new thought in many Member States on the topic. One of the biggest problems seemed to be that of collating the various activities and of establishing a comprehensive infrastructure - which called, of course, for national policies. And although many Member States were seeking to involve their populations in health care development, it was not always clear whether the proposals being put forward were intended to link population activities with national systems or to keep them separate. His country was eager to develop collaboration between its citizens and the national system; it was important to develop the people's confidence in the service and develop a sense of responsibility and cooperation. In that connexion it should not be overlooked that, although the Chairman's proposed division of subjects for discussion was to some extent practical, all aspects of health services were closely related.

He was optimistic about the development of health services, although he doubted whether they could ever be perfected.

Dr DIALLO (Mali) said that there seemed to be some confusion about the definition of the various levels of health care. In remote areas of poor countries, a wound badly dressed could lead to ulcers, amputation and even death, and so for example, if a peasant in a remote area of Mali suffered an injury, and was sufficiently trained to clean it properly with alcohol and put a simple sulfonamide dressing on it, he was providing primary health care; in the same circumstances the most highly trained person would not be able to do more. If the wound was so serious that the patient was sent to a town hospital, the surgeon who operated, thus saving a life, was doing something that could not be done in a rural area, yet that was secondary health care. The most striking example was that of the recycled and upgraded traditional midwife: she had been trained in improved techniques - to use a razor blade to cut the cord and apply clean dressings - and to recognize certain birth complications and refer difficult cases to a doctor, all of which saved lives. Once the case reached the health centre where a doctor could perform a sometimes very simple procedure, or even a caesarian, that too was secondary care though the vital, life-saving decision might be that of the retrained traditional midwife out in remote areas. The work of such personnel posed particularly difficult problems in relation to the various levels of care and agreed definitions were most important to an understanding of current discussions.

Mr PAGÉS PIÑEIRO (Cuba) said that his delegation agreed with the Executive Board (paragraph 63 of its report on the proposed programme budget) on the need for further clarification under programme 3.1.1 (Health services planning and management), of the aims and modus operandi of the so-called networks of national health development centres, and in particular the links between their technical activities and the political decision-making process.

As to programme 3.1.2 (Primary health care), he fully agreed with the delegate of the German Democratic Republic that full coverage of the whole population by primary health care services was essential if the goal of health for all by the year 2000 was to be achieved, and that the full participation of the community was essential. But communities must not be left to rely on their own meagre resources to meet their primary health needs. The Cuban Constitution provided clearly that the State was responsible for health services, with no restrictions as to social, economic, racial, cultural or geographical considerations. If
primary health care was not closely linked with more complex medical services, through proper reference procedures, its success could only be very limited.

Professor LISICYN (Union of Soviet Socialist Republics), while commending the Secretariat for providing such comprehensive information under Appropriation Section 3, said that the concept of comprehensive health services in paragraph 1 of the narrative for major programme 3.1 should be more clearly defined. Before the exact meaning of the concept was determined, further scientific studies should be undertaken covering not only the objectives mentioned in that paragraph but also the right to health, the prevailing social, economic and political conditions, the strategy and the programme for its implementation both in WHO and in national institutions, and the main trends in the development of public health, especially preventive services. Account should be taken of the information gathered by WHO during the study of the Organization's structures in the light of its functions and during the preparation of the Seventh General Programme of Work, particularly with regard to the new strategy for health for all by the year 2000. Resources should be set aside to enable the study of the development of comprehensive health services to continue.

The formulation of the strategy for health for all was very important and, when defining the concept of primary health care, reference should be made to the Declaration of Alma-Ata and the other documents adopted at the International Conference on Primary Health Care, which dealt not only with primary health care but also with many other problems related to the development of national health services such as the interrelationship between primary, secondary and tertiary levels of health care, and the use of certain groups within the population, such as traditional, community and professional health workers. Those aspects were not adequately reflected in the proposed programme budget. He endorsed the proposal to undertake a survey of the relevant documents adopted at the Alma-Ata Conference and other meetings.

With regard to traditional health workers, emphasis should be laid on the scientific research approach to traditional medicine. In the USSR scientific work on traditional drugs had been carried out and the proposed programme budget should refer to the work of scientific institutions, especially the institute that had been set up specifically to study that problem.

Primary health care had existed before the Alma-Ata Conference but it was necessary to develop it further on the basis of the decisions taken at the Conference. Further scientific research on primary health care and its relationship to other areas of health care delivery would help to solve many other problems.

Dr QUAMINA (Trinidad and Tobago) said that during the Technical Discussions attention had been drawn to the critical importance of the new demands being made on supplies, supply channels and maintenance programmes by the introduction and expansion of primary health care systems. However, neither the proposed programme budget for primary health care (programme 3.1.2) nor the summary records of the Executive Board's discussions specifically mentioned such important structural requirements. Paragraph 14 of the narrative for programme 3.1.1 (Health services planning and management) stated that it was necessary to "meet the challenge of articulating the increasing demand for resources, their rising costs and their critical scarcity". She had therefore noted with concern the general decrease in budgetary allocations under the regular budget for that programme. In the Region of the Americas even the funds from "other sources" had decreased. Technical assistance and training in the management of supplies and maintenance systems was particularly important because many countries had not achieved their objectives for lack of just such expertise.

The essential role of hospitals in support of primary health care systems had been mentioned by Dr Patterson at the Executive Board meetings, but their importance was not recognized in the proposed programme budget.

Dr CABRAL (Mozambique) emphasized the important role of information systems in the development of health services. Mozambique faced enormous problems and information was often lacking, yet its scarce resources had to be used to maximum advantage. The development of a strategy for primary health care would require considerable resources and Mozambique could not afford to use its slender means wastefully. As it was a young country, social and cultural changes were taking place and it was necessary to be constantly aware of the interrelationship between such changes and the development of health services. Data on the type and efficiency of health services and health status of the population were required in order to undertake evaluation, planning and health services research studies. Long-term orientations were
necessarily set under way slowly, but they were reflected in short-term plans that had to be implemented as quickly as possible so as to meet the urgent health needs of the people. If the best possible results were to be obtained using the existing capacity, data from the periphery would be needed to show what was being done to improve the health of the population. He had noted with satisfaction that the proposed programme budget emphasized the importance of health information systems and he hoped that the Director-General's next report on the activities of WHO would give further details on what was being done in the countries themselves.

Dr LOEMBE (Congo) expressed his satisfaction at the new direction taken by WHO, but regretted that only resources under the regular budget were proposed for the African Region under programme 3.1.0 (Programme planning and general activities). However, the resources proposed for programme 3.1.2 (Primary health care), whose importance was recognized by the governments of Member States, were considerable. Even the industrialized countries had started to show signs of interest in the concept.

The overall objective of health for all by the year 2000 was generally accepted, but strategies had to be defined at the national level. In that connexion, he noted that paragraph 1 of the narrative for programme 3.1.2 stated that one of the objectives was "to increase the capability of governments for formulating policies, plans and programmes . . .", whereas it should have read "to encourage governments to formulate policies, plans and programmes . . .". A similar change should have been made in the following paragraph.

Dr ÁLVAREZ GUTIERREZ (representative of the Executive Board) said that the Board had discussed primary health care at length. Although it was difficult to define the concept and further studies were needed, the Board had agreed that it constituted an overall health system. He agreed with Professor Spies that it was difficult to develop primary health care if the secondary and tertiary levels were not well organized. Each country distributed health centres according to its own structures and organization, for example, the front-line hospital mentioned by the delegate of India might be at different levels depending on a country's organization, but it was essential that it should form part of the system.

The delegate of Sierra Leone had referred to traditional medicine; the Executive Board had been in full agreement that WHO should give all possible support to the development of such health care and personnel in Member States. It was, of course, necessary to carry out research so as to distinguish elements that were scientifically valid from others that were not. The Board had recognized that traditional medicine did not mean second-class medicine for the poor and that it had its place at all levels, as had been shown in many countries. The problem of how to develop and integrate traditional medicine raised by the delegate of Sierra Leone had been answered by the delegate of Senegal, who had made it clear that each country would have to adopt its own legislation on the matter.

In reply to the delegate of Cuba he recalled that the Executive Board had fully discussed the question of networks of national health development centres. There had been many different views on the subject and the Executive Board had submitted to the Health Assembly only the general observations that had met with agreement. Dr Acuna had mentioned that, in the Region of the Americas, there were certain legal difficulties in setting up such networks. However, the idea was that knowledge should be shared at the country and intercountry levels and that measures should be adapted to suit each country. The Board fully shared the view expressed by the delegate of Cuba: in no country would the State relinquish its prerogatives to the community, whose organization, orientation and education would remain a State responsibility.

In reply to the delegate of Trinidad and Tobago, he said that the Executive Board had noted the decrease shown under programme 3.1.1 (Health services planning and management) but had accepted, in the light of the examples supplied, the explanation that many of the activities formerly under that programme were now budgeted for under others, which showed an increase.

Dr SANKARAN (Director, Programmes of Traditional Medicine and Essential Surgery), replying to the delegate of Sierra Leone, said that WHO could only make recommendations but it would lend its support to any resolution that encouraged the acceptance of traditional healers within their respective health systems, taking into account the health legislation prevailing in a particular country. Such a position also applied to the question of community health workers raised by the delegate of Senegal.

The delegate of Mali had referred to various levels of responsibility with regard to traditional birth attendants and compared them with the traditional practitioners. The legal implications were the same as stated above.
The Director-General had set up a programme of essential surgical care whose basic philosophy was to save life and limb. This would be practised at the first-level hospital, and physicians would be trained in basic surgical techniques so as to deliver surgical services at the periphery. The programme was being elaborated with the assistance of non-governmental organizations and it was hoped that it would be implemented within a year.

With regard to scientific input in the field of traditional medicine raised by the delegate of the Soviet Union, there had been two developments: the first was the acceptance of collaborating centres recognized by WHO with the agreement of the government and recommendation of regional offices concerned. The centres had specialists in various fields of traditional medicine and modern pharmaceutical techniques who were carrying out valuable work in identifying plants and treatment criteria used by traditional practitioners. Work was also being undertaken on acupuncture in collaborating centres in China.

Secondly, an expert advisory panel in the field of traditional medicine, composed of 33 experts from various parts of the world, had been established in which the scientific and research outlook was being emphasized.

Dr TARIMO (Director, Division of Strengthening Health Services), referring to the questions raised by the delegates of India and Mali, said that, in accordance with the report of the Alma-Ata Conference, the primary health care approach applied equally to all levels of the health system. The report mentioned eight components of primary health care that constituted essential care, but the details varied from country to country. In some countries the eight components could be made available at the most peripheral level while in others it was necessary to go to the next level. The most important factor was that the components should be made available as near as possible to individuals and communities.

The delegate of Sierra Leone had pointed out that many donor agencies were reluctant to provide support for first-level hospitals. If it were recognized that primary health care did not only mean activities at the peripheral level but also support at other levels the problem would be overcome. WHO emphasized that particular aspect to donor agencies and other groups involved in primary health care.

Replying to the delegate of the German Democratic Republic, he said that in many cases activities promoted by communities were not well linked to the necessary support. A health facility might be set up by the community and then it would be found that no provision had been made for staff, equipment or supplies. The solution to the problem was appropriate planning at the various levels in order to ensure that development of manpower resources was linked to the facilities provided by the community.

With regard to the question raised by the delegate of Cuba concerning networks of national health development centres, the Executive Board had emphasized that, in the light of the objective of primary health care and health for all by the year 2000, each country would have to elaborate improved methods of mobilizing both human and institutional resources. The form would vary from country to country.

In reply to the questions raised by the delegate of Trinidad and Tobago in particular on the repair and maintenance of medical equipment, he said that relevant activities were referred to under appropriate technology for health (programme 3.1.5), in paragraph 19 of the narrative for instance. With regard to the decrease in the budget for programme 3.1.1 (Health services planning and management), information was provided in paragraph 19 of the narrative.

The delegate of Mozambique had referred to the programme on information systems, which was receiving attention in WHO. A WHO team was collaborating with UNICEF on the matter and on how to support countries in monitoring progress in primary health care.

The comments made by the delegate of the Soviet Union would be particularly useful when developing further the activities discussed.

Dr BARAKAMFITIYE (representative of the Executive Board) said that, in his opinion, the primary health care concept had not been defined so clearly that it called for no further discussion or research; that was all the more so in that it was a concept that was evolving and required continuing adaptation to the socioeconomic situation. On the other hand, following the discussions that had taken place after the Alma-Ata Conference, at World Health Assemblies, the Executive Board, in the regional committees, at the United Nations General Assembly and in other bodies, the question was whether the concept had not been sufficiently defined in order to enable programme budgeting for its implementation to go ahead. The Executive Board had agreed that it had. A solution to a specific problem remained to be found; a large number of people did not benefit from health care, whether primary, secondary,
tertiary, or quaternary. Was it necessary to wait until all the detailed aspects of the primary health care concept had been elaborated before anything could be done?

Finally, he pointed out that primary health care concepts existed in all the programmes and if the resources allocated to all those programmes were taken into account the amount would be very large.

The meeting rose at 18h00.
PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA33.17, para. 4 (1), and WHA33.24, para 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2) (continued)

DEVELOPMENT OF COMPREHENSIVE HEALTH SERVICES (Appropriation Section 3; Documents PB/82-83, pages 100-112, and EB67/1981/REC/3, paras 74-99) (continued)

Health services development (major programme 3.1) (continued)

Workers' health (programme 3.1.3)

Dr OSMAN (Sudan) said that the Alma-Ata Declaration emphasized the equal standing of the workplace and the place of residence in health care. It stressed the role of occupational health in the development of primary health care in working communities in agriculture, where there was exposure to pesticides and other chemicals, forestry, fishing, mining, and in small industries - in which workers were exposed to many hazards and were often overlooked in the health arrangements of many countries, especially in the developing countries. It was most important, in deciding on the strategies for health for all, to include what had been called for by the Alma-Ata Declaration. It appeared that the second part of the Declaration, referring to the place of work, had been partly neglected. Yet 80% of the population in the developing countries had the right to have their health needs catered for at their place of work.

There must be an innovative approach to the problem to enlist cooperation with the health departments on the part of the various other ministerial authorities involved, e.g. industry, labour, irrigation and pesticide development. In Sudan an intersectoral coordinating board had been set up to coordinate activities. The duties of the board, which also dealt with activities at the regional and local levels, included the organization and supervision of health inspection at workplaces; the nutrition of workers and their families; workers' health education programmes; and the organization of training and primary health care supervision at work, together with a continuing education programme.

There should be more emphasis at all levels on such questions as the employment of women and children, and UNICEF's support for such programmes could be sought. In connexion with the International Year of Disabled Persons, 1981, activities could be directed towards the disabled section of the labour force.

His delegation was gratified that there had been some increase in the extrabudgetary funds allocated to the programme as a whole, but it was concerned about the effect of the decrease in human resources at both headquarters and regional levels; it seemed doubtful that the budgetary increase could have any significant effect if the human resources were being curtailed.

Finally, he stressed the importance of enlisting the cooperation of nongovernmental organizations in programmes concerned with workers' health.

Dr WILLIAMS (Nigeria) said that, in view of the importance of workers' health, WHO should be more active in that area. In various countries the ministries of labour or employment were already competing in the provision of health services for workers. There must be a clear delineation of functions and responsibilities between WHO and ILO in the occupational health field, in order to avoid duplication. In many Third World countries there had recently been a marked increase in industrialization and modernization of
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Agriculture, involving hazards to the health and safety of workers through exposure to toxic chemicals, dangerous manufacturing practices, and the risk of serious accidents. Another recent development which increased the risks both to the health of workers and to the environment, had been the tendency to export polluting industries to Third World countries in order to avoid pollution control laws that increased costs. A few years ago Nigeria had experienced health problems in the asbestos industry, and had had to seek WHO's help in formulating a code of practice.

Workers' health was largely neglected in Third World countries, and where employers had introduced health programmes, these were mainly curative. Programmes should be developed with more emphasis on the monitoring of workers' health and environment, and appropriate legislation should provide for proper compensation for industrial accidents or occupation-related disease, as well as for the reduction of hazards to health and safety. In all those areas WHO had an important role to play, and he was pleased to note that there was an increase in the budgetary appropriation for the African Region.

Dr BEAUSOLEIL (Ghana) said that the workers' health programme was particularly important because the labour force constituted a high proportion of the total population; the objective of health for all by the year 2000 could not be achieved without emphasis on the health of the working population, especially those engaged in both large- and small-scale industry and agriculture. He therefore shared the concern expressed by the Board at the possibility of workers' health programmes being developed that were separate from the other health care programmes available to the family and the community. It was imperative that there should be close cooperation between WHO and ILO at the global level and between ministries of health and ministries of labour and other bodies at the national level. It was also essential to develop modalities for incorporating workers' health programmes within primary health care. In the restructuring of the Organization and its functions, special attention should be paid to the strengthening of capabilities, especially at the regional level.

Dr BAJAJ (India) said that India's Ministry of Labour had established a state corporation to look after the health of two million workers. It was based on contributions from workers, employers, and the corporation itself, and provided a comprehensive programme for looking after the workers. Occupational health problems varied from one country to another, and he would ask WHO to produce a manual setting forth the precautions that should be taken by workers in the various industries. For example, in India workers in both the jute and slate industries were liable to suffer lung damage. A WHO manual on precautions would be most useful.

He noted that in the proposed programme budget for 1982-1983 there was a marked decrease in the allocation for the workers' health programme in the South-East Asia Region, and asked for an explanation.

Dr STOKE (New Zealand) endorsed the comments made at the previous meeting by the delegate of Guyana, and at the present meeting by the delegate of Nigeria, on the need for coordination with ILO. When resources were limited it was important to avoid any duplication or potential conflict. One recent example was the use of the ILO hazard alert system to issue a warning that a chemical was a potential carcinogen; such statements should not be issued without reference to WHO, whose comments should be added.

Regarding paragraph 6 of the narrative and, in particular, the need for training, he said that a major problem in the organization of efficient occupational health services was the shortage of suitably trained staff at all levels. He asked if it was intended either to establish regional networks of training institutes or to increase the number of regional workshops on occupational health topics. If there were no such training, it seemed impossible for the objectives of the programme to be achieved.

Dr TOURE (Senegal) welcomed the workers' health programme, especially for the least-advantaged groups in agriculture and small industry in the developing countries. The promotion of workers' health was a matter of concern to his Government. In the developing countries the approach should be integrated, both preventative and curative. It should include control of health risks, safety measures, early determination of health risks, and health care for both workers and their families at the place of work. That called for trained staff and appropriate technology, and unfortunately both were lacking in most developing countries. Accordingly his country supported the workers' health programme as set forth in the programme budget - including the establishment of an appropriate infrastructure to promote workers' health within the rural
health services, research to ascertain hazards, and the introduction of control measures. The industrialization of the developing countries required policies for protecting the workers, and also the population in general and the environment, and his delegation would accordingly welcome recommendations for the definition of standards and methods in occupational health and a well-coordinated international research programme.

Workers' health could not be dissociated from the health of the family and the community. But occupational health programmes were often under ministries other than the ministry of health, and careful coordination of those activities was therefore necessary. That was the case in Senegal, which was now defining its policies regarding workers' health. A study group had been established to seek a more dynamic approach; a WHO expert would be of assistance to that group, helping to promote training and the use of appropriate technology.

Mr PAGÉS PINÉIRO (Cuba) said that it was impossible to refer to primary health care without referring to workers' health - which should constitute a basic concern of all ministries of health. There was a need for trained staff, and in that area technical cooperation among developing countries could be most valuable. The ministries of health should promote legislation on occupational health to protect workers from risks of disease and disablement, and define the responsibility of employers in the reduction of chemical and other hazards. They should ensure that the workers knew what the hazards were and the importance of taking steps to protect their own health. Through the cooperation of the trade unions, means should be found of ensuring the workers' participation, indicating harmful working conditions, and requiring enterprises to reduce risks.

He stressed the problem of the continuing fight against unemployment. There were now 24 million workers unemployed through no fault of their own; that situation constituted a threat to health, and should not be overlooked in the workers' health programme.

He asked why there was no allocations under the regular budget for the workers' health programme in the Region of the Americas - neither for 1980-1981 nor for 1982-1983. Moreover, the sums available from other funds were grossly inadequate to deal with that important problem, particularly since so many countries in the Region of the Americas were developing countries.

Professor SPIES (German Democratic Republic) expressed his delegation's general satisfaction with the programme. He noted, however, that there did not appear to be much reference to special risks in highly industrialized countries; rapid technological change was giving rise to new problems, and he would therefore like to have more information about the research component of the programme, which could not be deduced from the figures.

Perhaps some reference should have been made to specific problems as the most unhappy situation of working children. It might be combined with the question of more direct action by WHO for women, children and other less protected groups in the labour force. Regarding agriculture, the problems varied considerably from country to country; the main hazard was considered to be associated with chemicals, but in fact there were many other aspects - such as noise and vibration in mechanized agriculture, and various biological factors. Considerable research was being done in that field in his country.

In general he agreed with the approach to control measures. They should be based on accepted standards, with the force of law, and on close cooperation between the medical services, the workers, the responsible authorities in factories, and the trade unions; that should help ensure that occupational health aspects were always taken into account when introducing any technological or other changes affecting working conditions in industry and agriculture. In the German Democratic Republic occupational health services involved medical staff, technicians and voluntary groups, in both large- and small-scale industries. The most important feature was the independence of the occupational health care from industry; it was a state service forming part of the national health service under the Minister of Health and his staff, who were responsible for supervision and inspection. The industrial enterprises were required to supply premises, equipment and staff, but the staff were paid by the medical service, and not by the enterprise. It was important that activities concerned with the health protection of the individual worker were combined with the nationwide supervision of workers' health conditions and occupational disease; only then would it be possible to reduce risk factors and improve working conditions.

His country would cooperate fully in the programme and do all possible through its own institute, which was part of the network of collaborating centres. In both the industrialized and the developing countries there was a constant need to develop the scientific basis of occupational health.
Dr EL GAMAL (Egypt) said that workers' health programmes faced three main problems: isolation from a country's general health services; lack of cooperation between health and labour authorities at national and international levels; and insufficient trained manpower.

With regard to the first problem, it was significant that in the proposed programme budget both the primary health care and workers' health programmes were contained within the major programme of health services development. As indicated in paragraph 2 of the narrative, primary health care should cater for the health needs of workers - both within and outside the place of work. But guidelines were needed so that countries could choose a suitable type of programme. With regard to the second problem, he agreed that collaboration between WHO and ILO was essential. Such cooperation was not as strong as it could be; perhaps a standing committee of experts on workers' health, supported by the WHO and ILO secretariats, would be useful. With regard to the third problem, the question of manpower training now seemed to be receiving due attention.

Professor LISICYN (Union of Soviet Socialist Republics) stressed the importance of the programme on workers' health. As his delegation saw it, the proposed programme was a beginning, and could not reflect all aspects of the subject. He agreed with previous speakers about the need for a multidisciplinary approach, covering medical, psychological and other related aspects.

Since the proposed programme was an initial attempt to link workers' health with primary health care organization, greater attention should be paid to methodology, including means of relating institutions to health care delivery, perhaps at levels other than that of primary health care alone.

In many countries, including the Soviet Union, there was a special structure for medical care, including workers' health stations, forming part of the general health care network. There was a need for more attention to research and practical work in that area, and his delegation welcomed the attention given by WHO to such matters as standards and conditions of work. The approach was promising, and should be backed by further studies of standards of hygiene at the place of work. In particular, physical factors such as the effects of vibration and noise had not hitherto been covered. Nor had demographic aspects, as some previous speakers had noted - although his delegation welcomed the attention drawn, in the Executive Board's report, to the need for studies from the workers' standpoint not only as a whole but with regard to particular groups - for example, female workers - and to special types of work.

His delegation agreed with previous speakers who had stressed the need for more precise details about the coordination of activities between WHO, ILO and other organizations. In particular, his delegation would like to know whether the ILO/WHO joint projects mentioned, for which only WHO so far appeared to have assumed any financial responsibility, were to be funded by other agencies also.

Joint work with ILO on methodology and standardization was an important task; but it was not clear how the work was to be carried out. Perhaps a unified comprehensive programme could be set up to deal with that important topic.

Professor SENAULT (France) recalled that at the sixty-seventh session of the Executive Board Professor Aujaleu has asked for an explanation of the term "underserved workers", used in paragraph 14 on page 100 of the proposed programme budget (document PB/82-83); paragraph 2 gave some clarification, but his delegation would be grateful for further explanation with regard to paragraph 14.

The delegate of Cuba had rightly emphasized the importance of the health problems arising from unemployment. There were serious problems relating to individuals, which could lead to tragedies such as alcoholism and suicide; but there were also the effects of unemployment on the family as a whole. Research should be carried out on the medical, psychological and social consequences of unemployment.

He was pleased to note the considerable increase in the budgetary provisions for 1982-1983 for the European Region.

Mrs NGUGI (Kenya) noting that the primary health care concept permeated the Executive Board's report on the proposed programme budget (document EB67/1981/REC/3), wished to make some general remarks.

Her delegation was keenly interested in WHO's activities to increase the effectiveness of nurses in the provision of primary health care. In 1979 WHO and the International Council
of Nurses had jointly sponsored a conference on primary health care, in Nairobi, and interest among nurses had remained very high. In Africa, as in many other parts of the world, most primary health care was provided by nurses, and it was to be hoped that WHO would be able to devote increased attention to the role of nurses in primary health care.

The Kenyan Government had established a department of occupational health within the Ministry of Labour; its staff included doctors, public health officers and lay administrators, and would soon include nurses. The department would deal with all health problems associated with industry and agriculture. In addition to the hazards of chemicals, changes in an area's ecology gave rise to disease; for example, an area in Kenya formerly devoted to maize cultivation, when irrigated for rice-growing, had been affected by schistosomiasis. It was also hoped that the newly-formed department would be able to reduce or eliminate other health hazards such as alcoholism and other problems stemming from seasonal work and sudden increases in income.

Dr VAN WEST CHARLES (Guyana) said that his delegation accepted the objectives set forth in the budget document. It was essential that occupational health form an integral part of the entire health system. Unfortunately, paragraph 78 of the Board's report implied acceptance of the fact that children formed part of the permanent workforce. Such a view was morally unacceptable and he hoped that some modification could be made to avoid that implication.

He shared the view of the delegate of Cuba concerning the allocation of funds for the Region of the Americas; the sum allocated from extrabudgetary sources was very small, bearing in mind the rapid expansion and industrialization in the Region.

Dr QUAMINA (Trinidad and Tobago) referred to paragraph 4(5) of resolution WHA33.31, in which the Thirty-third World Health Assembly had requested the Director-General to undertake, in cooperation with ILO and other United Nations agencies concerned, a study on the role of various ministries in the field of occupational health and control of the working environment. She asked what progress had been made in that respect. The programme under consideration seemed to contain no provision for any global or interregional consultations.

Her delegation endorsed the view that workers' health should be an integral part of the entire health care system; but such integration would require special intervention in many cases. It also shared the concern expressed by other delegations about the budgetary allocation to the Region of the Americas.

Dr GAMA (Swaziland) noted with satisfaction the budgetary allocations for the African Region, and hoped that WHO would provide personnel to enable African countries to establish departments to deal with workers' health.

His country faced a problem stemming from occupational diseases contracted by many of its citizens who crossed into neighbouring, more industrialized countries as migrant workers. It was hoped that legislation could be provided, probably through intergovernmental consultations, to protect such workers.

There should be means of making employers comply with their duty to provide workers with suitable health education and protection, including clothing and other safety measures; unfortunately, no such provisions were reflected in the programme under consideration.

Dr H. SYLLA (Guinea) said that studies were being carried out in Guinea on the working environment and various other aspects affecting workers' health. It seemed that many workers retired just in time to die, and it would be useful if WHO could undertake a study that might serve as a basis for recommendations concerning retirement age, in accordance with life expectancy.

Mrs BROWN (Bahamas) shared the wish of previous speakers to see combined action by WHO, ILO and ministries of health regarding workers' health programmes. Although the topic affected all countries, the developing countries' health authorities had the additional problem of trying to influence governments, which were often attracted mainly by the financial prospects of industrialization, and business enterprises, which hoped to profit from working conditions of lower standards than in developed countries. Often the developing countries did not have the required capability to establish the necessary criteria and legislation. The WHO regional offices might play a valuable role in that connexion.

Dr CHIRIBOGA (United States of America) reiterated the importance of integrating the workers' health programme within primary health care in order to achieve health for all by
the year 2000. His delegation welcomed the steps taken in that respect by Sudan and other countries; the United States also was making efforts in that connexion. He stressed the role of community work in regard to the working environment, and the need to determine the administrative level at which technical support for occupational health programmes could be applied most effectively. Increased emphasis on occupational health at all levels of primary health care would do much to improve the health of workers.

Dr STILON DE PIRO (International Labour Organisation) said the subject of workers' health was an area of traditional significance and importance to ILO. Cooperation between ILO and WHO in many fields had been under review for some time, and joint activities were being encouraged, as could be seen from the proposed programme budget and the Executive Board's report; the results had been heartening. ILO fully supported the general lines of WHO's programme for workers' health, and looked forward to closer collaboration with WHO in that field.

Dr CASTELLON (Nicaragua) shared the view of the delegate of Guyana concerning the reference to child labour in paragraph 78 of the Board's report. The text concerned should have reflected the fact that children should not be working at all in difficult environments. He endorsed the remarks made by previous speakers concerning the funds allocated to the Region of the Americas.

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board) said that the health of children had been discussed at length by the Executive Board, whose view coincided with that expressed by the delegates of Guyana and Nicaragua. The basic notion was not that children should have a safe working environment but that they should not be working at all. He agreed that the Executive Board's view had perhaps not been adequately reflected in the report.

Dr CASTELLON (Nicaragua) accepted that explanation, but still felt that the text in question should be clarified.

The CHAIRMAN said that the Secretariat had taken careful note of that observation.

The DEPUTY DIRECTOR-GENERAL said that during the past few years WHO had paid particular attention to the question of workers' health. Some of the major difficulties encountered had been at the national level, where there was inadequate articulation and strategy. A critical examination of national health programmes showed that first attempts at integration had been made, and WHO continued to encourage such efforts. In that connexion, the delegate of Trinidad and Tobago had asked what was being done in pursuance of paragraph 4(5) of resolution WHA33.31. An account of WHO's activities could be found on pages 94-97 of the summary records of the Executive Board's sixty-seventh session (document,EB67/1981/REC/2). The delegate of Kenya had mentioned the role of nurses, and WHO fully recognized their importance at the regional and national levels. Nevertheless, much remained to be done in order to integrate the role of nurses in workers' health with that of other health workers. He assured the delegate of New Zealand that the training of personnel of all grades and at all levels constituted one of the major components of WHO's programme, although further work at the regional and national levels was required. Seminars and training courses were promoted, and WHO had emphasized that training should play an important role in the programme on workers' health.

Several delegates had mentioned research. WHO was paying close attention to it, but it was expensive and, in view of the scarcity of funds, the Organization relied on work carried out in centres that had the necessary capacity. In that connexion, the delegate of France had referred to research on the psychological and medical aspects of unemployment. A centre in France had been carrying out a considerable amount of research on the question and was to be designated a WHO collaborating centre. Research was also being carried out in the USSR,
the United States of America and many European countries. WHO would continue to encourage the exchange of information and participation in this area.

With regard to the point raised by the delegate of Senegal concerning recommendations for standards and methodologies, he hoped that strong recommendations would be adopted. WHO would encourage Member States to enact more comprehensive health legislation and to adopt better articulated national policies in the field of workers' health.

One of the most important areas was cooperation between WHO and ILO. The delegate of Egypt had referred to the lack of cooperation between the health and labour authorities at the national and international levels. In his view, the greatest difficulty was at the national level, and the Director-General hoped that there would be closer relations between the ministries concerned with all aspects of workers' health. At the international level, the representative of ILO had mentioned the excellent cooperation between ILO and WHO. The second paragraph on page 95 of the summary records of the Executive Board's sixty-seventh session (document EB67/1981/REC/2) contained an amplification of WHO's intentions regarding the development of policies and strategies in that respect in the coming biennium. It was difficult at present to make budgetary provisions, but the matter was being kept in mind.

WHO staff were working extremely hard to implement the most essential components of the workers' health programme in view of their importance for development in the majority of Member States.

With reference to the remark of the delegate of the Bahamas, he confirmed that it would be extremely beneficial to workers' health if regional offices played a more dynamic role in strengthening workers' health programmes, promoting their integration into primary health care and giving them a more prominent role in the overall health strategy at the regional level.

The delegate of India had asked that a manual be developed, and his proposal would be taken into consideration.

Dr KO KO (Regional Director for South-East Asia), replying to the delegate of India, said that the decrease of approximately US$ 200 000 under extrabudgetary funds was related to a UNDP project. At present, the next planning cycle was being elaborated and it was not possible to include the amount. The funds were for an occupational health project in Burma in which occupational health services were being established in a newly industrialized area as an integrated health programme. Nevertheless, he hoped that by 1982-1983 the funds from UNDP would be available.

The decrease of US$ 51 500 under regular funds was due to small reductions in the budget for Mongolia and Sri Lanka because of reduced needs of the programme in those countries.

Dr DEL CID (Assistant Director, Regional Office for the Americas), replying to the delegate of Cuba, said that both when workers' health had been discussed in the Region of the Americas and during the Technical Discussions on "Coordination between social security and public health systems" that had taken place in 1977, stress had been laid on the importance of coordination between the ministries of health and labour so that action could be integrated in the overall health system. WHO had coordinated certain general activities. The delegate of Cuba had emphasized that in coming decades primary health care without workers' health would be inconceivable, and he fully endorsed those remarks. Programme 3.1.0 (Programme planning and general activities) and programme 3.1.2 (Primary health care) highlighted the importance of social security for primary health care. Paragraph 12 of the narrative on programme 3.1.2 stated: "In the Region of the Americas the plan of action covers the definition of levels of care and their content, and the establishing of organizational requirements for each level. Special emphasis will be given to the technology and content of first-level care. Other services will be designed to ensure equal access for all; to coordinate the delivery of personal health services by the different agencies that make up the health sector, particularly the ministries of health and the social security organizations."

If health for all by the year 2000 was to be achieved, workers' health could not be ignored. In the Region of the Americas more than 50% of the population was covered by social security, especially for medical services, which was the responsibility of the ministry of labour. The Deputy Director-General had mentioned the difficulty of coordinating such activities because they were the responsibility of two different ministries. Nevertheless, in view of the resolutions adopted and the obligation to take care of that particular group of the population, efforts must be made in the field of planning as well as in primary health care; funds had therefore been increased for the coming biennium. It had to be accepted that in the Region of the Americas resources for workers' health were too low, and were drawn from other sources. Donors had provided funds
for projects on occupational health, with particular reference to the environment and laying special emphasis on radiation protection.

In view of the importance of the subject, greater emphasis should be given to coordination of activities between ministries of health and labour, especially with regard to workers' health. The remarks made during the discussion would be taken into consideration and the governing bodies of FAHO would be informed accordingly.

Care of the aged, disability prevention and rehabilitation (programme 3.1.4)

Appropriate technology for health (programme 3.1.5)

Health services research (programme 3.1.6)

Dr CHANG (Republic of Korea) said that disablement was a major problem in his country, where the disabled, about one million, constituted about 2.9% of the population. In many countries there were legal provisions to protect the disabled and make their lives easier, but in most developing countries only limited progress was being made.

In connexion with the International Year of Disabled Persons, 1981, the media in the Republic of Korea were emphasizing the problems of the disabled, and efforts were being made to provide more facilities for them. The Government was also about to enact a welfare law for the disabled which would cover disability prevention and early detection, regular surveys and registration, medical rehabilitation, vocational training and employment, supply of special equipment, the establishment of welfare and rehabilitation institutions, and the provision of public facilities. The existing programmes represented only a preliminary stage, and his country looked forward to cooperating with WHO in this field.

Dr KLIVAROVÁ (Czechoslovakia), referring to programme 3.1.4 said that Czechoslovakia had set up a system for care of the aged that had proved to be most effective. Each medical district provided nurses and other personnel specialized in care of the aged, and training courses had been established. She suggested that an institute specializing in the problem might become a WHO collaborating centre.

With regard to programme 3.1.6 (Health services research), she noted that, despite the extensive programme in the European Region, including the convening of a working group, it seemed that no funds had been allocated in the budget. She wondered whether the intention was to make use of funds within the Member States themselves or to allocate funds shown under global and interregional activities for health services research in the European Region.

Dr BORGÓN (Chile) said that greater emphasis should be placed on overall rehabilitation: it had to be considered in its social, economic and family aspects, and not only in its physical aspects. The family's contribution to rehabilitation was vital.

International cooperation in the training of personnel and the exchange of information and technology were important, particularly in the field of prosthetics, in which personnel were limited, especially in developing countries; it was useless to prescribe a prosthesis if the concept of rehabilitation was incomplete.

He also drew attention to the importance of prevention. In the case of poliomyelitis, epidemics in many parts of the world meant that large numbers of children needed rehabilitation. In the field of workers' health, there was the problem of invalidity caused by occupational diseases such as silicosis.

Finally, he asked whether he was correct in his understanding that the Committee would have an opportunity, under agenda item 24, to discuss the purely technical aspects of the programmes currently under consideration from the budgetary point of view. If so, members of the Committee should perhaps refrain from raising such technical aspects for the time being and bring them up under that item.

The CHAIRMAN explained that, of course, budgetary considerations on technical programmes could not be entirely divorced from technical considerations and during the current discussions there would arise technical issues that the Committee obviously wished to discuss. Item 24 had been included in the agenda to provide the Committee with an opportunity to take such matters up later. A similar item had been included in the Committee's agenda on previous occasions when it had reviewed the proposed programme budget.
Dr LENFANT (United States of America) welcomed the active programme proposed by the Organization for the care of the elderly, which represented an important step forward in response to the growing concern for that subject in many countries. The aging of the world's populations was a reflection of the successes achieved in biomedical research and of advances in health care, and WHO deserved much credit for those achievements, since its programmes had contributed to extending the lifespan in nearly all countries.

Unfortunately the proposed programme did not include a research component. Social and economic considerations alone would not be sufficient to enable countries to cope effectively with the problems of their aging populations. More research in areas such as nutrition, immunology, and cardiovascular, respiratory and neurological disorders was needed. It would subsequently be important to ensure that the findings from such research were made available and applied in all countries. Failure to secure a sound basis of research would limit the capacity to attain the goal of health for all by the year 2000.

His delegation hoped that WHO would attempt to interest countries in treating research on aging as a primary item; the United States would cooperate in that endeavour in every possible way. More needed to be done to develop effective programmes that would bring real benefit to the world’s increasing elderly population.

Dr BAJAJ (India) said that the best way of providing care for the aged, preventing disability and promoting rehabilitation, was to develop a joint family system - a field in which the west had much to learn from the east. If families stayed together the aged could look after young children and help in running the home when the breadwinners were away at work. Furthermore, children could help old people to move about and to avoid accidents. The joint family system could be used as a pilot project in connexion with the kind of research suggested by the United States delegate.

Referring to paragraph 12 under programme 3.1.5, he asked for further information on the items included in the basic radiological services, and on the criteria for the selection of countries to be included in the programme.

Paragraph 13 under programme 3.1.6 stated that support would be given to health services research in priority areas of national and regional interest in the South-East Asia Region; he asked whether any such areas had been identified.

Dr ABDULLATIF (Democratic Yemen), referring to paragraph 81 of the Board's report on the proposed programme budget (document EB67/1981/REC/3), asked what definition of old age had been adopted with regard to the plan of action for programme 3.1.4; it was necessary to know what that definition was in order to identify the countries that would benefit. Definition in terms of the prevailing sociocultural situation would be more appropriate for most developing countries. He also asked why the prevention of road traffic accidents, which affected all ages, had been included in the programme on care of the aged, disability prevention and rehabilitation. It might be more suitably included under workers' health.

Dr BULLA (Romania) said that appropriate technology for health was needed not only at the peripheral level, but also at the intermediate and even the central level in order to avoid money being wasted for the benefit of a few. It was regrettable that no information was available on the total amount of funds devoted to that important component of health for all. Greater emphasis was needed on the expansion of appropriate technology in fields ranging from laboratory techniques, reagents and the cold-chain to environmental hygiene and foods. Since extensive studies were often required in order to establish an appropriate technology he suggested that there be a stock-taking of the large number of existing and forgotten innovations, inventions and licences, to allow for efficient retrieval.

Professor ARAUJO (Cuba) said that the problems of health care for the elderly had socio-economic and cultural implications as well as purely medical aspects. The proportion of the world population aged over 60 years was increasing, and the administration of health services had to be planned accordingly. Old age was not a disease, and the changes initiated at conception continued their rhythm - which was different in each human being - into later life. Although the figure was arbitrary, his delegation accepted the 60-year limit which WHO had proposed as the beginning of old age; it was an age at which persons were usually more vulnerable to cardiovascular and cerebrovascular disease, mental disorders and cancer - diseases which, although they began earlier in life, progressed insidiously after the age of 60. Also, accidents, such as falls, with concomitant osteoporosis resulted in
fractures, often leading to complications that contributed to fragility in old age and the need to increase prophylactic measures in the environment and transport.

In Cuba the present proportion of the population over 65 was 6.9%, and it was expected to reach 8% in 1985; life expectancy at birth was 73.5 years for women and 70.3 years for men. There were 64 old peoples' homes with 7500 places in which medical and social care was offered to those who, for lack of family support, needed institutions of that kind. Recent years had seen the initiation of a policy to establish day care homes where old people remained during the day and returned at night to sleep in their own homes. A home medical care service which enabled every elderly person to be visited in his home by a doctor from the local clinic was guaranteed, as well as an anti-tetanus vaccination service.

The present policy was to increase the number of geriatric units and the quality of medical and social care, to promote training for medical and paramedical personnel, and to carry out morbidity surveys on chronic diseases and research on nutrition, life-style and psychological characteristics in old age.

In connexion with the various events to be convened by the United Nations in 1982 it should be borne in mind that in the changing world of today, in which the population explosion, growing urbanization and the trend towards family disintegration were imposing new ways of life and new requirements, the concept of old age was also changing. The number of persons who reached retirement age without being either organically or psychologically prepared to stop work was constantly increasing, and it had to be recognized that continuation of work - sometimes with a reduced timetable and modified norms - served to promote the welfare of the human being concerned, who continued to be happy so long as he felt useful and really began to die when he was made to feel that he was an impediment to be cast aside. As the average age of a country's population increased, new retirement limits should be studied, as well as new forms of work which would make possible a rational utilization of residual capacities.

The health of the elderly should not be made to depend solely on the sound function of their organism and intellect, and importance should be attached to basic social factors such as guaranteeing adequate employment or a decent retirement, adequate accommodation and transport facilities, and appropriate recreation in accordance with the individual's interests and propensities. The goal should be to improve living conditions, ensure free access to medical care at all levels, and preserve human dignity.

His delegation agreed that, although the 60-year limit was arbitrary, it was acceptable as the beginning of old age, 75 years marking the beginning of senility and 90 years, longevity. Health education to prolong the active life of the population should be initiated in the form of national campaigns against smoking, obesity and sedentary life. In international geriatric research priority should be given to projects designed to identify habits conducive to longevity and to transcultural studies which would help to determine the influence of climatic, nutritional, occupational and psychological factors in the preservation and maintenance of health in the elderly. In a world characterized by the advance of the scientific and technological revolution, it was necessary for the more developed countries to assist the others by making available to them resources which could be useful in prolonging life - through the exchange of experience and information and the provision of specialized aid. The convening of the United Nations World Assembly on Aging in 1982 would doubtless make it possible to develop further the study of various aspects that would help guarantee the welfare and happiness of the elderly.

Dr CHARBONNEAU (France) agreed with the delegate of Democratic Yemen; it was confusing to include under one heading such widely differing subjects as care of the aged, disability prevention, and road traffic accidents. It might have been preferable to consider, firstly, the prevention of disability (whether due to age, illness or accident) and secondly, the care of disabled or dependent persons.

An extremely high proportion of France's population was elderly, and in recent years the Government had been trying to find solutions to the problem. There were two main approaches. The first was a policy to enable the elderly to continue to live at home. The aim was to provide not only medical care and financial assistance for those who had no pension, but also household aides and centres and various facilities enabling them to remain active and in touch with life. The second approach was institutional: whatever other action might be taken, institutions would always be needed - not only for old people without families, but for all those, whatever their age might be, who had lost their independence as a result of some disability.
Dr LEPO (Finland) said that, as had been noted by the Executive Board and by previous speakers, programme 3.1.4 (Care of the aged, disability prevention and rehabilitation) was very heterogenous. It was, in fact, impossible to identify the relative shares of the various programmes. The components relating to the care of the aged, disability prevention and rehabilitation, and the prevention of road traffic accidents should be set out separately in future programme budget documents in order to facilitate their analysis.

His delegation welcomed the programme on the prevention road traffic accidents (mentioned in paragraph 11 under programme 3.1.4), but considered that a thorough report on the subject should be prepared. In particular, in view of the scarcity of funds great care should be taken in expanding the programme to cover other accidents. In any case, if other accidents were to be included there should be a thorough policy analysis and a clearly defined programme. He noted that there was also a reference to traffic accidents in paragraph 17 under programme 5.1.3 (Recognition and control of environmental hazards). The Secretariat might wish to offer an explanation of that apparent inconsistency, and to state what was the total allocation for the prevention of road traffic accidents.

Dr IBRAHIM (Egypt) commenting on programme 3.1.4, said that the difficult process of rehabilitation should not be conceived in purely medical terms; it also had social, psychological, occupational and educational aspects. It would be interesting to know whether the proposed manual would meet all the needs of the disabled person, and in what ways. The activities referred to in paragraph 9 were very vague. Moreover, in the following paragraph, which referred to evaluation of the training manual, there was no mention of the period of time after which such evaluation would be possible; a period of at least three to five years would seem reasonable.

Dr EL GAMAL (Egypt), referring to programme 3.1.5, said that the two main aspects of appropriate technology for health concerned laboratory services and radiology. His delegation strongly supported the establishment of efficient and effective health laboratory services at front-line level, bearing in mind the limitations imposed by needs and capabilities at that level.

On the other hand, great care should be exercised in supplying front-line health facilities with radiological technology. Firstly, a sophisticated level of curative facilities was required if the results of the radiological services were to serve a useful purpose; such facilities were not available at the front line, so that the effort might well be futile. Secondly, the use of radiological devices required a certain amount of protection for the health worker and the patient; such protective measures were often not applied in developing countries, so that the use of radiological devices at the front line might well be dangerous. Thirdly, the equipment supplied to basic radiological services in some countries, including Egypt, was old-fashioned and rather primitive. Reference was made in paragraph 12 to expanding the basic radiological services programme to include Egypt; in fact, some work was being carried out in that connexion at one of the universities in Egypt, but the Ministry of Health did not favour the programme. For all those reasons, his delegation requested that Egypt be deleted from the list of countries in which the basic radiological services project was to be tested.

The meeting rose at 17h25.
FIFTH MEETING
Thursday, 14 May 1981, at 14h30

Chairman: Dr E. P. F. BRAGA (Brazil)

PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA33.17, para. 4(1) and WHA33.24, para. 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2) (continued)

DEVELOPMENT OF COMPREHENSIVE HEALTH SERVICES (Appropriation Section 3; Documents PB/82-83, pages 103-112, and EB67/1981/REC/3, paras 79-99) (continued)

Health services development (major programme 3.1) (continued)

Care of the aged, disability prevention and rehabilitation (programme 3.1.4) (continued)

Appropriate technology for health (programme 3.1.5) (continued)

Health services research (programme 3.1.6) (continued)

Referring to the question raised at the previous meeting by the delegate of Chile regarding the use of item 24 of the agenda, the CHAIRMAN said that the purpose of that item was to provide for further consideration of those specific technical topics raised during discussion of item 19.1 but having no direct bearing on the proposed programme budget.

Dr GURMUKH SINGH (Malaysia) said that his delegation noted with satisfaction the increased emphasis on prevention where road traffic accidents were concerned and, in particular that the preventive programmes would also focus on the developing countries. Although Malaysia was a developing country, over 11% of hospital admissions were traffic accident victims, who also constituted the majority of deaths in hospital. Doubtless the same pattern existed in other developing countries and effective action was needed to bring about an improvement. The problem was multisectoral but, as in the case of other multisectoral programmes, WHO should act as focal point, providing coordination and leadership.

He agreed with previous speakers that the practice of grouping unrelated programmes of very diverse content should be reviewed, since there was a danger that one or other of the individual programmes might lose its rightful priority.

With regard to appropriate technology for health (programme 3.1.5), his delegation noted with surprise a reduction of over US$ 500 000 in the allocation for the Western Pacific Region, the reason given being a reduced volume of requests for cooperation. His delegation welcomed WHO's adoption of the goal of health for all by the year 2000, but considered that a great deal of new scientific knowledge, on both new appropriate technology and its application, would have to be acquired if the health services provided to the periphery were to be of a standard acceptable to the people. If it was accepted that the search for such knowledge was to be conducted at the regional, as well as the headquarters level, any reduction in the funding of the programme at the moment could be regarded as going against current efforts to translate noble intentions into practical plans.

There was a need for more emphasis on health services research (programme 3.1.6). For in the attempt to distribute resources more equitably and bring health services to entire populations, existing systems were bound to undergo structural changes which had to be carried out on sound scientific principles. Since health services research was a new activity for most developing countries, WHO should be ready to provide increased support, because long-term benefits could accrue only if structural change was carried out properly.

Professor ADENIYI (Nigeria) said that his delegation was particularly interested in appropriate technology for health in the context of health for all by the year 2000. In a dynamic
world, however, what might seem appropriate at present could soon become outdated. Neither must the developing countries be left to develop their own front-line technology when effective technology already existed. His delegation endorsed the Deputy Director-General's remarks concerning the role of WHO in research. In that connexion, care must be taken to avoid unnecessary expenditure on technology in the name of research, in which context the universities and laboratories could play an important role. His delegation welcomed the establishment of an Appropriate Technology for Health Information Service. It also agreed that some guiding principles were urgently needed for the establishment of effective laboratory services, not only in the front line, but at all levels.

As regards the acquisition of equipment the developing countries found themselves under constant pressure to purchase inappropriate or low-quality material and thus waste valuable foreign exchange. The possibility of establishing suitable legislation or a code of marketing ethics deserved serious consideration. Whilst his delegation fully supported the proposed programme for fostering training and management in maintenance and repair of equipment, it thought that WHO should provide help in monitoring supplies and services in order to prevent exploitation by some manufacturers and suppliers.

His delegation was unhappy about the real reduction in the financial allocation to programme 3.1.5, although it understood that there was some underpinning in the programme of health services research. It advocated encouragement for local technology wherever that had proved effective.

Dr ESCALA (Panama) noted with satisfaction the emphasis placed on the development of appropriate technology in all countries. A strenuous effort should be made to ensure uniform development in the application of science and technology in health care. One problem was the variation in equipment of different manufacturers, which meant that items could rarely be interchanged. Efforts should be made to standardize equipment and develop some principles of commercial ethics as the delegate of Nigeria had suggested. Welcoming the development of newer and more suitable equipment, such as solar-energy-powered refrigerators, and safer techniques, such as echography in the prevention of perinatal mortality, he suggested that WHO should help countries to make the best use of such new technology which was available to them all, though sometimes only at a considerable price.

It was important that the benefits of advances in science and technology should be brought to all people within the framework of primary health care. That called for a comprehensive transport and distribution network. There were, of course, problems in that connexion for countries such as his own which were badly affected by the steep rises in petroleum costs.

Health for all by the year 2000 was a laudable goal, but he felt somewhat pessimistic about the prospects for its achievement against a background of recurring economic crisis, disparity in development and disagreement between nations in fields other than health. In his view the solution would be to focus attention on that goal on which all were agreed, and then all other objectives could be subordinated to it. For example, the development of cheaper transport of all types, though not generally regarded as particularly relevant to the concerns of WHO, became relevant and could be promoted effectively as part of the effort to provide the best possible health care for people everywhere.

Professor HAVLOVIC (Austria), referring to programme 3.1.5, and the development of radiological technology in particular, said that diagnostic radiology formed an integral part of health care systems. Therefore diagnostic methods should be made available throughout the world, which meant active promotion in many developing countries. Even nuclear medicine with its various diagnostic possibilities should also be regarded as a component of health care at a certain stage of health services development. The steeply rising costs of health care in industrialized countries and the need for optimal use of health service resources in developing areas called for increased efficacy and efficiency in diagnostic radiology and nuclear medicine. Austria therefore welcomed the proposal for a comprehensive programme of quality control and assurance in radiodiagnostic and nuclear medicine in order to improve the quality of diagnostic procedures and reduce radiation exposure and waste. In his delegation's view such quality control should be extended to radiopharmaceutical products. WHO had recently organized two important workshops on quality assurance, one in October 1980 relating to diagnostic radiology, and one in November 1980, relating to nuclear medicine, both held in, and financed entirely by, the Federal Republic of Germany. Unfortunately, owing to lack of funds, the findings on the practical management of quality control at the national level had not been published, and his delegation regretted that WHO had not financially supported such important interregional activities from the regular budget.
Mr HUBER (International Society of Radiographers and Radiological Technicians), speaking at the invitation of the CHAIRMAN, said that the International Society realized the need to make radiological services available to as many people as possible and was particularly interested in radiodiagnostic technology at first-referral level. In that connexion, an international seminar had been held in Nigeria in August 1980 on training requirements for radiography in basic health care. The need for a programme in that field was obvious though its formulation and application would give rise to doubts and criticism about its viability owing to the practical difficulties and dangers of radiation. However, based on the field evaluation tests in Finland, Greenland and Scotland, a specially designed X-ray unit, together with a training plan, had been established and would undergo field tests in Yemen and Colombia. In 1979 a meeting had been held in Munich (Federal Republic of Germany) to evaluate the use of radiological techniques for diagnosis, including appraisal of cost-benefit ratios and the problems of excessive use of radiographic techniques, and a report had been prepared. Eighty trainers from some 30 countries had attended the sixth international seminar of teachers organized by the Society and held in Nigeria; the seminar had analysed the practical possibilities of a radiography programme as part of basic health services. On the basis of information received and the current situation and future prospects regarding manpower resources, the meeting in Nigeria had devoted its efforts to drawing up an effective plan of action.

The Society realized the problems involved but nevertheless fully endorsed the view that greater use should be made of radiodiagnostic techniques in providing health care for entire populations, particularly in view of the importance of early diagnosis and treatment to the survival of the family unit. At the same time the Society remained aware of the importance of other aspects of radiological technology, such as radiotherapy, nuclear medicine and protection against radiation. The Society assured WHO of its continued support and expressed the hope that its practical work would contribute to WHO's efforts.

Dr WILLIAMS (Sierra Leone), referring to programme 3.1.4, in connexion with the rehabilitation of the disabled said that in her country there was widespread blindness due to onchocerciasis; the manual on the training of the disabled in the community (paragraph 8 of the narrative) would be of assistance in helping the victims. In that connexion, her delegation wondered whether WHO could organize teacher training courses in occupational therapy, so that fieldworkers could be trained to teach crafts and trades to the blind thus enabling them to become useful citizens, rather than beggars.

In Sierra Leone the disabled and mentally handicapped were cared for by voluntary organizations but assistance would be needed. She would like to know whether the manual to which she had referred covered the rehabilitation of the mentally ill. As regards the care of the aged, old people were looked after by their families. The situation was changing rapidly, however, on account of the brain drain, which affected many developing countries, including Sierra Leone, and meant that fewer relatives were available to care for the elderly. Perhaps WHO could study the situation of old people in the developing countries and publish the results so that something could be done to arrest the process and prevent from arising the situation prevalent in many developed countries in which old people often found themselves alone. There were also problems stemming from alcohol and drug use and from the increase in road traffic. Training in highway use and in driving and vehicle maintenance was needed, as well as stricter legislation - which meant realistic salaries for those responsible for enforcing it so as to strengthen their resistance to bribery - and such items as audiovisual aids for health education in disability prevention and materials for the production of prostheses for the physically handicapped.

Professor SPIES (German Democratic Republic), referring to the grouping of programmes 3.1.4, 3.1.5 and 3.1.6, said it appeared from the documents before the Committee that even the Executive Board had had difficulty in trying to consider all the programmes at once. Whilst he was aware of the overall goal of health for all by the year 2000, it seemed unwise to rely on that alone without clear assessment of work to be done, identification of priorities, and planning and evaluation of progress, step by step. The combining of programmes and strategies might give rise to confidence, but there did not yet appear to be a clear understanding of how to deal with the various topics involved.

One example was the question of care of the aged; the impression might be gained that it was a question of care for a distinct group of people at special risk. But in fact there was not even a clear definition of old age or the special connotations of prevention in relation to the disabilities of old age. Moreover, there were additional complications in respect of such special groups as old people in hospital and those suffering from chronic diseases. There were also problems relating to retirement, and the various psychological, social and cultural
problems which beset the elderly. As a result, it was difficult to envisage the elderly as a separate, homogeneous group. Whilst the exchange of experience could be useful, it also highlighted, often without offering solutions, the differing conditions in various countries and regions, with regard not only to problems and diseases, but also to organization of health systems. In that connexion he considered that the programme did not place enough emphasis on research. For all those reasons the care of the aged should be part of primary health care rather than a separate activity, and should be dealt with under that heading in the programme of WHO.

With regard to disability prevention, increasingly occupational illnesses contracted during active life came to notice in old age; that aspect of the question was not well reflected in the programme under consideration. The question of rehabilitation should be viewed, not only in relation to the social and physical aspects of the disablement, but in the context of return to work or adaptation to new trades and professions. He hoped that the rehabilitation of the disabled would not remain the foremost problem among the older population.

There was also the question of medical care in hospitals for the elderly sick; in some countries, the provision of such care was concentrated in special institutions. That particular aspect of the problem should also feature in WHO's programmes and should not be confused with the provision of residential accommodation.

The activities to be set up would have to be interdisciplinary, if they were to be successful, as would those in the field of prevention of road traffic and other accidents.

The estimated obligations for the care of the aged and for disability prevention and rehabilitation were US$ 5 112 100, for appropriate technology for health US$ 9 559 800 but for health services research only US$ 2 383 200, although it was not possible to achieve practical results over a long period without it. The programme on appropriate technology for health was a good one; but without the results of research to enable it to form a strategy it could not succeed. For example, a modern radiation unit at the first-referral level would be useless without trained personnel or a support structure to ensure that people were referred to it. It must constantly be borne in mind that primary health care was composed of different but interconnected elements that included the various levels of service. In his view, the main problems were to ensure that all the elements of the programmes under discussion were consistent with the primary health care concept and to choose priorities that enabled progress to be made.

His delegation supported the proposed programme for health services research, which would need to be developed as time went on. The Regional Committee for Europe and the regional Advisory Committee for Medical Research had discussed the objectives and definitions of health services research and they had reached the conclusion that it had an important role to play in the application and adaptation of new scientific knowledge to health systems and in making the benefits available to the population. Another important aspect was the feedback from health services research to policy-makers and to biomedical research programmes.

The regions should make a more comprehensive evaluation of national programmes, belonging to the three programme areas under consideration, singling out specific problems for attention, in view of the importance of the regional and national situations, of the expectations to be fulfilled and the opportunities for application of new knowledge and experience.

The CHAIRMAN emphasized that the programme budget approach could prove confusing to those accustomed to more traditional budgetary presentations. The proposed programme budget for the 1982-1983 biennium was the first one entirely prepared after the International Conference on Primary Health Care (Alma-Ata). Future programme budgets would no doubt be an improvement.

The programmes under Appropriation Section 3 had been elaborated from the overall point of view of primary health care, with the family as the smallest social unit, and as far as health was concerned the family was indivisible. If countries were to make progress in improving the health of their populations, they would have to organize national, comprehensive health services within the concept of primary health care. The discussions that had taken place would be particularly helpful to the Committee when it took up item 21 of the agenda - Health for all by the year 2000.1

Dr MARKIDES (Cyprus) congratulated the Executive Board and the Director-General on the proposed programmes. However, three important programme areas had been amalgamated under programme 3.1.4 and he considered that it would be preferable to separate them. The problem of care of the aged was becoming increasingly important in many developing countries and Cyprus

1 Item subsequently transferred to the agenda of Committee B; see summary record of the fourteenth meeting of Committee B, section 3; fifteenth meeting, section 2; sixteenth meeting, section 1, and seventeenth meeting, section 3.
already faced serious problems. Following the tragic events of 1974, the situation of the aged had become critical.

He had noted with satisfaction the emphasis on road traffic accident prevention, since in Cyprus accidents were a major cause of mortality. The victims were frequently young, healthy persons of working age. With a well-organized prevention programme the number of victims could be reduced and such programmes were a good example of multisectoral cooperation. In the developing countries traffic accidents would undoubtedly also become a major problem owing to the introduction of modern life-styles and the increased number of motor vehicles in spite of the lack of a suitable highway infrastructure. He hoped that more information would be made available on the programmes.

Appropriate technology was becoming increasingly important because if primary health care were to succeed it had to be supported by appropriate technology, i.e. simple and effective technology with appropriate maintenance services. Health centres often lacked appropriate technology and thus became simply first-aid posts directing patients onto the next level. The result was that the population lost confidence in the primary health care system. His delegation therefore hoped that further research into appropriate technology would be undertaken. He had noted with satisfaction that activities in Cyprus were included in the programme and his country looked forward to collaborating in their implementation.

Mr HALLOWELL (United Kingdom of Great Britain and Northern Ireland) did not consider that the areas under programme 3.1.4 formed a disparate group since disabilities of all kinds were commoner among the aged and the latter as a whole made the greatest demands on rehabilitation services. For countries such as the United Kingdom, the linking of such areas was not incongruous. Nevertheless, disability and rehabilitation also affected the young and middle-aged and in the international context the aged represented a smaller proportion both of the total population and of those needing rehabilitation services than was the case in industrialized countries alone. It was therefore perhaps correct, in world health terms, to seek a different grouping that was more universally appropriate and more internationally acceptable. Whatever grouping was adopted, it must not be allowed to disguise the extent to which topics such as disability prevention and rehabilitation remained interrelated and had to be considered together, particularly in the case of road traffic accidents. He had noted with satisfaction the emphasis placed on that problem in the programme, as well as the interest shown by many delegates. His delegation strongly supported the proposal to establish a focal point to facilitate collaboration, although the most appropriate place to discuss the proposal would be under "Technical activities and questions identified for additional examination during the review of the proposed programme budget and of the Executive Board's Report thereon" (item 26 of the agenda). He likewise reserved the right to speak on points of detail concerning programme 3.1.6 under item 24.

Commenting on the priorities for research in the European Region (paragraph 14 under programme 3.1.6), he expressed the hope that the proposed research on problems of health care delivery would include studies on perinatal health and on subjects especially relevant to the older sections of the community. His delegation endorsed the comments already made urging that greater emphasis should be laid on research into the whole subject of prevention because prevention really was better than cure.

Finally, he hoped that more attention would be paid to cost-benefit studies. In view of present constraints, it was essential to ensure that the best possible benefits were being obtained.

Dr OLDFIELD (Gambia) recalled, from his experience of working in a geriatric unit in a western country, that the success of its rehabilitation programme had led to the admission of younger patients. The unit had had a measure of success in incorporating the family unit in its programmes; in Africa, however, there was less need for that because care of the aged within the family was well developed. In Africa, on the other hand, the physical handicaps that often affected the aged, and even those in younger age-groups, were not dealt with so well. He therefore welcomed the idea of home based rehabilitation, as well as the research done in that area.

The delegate of India had stated that the developed world could benefit from the experience of the developing world in the care of the aged. In the past, care of the aged in western society had probably had a stronger family base, but society had become the victim of its own evolution. Attitudes to aging differed from culture to culture and from individual to individual. In the Gambia, the family unit was proud of its older members, but the situation might change under the stress of modern living. He suggested that research should be undertaken on positive attitudes to aging.

In conclusion, he emphasized that new terminology applied to the aged must be acceptable to them.
Dr BEAUROLEIL (Ghana) had noted with concern that the estimated obligations for the African Region under health services research (programme 3.1.6) had decreased by US$ 60,000. Health services research was vital for the successful implementation of the strategy for achieving health for all by the year 2000, especially in the African Region where there were so many problems awaiting solution. For example, in the case of malaria it was necessary to work out the modalities of drug distribution because the first tactical variant had been adopted as a malaria control method. Although the estimated obligations were based on a number of factors, such a large decrease was a cause for concern and he would like to have further information on the matter.

Professor LISICYN (Union of Soviet Socialist Republics) agreed with the delegate of the United Kingdom that the areas under programme 3.1.4, were closely linked. However, while acknowledging the efforts that had been made to reflect the decisions of the Alma-Ata Conference in WHO's programme budget, he appreciated that there might be some difficulty in seeing a connexion between the various headings in that context.

In his view, traffic accident prevention, whether with regard to the aged or to other population groups, was an important part of WHO's activities. The problems of the aged were important but they were not the only problems; social, economic and cultural factors also had to be taken into consideration when determining priorities and he proposed that a list of priorities should be drawn up. It would be helpful if the proposed programme budget could contain brief comments on related problems that had already been solved, particularly when they had been discussed in detail during previous Health Assemblies. Such a procedure would almost certainly help in the solution of a number of current problems. For example, the Regional Office for Europe had already studied many problems related to prevention of road traffic accidents and care of the aged. A group of experts or the Secretariat could be asked to prepare a document on the more complicated medicosocial problems, setting out a definition of objectives, the priorities that had been set, possible methods of solving such problems, what results it was hoped to achieve, how the results could be used in practice and what the future prospects were. Such an approach would be along the lines of the systems approach that had already proved its worth in WHO.

He agreed with previous speakers that in the field of appropriate technology it was necessary to devote attention to radiodiagnostics and nuclear medicine. Bearing in mind the prospects for "isotope diagnosis", vast technology and considerable resources were not required. Scientific research in the health field could provide a theoretical basis for the provision of appropriate technology. The significance of programme 3.1.6 (Health services research) had been underlined by previous speakers and he hoped that the Director-General would present the programme in greater detail using a more systematic approach, defining priorities and showing the link between it and other WHO scientific research programmes. Although the overall strategy was quite clear in the proposed programme budget, certain aspects had been left out, for example, standardization of methods, research into the effectiveness and evaluation of health services, the impact of epidemiological and social factors on the prevalence of disease, coverage by health services, and assessment of therapeutic and diagnostic substances. The regions' task was not merely to collect information. The problems should be studied from a global viewpoint in order to avoid overlapping.

He realized the difficulty of making a brief, scientifically based presentation of the programmes under discussion. It was easier to criticize than to make constructive proposals, however, he was sure that the presentation could be improved.

Professor JAKOVLJEVIĆ (Yugoslavia) considered programme 3.1.6 (Health services research) to be extremely important. The Director-General had stated on several occasions that the reorientation of existing health systems and the parallel establishment of a sound managerial process for health development were essential prerequisites if health for all by the year 2000 were to be transformed from an abstract idea into reality. He had also mentioned the need for a new profile of the health systems research worker and the shortage of health workers who could undertake planning and evaluation. Such a situation existed in both developing and developed countries.

He also agreed with the Director-General that conventional scientific methods could not usefully be applied to the operational problems of health care delivery. He had therefore been particularly pleased to note that the plan of action included activities in all WHO regions. However, the plan of action for the European Region was particularly noteworthy; it included activities such as training in health services research and courses that would be open to participants from other regions. Such activities would undoubtedly contribute to strengthening
national capabilities for health services research, but much remained to be done in order to meet all needs in the field, and he hoped that the question would receive more attention in the next programme budget. In conclusion, he stated that Yugoslavia was ready to cooperate and to facilitate arrangements for training courses and other activities.

Dr MKAANDAWIRE (Malawi) said that health services research was a new field and it was important that it should be properly understood. Although there had been some progress in the Eastern Mediterranean Region, very little progress had been made in the African Region, for which the budget allocation had been reduced. It was therefore necessary to make a greater effort to define the field of health services research, particularly with regard to traditional medicine, in which would-be research workers were discouraged by the lack of a full compendium of available literature, and needed technical assistance and guidance.

The CHAIRMAN said that the points raised by the previous speaker would certainly be discussed when the programme on research promotion and development was considered. The health services research now being discussed was greatly needed by governments to guide them in the appropriate utilization of public funds in the health sector.

Dr ARDULLATIF (Democratic Yemen), referring to programme 3.1.5, asked whether appropriate technology at the front-line level involved other organizations, apart from WHO and whether the Organization intended to indicate fields in which they could participate.

Regarding programme 3.1.6, he noted that paragraph 4 referred to the formulation of national, regional and global policies in health services research. Since the present Assembly was to adopt a Global Strategy for health for all by the year 2000, with health services research a component of that strategy, the implication of that reference was unclear.

Dr LOCO (Niger), commenting on programme 3.1.5 (Appropriate technology for health), said that in 1979 his country had opened a medium-level laboratory workers' section within the national public health school, pending the construction of a laboratory workers' school under the next development plan; there were at present 25 students. The three objectives were to reinforce the analysis capabilities of hospitals, maternal and child health centres, and mobile health teams; to reinforce the supervisory capacity of the national office for pharmaceutical and chemical products in regard to the toxicological laboratory and the institute of traditional medicine and pharmacopoeia that was to be established under the 1979-1983 development plan; and most important - to establish peripheral health laboratory services in the country's 38 medical areas. It was estimated that some 300 medium-level laboratory workers would be required by 1995. Such a programme would require not only an effort by Niger but also the support of the countries and agencies with which it cooperated - including that of WHO with regard to expertise in the training of higher-level staff and the supply of reagents and training equipment.

The Technical Discussions at the present Assembly had clearly shown the need for the establishment, at both national and regional levels, of facilities for repairing medical equipment and training appropriate staff. Five years ago Niger had established a medical equipment maintenance and repair service at the central level, with the aim of eventually decentralizing it to the country's seven departments. It was functioning quite satisfactorily, but difficulties were being experienced in the training of personnel and the procurement of spare parts. Notwithstanding the budgetary constraints, WHO should make an even greater effort in that field.

Regarding radiology, he stressed the importance of radiation protection, in that connexion his country placed great hope in the work being done jointly by WHO and IAEA on thermoluminescent dosimetry intercomparion.

Professor SYLLA (Senegal) said that his delegation attached great importance to the programme on the care of the aged, especially in view of the privileged place which traditional African societies gave to the aged, who were generally the object of real veneration: indeed, a wise Africanist had declared that when an old person died a library was burnt. So the need to provide old peoples' homes had not yet arisen in most African countries. His country, was, however, following attentively the work being done in that field. It was participating in the preparation for the United Nations World Assembly on Aging, and was in favour of promoting the non-dependence of the elderly and of enabling them to stay at home.

Dr CHANG (Republic of Korea) said that his delegation was pleased to learn that WHO's recent activities in the field of health services research had led to a remarkable improvement
in the coordination of research activities at the national and regional levels. As stated in paragraph 42 of the Executive Board's report, extensive research programmes on cancer, cardiovascular diseases, rheumatism and other diseases had been carried out in the industrialized countries, but it was also important that more should be done in health services research in the developing countries - particularly in areas such as tropical diseases, human reproduction, viral diarrhoeas and nutrition in relation to weaning and diarrhoea. Several institutions in his country were collaborating with WHO on such matters.

In the Republic of Korea recent trends in economic development and the expansion of medical insurance programmes had led to a rapid growth in the demands made upon the health sector with regard not only to communicable diseases, but also noncommunicable diseases - particularly those prevalent in old age. In that connexion WHO's technical cooperation had proved most valuable. In most countries noncommunicable disease control measures were not taken by the government itself, but depended largely on voluntary activities with the financial support of the government. In view of the considerable funds required, it was almost impossible for developing countries to conduct such research. An intensive research programme was therefore needed, with WHO's collaboration, in order to identify effective control measures against noncommunicable diseases in the developing countries.

Dr ÉLÍÁS (Hungary) said that, in the light of experience over the past 30 years, his country was very much aware of the importance of the problems of the aged and the handicapped, not only for the health services but also for all strata of society. In many cases an aged or handicapped person ruined the lives of several family members when they had to adjust their activities to support and care for him.

He agreed with the view of other delegations regarding the difference between chronological and biological age. In Hungary the retirement age was 55 for women and 60 for men. He agreed with the remarks of the delegate of Finland concerning the heterogeneity of the components of programme 3.1.4; they should be separated in some adequate way. He also fully supported the comments made by the delegate of the German Democratic Republic on that programme.

Dr HOPKINS (United States of America) said that health services research was very important for the effective implementation of primary health care at country level and deserved the high priority given to it by the global Advisory Committee on Medical Research. Health services research must respond to the combined challenge to extend health services to entire populations as the central principle of health for all by the year 2000; limited and even contracting resources, and the rising costs of health care. Health services research could make it possible to ascertain the extent of coverage and utilization of services, to determine the effectiveness of services in dealing with priority health problems, to analyse the cost and cost trends of health services and alternative approaches to financing them, and to assess alternative options for health services programmes when priority decisions had to be taken.

In his country, increasing emphasis was being placed on strengthening capabilities in health services research. In addition, health services research was included as a major area of cooperation in several bilateral relationships. For example, under one binational health agreement health services research teams were being exchanged with a view to enabling them to study selected primary health care sites in the other's country. The aims were to learn about the other country's health care systems, to share knowledge about health services research methods, to identify research areas which could be pursued jointly, and to contribute to improved health in both countries.

Dr MTERA (United Republic of Tanzania) expressed appreciation of WHO's increasing concern for care of the aged, disability prevention and rehabilitation.

In his country, as in other countries in Africa, the care of the aged was not at the moment a problem because most families were still living in the extended family life-style, which took care of the aged. In Tanzania the impending danger that the aged might have nobody to take care of them was attributable not so much to the brain drain to other countries - to which the delegate of Sierra Leone had referred - but to the movement of able-bodied persons from rural to urban areas. At the time of independence only 3% of Tanzania's population lived in urban areas, and since most of them had been born in the areas where they lived they were protected by the extended family life-style. However, according to the 1978 census approximately 10% of the country's population lived in urban areas, most of them immigrants who had come from rural areas to seek employment. Accommodation in the urban areas did not permit adoption of the extended family life-style, with the result that the aged were left behind in the rural areas with hardly anybody to take care of them. A problem was therefore imminent in Tanzania.
The best solution would be to take care of the aged in the setting to which they were accustomed. The Government was still seeking ways of doing that, and suggestions from other countries which had successful experience in that field would be welcome.

There were approximately 600,000 disabled persons in Tanzania, and a national committee for disabled persons had been established in connexion with the International Year of Disabled Persons. Its first task had been to make a survey of the disabled persons in the country, recording the type of disability, the age and, if possible, the cause of the disability. That was being done in order to determine the magnitude of the problem and to elaborate appropriate means of providing help. In the meantime the Ministry of Health was carrying on its activities regarding the Expanded Programme on Immunization, maternal and child health services, and nutrition education as ways of preventing disabilities. The national committee for disabled persons had requested the Ministry of Health to invest more funds for the prevention of disabilities. The cooperation of WHO, DANIDA, USAID, UNICEF and other agencies in the area was greatly appreciated. Increased emphasis by WHO on collaboration with Member States in that field would do much to promote the efforts for health for all.

As far as rehabilitation of the disabled was concerned, occupational training was being given to enable disabled persons to take their place in the workforce and thereby become to some extent self-reliant. Legislation was being prepared to require ministries and companies to employ disabled persons who had the appropriate skills for the job. With the cooperation of a friendly country a workshop had been set up for the local manufacture of artificial limbs and other prostheses.

The problem of road traffic accidents was complicated in Tanzania by the poor roads and the lack of spare parts for cars. The Government was undertaking research on the factors contributing to accidents, and the extent of the problem, so that appropriate measures could be taken.

Dr WROBLEWSKI (Poland), referring to programme 3.1.4, said that the plan of action regarding care of the aged merely touched the tip of the iceberg. It referred to "cooperation with voluntary agencies, ...; the development of a self-care manual for the elderly; the preparation of guidelines for assessment of related technology, training of personnel, and introduction of preventive measures in younger age groups to counteract certain adverse factors in aging." All those aspects were very important; but it was not enough.

The demographic situation in Poland clearly showed that in the year 2000, when the total population would be approximately 40 million, 14% would consist of elderly people over 65 years of age - some 5,600,000 persons in all. If only 10% of them needed intensive social and health care, Poland would require 560,000 additional beds in special homes for elderly people. At present the country's hospitals had at their disposal about 200,000 beds, which meant that it would be necessary to provide three times as many additional beds in order to offer elderly people a place to stay. That was clearly an impossible task - not only in Poland; no developed or developing country could afford to put such a programme into effect. Other solutions must therefore be found. An effort must be made to return to the extended family system, under which elderly people could stay with their children and grandchildren in their home - as still happened in the rural areas of Poland. However, in order to achieve such an objective people had to have flats with enough room for the extended family. That constituted just one example of an area in which only intersectoral cooperation could succeed: the cooperation of the Ministry of Housing was required in order to change the size of flats, as well as that of the Ministry of Culture to change the attitude of young people towards their parents or grandparents, and that of the Ministry of Planning to include all those points in the national development plan. Other ministries might also be involved.

His delegation was not the only one to take that view. At the past Health Assembly the delegate of the Gambia had mentioned the ever-increasing problem of elderly people, under conditions of specialized agriculture, in his country and other parts of Africa; at the previous meeting of the present Committee the delegate of India had drawn attention to the same problem. In fact, if the idea of health for all was to be anything more than a mere slogan in the case of old people, one obvious conclusion could be drawn - namely, that WHO and Member States should concentrate their efforts on finding a well-founded solution for a return to the concept of the extended family in order to reduce as far as possible the number of elderly people for whom the Government would have to provide intensive social and health care services.

Dr MWAMBAZI (Zambia) drew attention to the problem of continued imbalance in the area of appropriate technology. Those capable of producing appropriate technology were continuing to
do so for those who did not have that capability, and the danger was that that situation would be perpetuated, despite the aims of the New International Economic Order. That seemed to be reflected both in the programme budget document and in the Executive Board's report— in particular with regard to the development of radiological technology for primary health care. Perhaps his doubts were due to the terminology employed. He would, however, prefer a more cautious approach: for example, the development of an X-ray unit as suggested would not improve the value of health care, especially at the rural health centre level; on the other hand, it would undoubtedly lead to higher costs. He referred to WHO document RAD/77.1, entitled "A primary care radiological system", and describing equipment for primary health care use. That document might have information value, but contained no cost analysis and seemed to be of no practical value. A number of private firms were involved in developing the technology in question. It seemed that the equipment was to be developed in a non-developing country, although the product was intended for use in both developing and developed countries. He wanted to know if WHO supported that approach.

Mrs NGUGI (Kenya) said that the importance of health services research could not be overestimated. More resources should be devoted to it, particularly in the field of institution-strengthening, development and strengthening of research facilities, the training of research workers and direct research activities themselves. A further strengthening of the global, regional and national committees on medical research would also be welcome, since they could play a major role in research promotion and development and research capability development and strengthening as a whole. Her Government fully appreciated the voluntary contributions which had been received from various governments and organizations for research, health promotion and the development of self-reliance in the health sector, and hoped that such cooperation and support would continue to increase. In the particular case of the aged, research should be carried out with a view to establishing how they could be incorporated into health education programmes, especially in societies which still had intact their extended family system.

Dr PATTERSON (Jamaica) said that she found the programme budget document easier to follow than in earlier years. However, programme 3.1.4 was not very clear. It appeared that at an earlier stage the subjects concerned had been given a lower priority, but that in future programme budgets they would be dealt with as separate items.

With regard to the aged, she had been pleased to hear the comments of previous speakers concerning the general respect for the elderly in Africa. The health services research programme should include research on how old people could be kept happy within their communities and families. There should be a study of alternatives to the nuclear family. The extended family was an asset which should be studied and preserved; it was a far better solution than homes for the elderly, and more likely to provide peace of mind.

She was surprised that in the section on road traffic accidents there was no suggestion that the problem might be solved by making cars slower and reducing their number. As things stood it was the pedestrians who had to defend themselves—and if they did not succeed the State had to care for them; but it was the cars that did the damage.

As to programme 3.1.6, it was important that health services research should be carried out in the country concerned by those who understood conditions there. It was useless to import research documents that were not applicable or already outmoded.

The DEPUTY DIRECTOR-GENERAL said he wished, on behalf of the Director-General, to extend the thanks of the Secretariat to the delegates who had spoken on the three programmes under consideration. The Secretariat was very encouraged by the positive response from the delegations. However, several delegates had referred to a lack of clarity in the presentation. The classification of programmes was under review for 1984-1985, and in the next programme budget document it was planned to show the activities now included in programme 3.1.4 under separate programmes for accident prevention, health of the elderly, and rehabilitation—which should make the presentation clearer and easier to understand. Programmes on accident prevention and care of the aged were of course, now being managed by the Regional Office for Europe.

There had been many comments on health services research. The Advisory Committee on Medical Research had brought that into focus several years ago. It was important for both developing and developed countries. Many Member States were now spending tremendous resources on health services, and in some cases the benefits were not in proportion to the money spent, through a failure to understand the goals of the service or what was actually
being done. Health services research was therefore important as an instrument of rationalization, fact-finding and planning, in both developed and developing countries. However, the full participation of ministries of health was necessary. The traditional research bodies, such as the medical schools, national medical research councils and research institutes were not really interested in health services research. However, in recent years there had been much comment in the United States of America and in the United Kingdom, for instance, on the importance of the subject. Some ministries of health were trying to persuade the medical research councils to pay more attention to the subject, and it was important for those ministries to seek to ensure that it was included among national priorities. No doubt the subject would be further discussed at the next meeting, under the item on research promotion and development.

As to care of the aged, more research activities had been asked for by many delegations. He felt that the programme budget presentation did not make it sufficiently clear how much WHO was doing in that area. The research in one division alone covered a number of new projects, many financed from extrabudgetary sources, which were not shown in the programme budget. For example, a task force on neuro-endocrinology and behaviour, with emphasis on old age, was to meet on 1-3 June 1981. A meeting on the classification of mental disorders due to organic brain disorder had taken place in Ibadan, Nigeria, in November 1980, and there would be research planning to follow the review of psychological problems arising in old age, a subject which related to the questions raised by the delegates of Kenya and Jamaica on the need for research into the social, cultural and psychological aspects of the subject, especially in societies where there was still a strong culture with natural safeguards. There were joint plans with the Regional Office for Europe to carry out research on the epidemiology of dementias. Research on cerebrovascular disorders and on the assessment of drugs acting on the memory was also planned. That was just an example of the work being done by one division. He assured delegates that a great deal of research was being done not only in WHO but also at the national level. The main need was for the information on that research to be disseminated so that there would be no overlapping.

With respect to the presentation of the programme budget, the delegate of the Soviet Union had offered useful advice, proposing the systems approach in order to achieve a clearer presentation, particularly with respect to the general aims of the Organization. The Secretariat at headquarters and in the regions had given much thought to the matter and were in fact proud of the presentation for the current year. A change in the presentation to provide more detailed information might favour large delegations, composed of up to 20 members and with plentiful facilities, rather than smaller delegations from the developing countries, with only one or two members, where effective participation in fruitful discussions was concerned. Nevertheless, the Secretariat had taken note of the Soviet delegate’s comments.

With respect to appropriate technology, the delegates of Nigeria and Zambia had raised the question of whether the Organization favoured the present approach, of what was appropriate, who was to determine what was appropriate for individual countries, and at what level of development. That point had often been raised in the past, and was still a major problem in some developing countries. The delegate of Zambia had asked whether WHO favoured an approach involving the provision of technology by another country with greater capacity to do so. WHO could never be an instrument of exploitation, and always acted in good faith. It was a difficult subject that would no doubt be clarified with time. Developing countries were moving forward, and a technology that appeared appropriate at a particular stage might well be obsolete by the time it arrived.

Dr KAPRIO (Regional Director for Europe) said that he would speak first in his capacity as responsible for the two global programmes on road traffic accidents and care for the aged. He would also return to the latter subject when the World Assembly on Aging was discussed, under the item on collaboration with the United Nations system.\(^1\)

The delegate of Finland had asked about the policy regarding road traffic accidents, and the possibility of broadening the basis of the programme. As the Deputy Director-General had already indicated, the two programmes were recent as global programmes, although they had existed previously in the European Region. As from 1980 global responsibility had been assigned to the Regional Office for Europe, special provision being made for programmes in 1980-1981. Appropriate provision had been made in the 1982-1983 budget under global and interregional activities. Regarding the question about other funds - for road traffic accidents there was an additional amount of some US$ 900 000, made up of US$ 560 000 at the global level and US$ 339 000 under the European programme approved by the Regional Committee.

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\(^1\) See summary record of the twelfth meeting of Committee B, section 2.
Road traffic accidents were becoming an increasingly important problem everywhere, and there should be a study of the relationship between public and private transport, and of the multidisciplinary question of transport policy. There would be a conference on road traffic accidents in developing countries in Mexico as a major part of the global programme in 1981. In addition there was the Interregional Planning and Coordination Committee on Prevention of Road Traffic Accidents; a number of people appointed by the regions were discussing the question, together with several representatives of nongovernmental organizations and other intergovernmental organizations, including other organizations and bodies of the United Nations system. That group would determine how the programme could be developed for the Seventh General Programme of Work. There would also be an analysis of how accident prevention in general could be coordinated with the programmes on workers' health, child health, toxicology and traffic accidents under an umbrella programme for 1984-1985. He assured delegates that all their comments would be taken into account.

Speaking as the Regional Director for Europe, he said that the delegate of Czechoslovakia had noted that the regions did not have a standard way of presenting material on health services research. In the European Region "research coordination" was under item 2.4, with a restricted budget, but there were research activities, as approved by the Regional Committee, under more specific programmes. In 1982-1983 total research-related programmes - mainly related to health services research - amounted to US$ 1.5 million (the research element in the programmes on health care for the aged, traffic accidents, appropriate technology, maternal and child health and mental health).

The working group mentioned by the delegate of Czechoslovakia and systems analysis of national research programmes referred to by the delegate of the USSR would be undertaken as part of regional research coordination, but supported by extrabudgetary funds.

Returning to the subject of care for the aged, he said that he had been struck at one meeting by the comment of a representative of a developing country; he had said that in his country care for the aged was considered a natural return by the young for the care lavished on them as helpless children, and expressed his surprise at the European idea that they could be relegated to old people's homes. The speaker believed that respect for the family was returning. There was a need to discuss the social aspects of the family, and the responsibilities between the generations. The present-day prevalence of violence and youth problems indicated the need for the family safeguard to provide greater security.

Dr KO KO (Regional Director for South-East Asia) said that since 1976 health services research had been identified as a priority area in the South-East Asia Region, but focusing on alternative approaches to the delivery of health services. After the Alma-Ata Conference in 1978 a holistic approach had been adopted to health services research. Some broad research areas had been identified, such as needs and demands, operational research related to service delivery, control of communicable diseases - including the Expanded Programme on Immunization, manpower support and training, management and evaluation, maternal and child health - especially in perinatal mortality studies, human behaviour and various aspects of community action, intersectoral collaboration, the financing of health services, traditional medicine, and so on. Those activities were covered by the regular budget, but were conducted in cooperation with national governments and other agencies, with financial support as well. Now focusing on health for all by the year 2000, research needs were being reviewed in accordance with the guidance of the sixth session of the South-East Asia Advisory Committee on Medical Research in 1980 and discussed at the seventh session in 1981. There must be an effort not only in technology or techniques, but with strong emphasis on solving the human problems. Two meetings would be held at the end of July - the first one to translate policy into action regarding research needs to reflect the health for all by the year 2000 programme, and the second one to conceptualize health services research and develop detailed work plans.

The delegate of India had referred to joint family systems, which was an interesting idea. He would discuss privately with that delegate, to save time.

Dr MACFADYEN (Care of the Aged, Regional Office for Europe) thanked the 18 delegates who had commented on care for the aged, particularly those who had proposed collaboration with the programme at the national level. That proposal would certainly be pursued further. Seven delegates had suggested that the programme should contain a greater research component. Every effort would be made to get the right mix of research and service into the care for the aged programme, but a mandate was needed from the Advisory Committee on Medical Research so to the scope of research in the programme.

The meeting rose at 17h50.
SIXTH MEETING
Friday, 15 May 1981, at 9h30

Chairman: Dr E. P. F. BRAGA (Brazil)

PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA31.17, para. 4(1), and WHA33.24, para. 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2) (continued)

GENERAL PROGRAMME DEVELOPMENT, MANAGEMENT AND COORDINATION (Appropriation Section 2; Documents PB/82-83, pages 84-88, and EB67/1981/REC/3, paras 40-52) (continued)

Research promotion and development (major programme 2.4)

Dr BARAKAMFITIYE (representative of the Executive Board) said that, during the Board's consideration of the research promotion and development major programme, stress had been laid on the importance of a sound scientific basis for WHO's activities. WHO's leading role in coordinating research had also repeatedly been stressed.

WHO's main mechanisms for the promotion of research were the global Advisory Committee on Medical Research (ACMR) and the regional advisory committees.

Professor Bergström, the Chairman of the global ACMR, addressing the Board, had provided it with valuable information on health and biomedical research in general, and on WHO's unique role where research was concerned. A large proportion of the sums expended on health research worldwide was devoted to research on cancer, arteriosclerosis and rheumatism in the industrialized countries. In the developing countries, there was a greater need for research such as would yield rapid results, and so affect mortality rates - particularly those for infants and young people. The areas requiring particular attention were parasitic diseases, human reproduction, and malnutrition as related to weaning and diarrhoeal diseases. It was there that a strengthening of national capacity was most urgently needed.

The Board's consideration of the consolidated table of WHO's research activities according to major programme, programme and source of funds on pages 87-88 of the proposed programme budget (document PB/82-83) had shown that in budgetary terms, the programme areas in which WHO-funded research activities were particularly important included: health services development; the Special Programme of Research, Development and Research Training in Human Reproduction; mental health; bacterial, viral and mycotic diseases; the Special Programme for Research and Training in Tropical Diseases, including malaria, and vector biology and control; cancer, including the research work of the International Agency for Research on Cancer; cardiovascular diseases; and immunology. The Board had noted that the table dealt only with global and interregional research activities, and not with activities at country level. While it was as yet too early to identify the research components of country programmes, the Board stressed that research at country level offered an ideal field for WHO cooperation.

The regular budget allocation to research programmes with substantial extrabudgetary support varied: such allocations were intended to launch activities in a developmental period and to represent a visible expression of WHO's commitment to those programmes. Once the programme was well established the regular budget allocation was reduced, thereby releasing funds for other activities in a developmental phase.

Sometimes the importance attributed by WHO to a particular programme was judged by the size of the regular budget allocation. That was not valid, since WHO had to place its programmes within its overall priorities regardless of the source of funding. Regular budget funds were sometimes allocated to programmes receiving substantial extrabudgetary funds in order to ensure a basic source of funds not subject to the fluctuations that sometimes characterized external financing.
Regarding the programme functions identified, some concern had been expressed in regard to the analysis of national and regional research policies. WHO was making every effort to obtain the maximum of information on the various policies and priorities of Member States with a view to improving the procedures for research policy formulation.

The DEPUTY DIRECTOR-GENERAL emphasized the way research promotion and development had been strengthened within the Organization in the past decade. For the benefit of those not associated with the development of the programme, he explained that ten years ago very little research work had been conducted by the Organization. Today, however, the participation and services of large numbers of scientists had been mobilized, both individually and as an international scientific community. Professor Bergström would give up-to-date details of the evolution of the programme, but he would like to emphasize that such research had become an indispensable component of WHO's programmes, and its organization at all levels was being actively pursued.

At the national level, there was room for a better organization of research; some developing countries had not yet succeeded in putting forward well-defined and well-refined national research policies, and there was a lack of cooperation at national level among research councils. The point was worth making in order to remind delegates, more especially those from developing countries, of the need to put more effort into the whole area of national research and organization of research policies at national level. None the less, a lot of progress had been made in many developing countries - for example, in Senegal, where success in mobilizing resources within the country for the benefit of multidisciplinary research had been most encouraging. That approach was being aggressively pursued in a way which would bring great benefits to national endeavours.

The Organization had also been very active in the past five to six years in liaising with many nongovernmental organizations and organizations of a professional and scientific nature. Nongovernmental organizations had been extremely active with individual units and disciplines within the Organization. The relationship had proved very productive and stimulating, as also had the relationship with the Council for International Organizations of Medical Sciences (CIOMS), housed in Geneva and within the Organization. The President of the Council was present, and would be speaking to the Committee on the very encouraging way the relationship was developing.

WHO was not relying only on external mechanisms however, but continued to make efforts through bodies such as the Research Development Committee, an internal mechanism to overview research across the various disciplines. In recent times biomedical research, health services research, and social and behavioural sciences research had represented landmarks in the Organization's research programme and had reached a point in their development which he was extremely proud to be able to report to the Committee.

Professor BERGSTROM (Chairman of the global Advisory Committee on Medical Research) said that over the past ten years WHO's research effort had increased tenfold in the priority areas of tropical diseases, human reproduction and recently diarrhoeal diseases. With UNDP and the World Bank as co-sponsors, WHO-supported programmes were running at an annual US$ 50 million. It was gratifying that so many outstanding scientists and specialists in those priority areas were now thus directly and actively involved in WHO's efforts.

The programmes not only supported research and development, including health services research, but also promoted institution-strengthening and training in the developing countries. The impact reached far beyond the directly-funded activities. The figure of US$ 50 million in fact represented no more than an infinitesimal fraction of the total sums spent on medical research worldwide. The indirect effects of such expenditure were many and varied: medical research councils in many industrialized countries had markedly increased their efforts in the priority areas, and an increasing number of scientists, graduate students and trainees were starting to work in those fields.

There had also been an increase in the efforts of the pharmaceutical industry, apparently prompted by the prospect of WHO's involvement in the organization of clinical trials and field testing of promising vaccines and drugs - a particularly difficult area regarding tropical diseases.

The systematic strengthening of institutions and centres involved in such work, and the training of their personnel, also represented a most important long-term investment, and one which it was hoped, would attract a greater measure of voluntary support in the future. There seemed to be no more cost-effective method of ensuring technology transfer, scientific training and the building up of national self-reliance in research.
Such research programmes were managed like research councils in industrialized countries - groups of experts decided on how the money should be allocated and assessed and evaluated the results, and the secretariat function was performed by WHO staff. With regard to the Special Programme for Research and Training in Tropical Diseases, the Joint Coordinating Board was in practice a subcommittee of the Health Assembly: of its 30 members three represented WHO, UNDP and the World Bank, and the remaining 27 were appointed by governments; perhaps in the future they would report directly to the Assembly.

Over the past five years the creation of regional ACMRs had led to some very promising developments. In some regions they and their subcommittees had cooperated closely with the regional office in developing and executing new research programmes with funds obtained by the regional research promotion and development unit. There had been cooperative undertakings between neighbouring countries - a good example of technical cooperation among developing countries (TCDC). The Western Pacific and South-East Asia Regions had organized a joint global research programme on dengue haemorrhagic fever - supported by regional funds and drawing on scientists from other regions. Without strong national commitment, however, outside efforts would be unavailing. It was accordingly gratifying that one regional committee at least had set aside a specific percentage of country allocations for research purposes, with most important implications for the building-up of national research capabilities.

Such expansion of the research effort had led to a demand for a new and expanded information system, a development which was actively taking place and going ahead very efficiently. He was sure that any delegate could ask for a country profile showing what WHO was doing in any particular country and be provided with all the relevant data in a matter of hours. That was of course also a first step in developing a comprehensive and coordinated research plan for the future. The administration of research would likewise need to be modified to accommodate the large expansion of research activities.

Health services research, which had been discussed at all the ACMR meetings, covered a very wide range of activities, and the work being done was far more extensive than was apparent from the relevant budget section. A report on the subject would no doubt be prepared in 1982.

He concluded with a plea to Member countries to make - in time for the next Assembly - an assessment of the impact of WHO-supported projects on the national research effort because such a national assessment of research efforts would enable countries committing such large sums to learn from the recipients what was being accomplished.

Dr BELCHIOR (Brazil), speaking for the Council for International Organizations of Medical Sciences at the invitation of the CHAIRMAN, said that CIOMS was a nongovernmental organization which had for many years collaborated with WHO in various aspects of medical research promotion and development, and was extremely proud of the association. One extremely important joint WHO/CIOMS programme that was of great relevance to research promotion and development was the programme on research involving human subjects. He referred particularly to the joint preparation, by WHO and CIOMS, of the international guidelines for the establishment of ethical review procedures for research involving human subjects. A draft of those guidelines, which would soon be finalized and distributed, had been considered by the global ACMR the previous year and presented to the CIOMS Round Table Conference in December 1980 in Mexico, and would again be discussed during the next CIOMS Round Table Conference in Manila in September 1981.

The importance of the subject of experimentation on human subjects from the moral and ethical points of view and its relevance to progress in medical knowledge in general needed no emphasizing. The guidelines were particularly aimed at helping developing countries, and were based on surveys carried out in the medical schools of developing countries and on consultations with many national and international institutions. They had been prepared in close collaboration with the global and regional ACMRs. It was worth mentioning that, even at the present preliminary stage, they had already had a very positive effect on the development of national ethical review procedures in his own country, Brazil.

CIOMS would do its utmost, in cooperation with WHO, to finalize the document and give it the widest possible distribution. It was, moreover, ready to cooperate with WHO in any other field that might be of mutual interest to the two organizations.

Dr SARTORIUS (Director, Division of Mental Health), speaking as chairman of the Research Development Committee, said that the Committee had been created by the Director-General to fulfill three main purposes. The first - to ensure uniformity of approaches in WHO's research programmes - had become necessary in view of the rapid recent development of the WHO research effort. Many new ideas and ways of managing research had been produced, and while diversity was both useful and inevitable to some degree, there was also a need to make WHO approaches to
research more consistent and rational. The Committee was to help in that particular area. The second purpose concerned administrative coordination and was intended to help achieve agreement on the most appropriate procedures which would facilitate coordination among programmes. The third purpose was to monitor opportunities and needs for WHO's intervention in research and technology development, identifying interprogramme opportunities and research areas hitherto missing from WHO's programme.

In order to fulfil those functions, the Committee was composed of all programme directors at WHO headquarters, the secretary of the Committee for Research Involving Human Subjects, and the secretary of the Headquarters Programme Committee. Similar research development committees had been established in all the regions, involving senior programme managers, and links between the committees at global and regional level were informal and effective.

To give delegates an idea of the Committee's work, he would give examples of what the Committee had actually accomplished during the past 18 months. It had reviewed an overall plan for the management of research in WHO, and agreed on procedures for its implementation; worked with the Office of Research Promotion and Development on the development of the medium-term programme of biomedical research, which was to be submitted to the governing bodies; collaborated in preparing regulations for expert advisory panels and WHO collaborating centres; worked on and developed proposed formats for WHO research projects; reviewed and attempted to coordinate the terms of reference of different WHO bodies dealing with research strategy, and studied the dissemination of information on WHO research activities; reviewed the management of research training activities in WHO, since that aspect affected a number of programmes in common; and contributed to the agendas of global and regional ACMRs.

The next few meetings of the Committee would be discussing subjects such as the implications of reliance on extrabudgetary support for research development; the methods of coordination of research, initiated at different echelons of the Organization; the role of the Secretariat in planning, monitoring and evaluating research; the administrative implications of projects for the strengthening of large institutions; and ways of providing WHO support to non-WHO research at country level.

The CHAIRMAN suggested that the Committee, faced as it was with the exceptionally broad field of scientific research in medicine, should as far as possible concentrate on the narrower aspect of scientific research in the context of the budget for the biennium 1982-1983.

Dr LENFANT (United States of America) expressed strong support for the research promotion and development programme. He believed that the global and regional advisory committees on medical research had a most important part to play in the achievement of the Organization's goals, especially health for all by the year 2000. Those committees constituted an asset of great value which was available to all Member countries and could be used for the determination of research needs and priorities. He expressed particular support for the activities on prospective research and development - an essential means of establishing the foundations of a strong and effective primary health care programme.

Dr QUAMINA (Trinidad and Tobago) found great merit in the format adopted for the section of the budget under examination; it brought out very clearly how each major programme had its own research component, and she hoped that it would encourage individual countries to make provision for a research component in their respective programmes. It should not be forgotten, however, that those who were responsible for health service administration in ministries of health had to give priority to the requirements of service over those of research.

She welcomed the suggestion that ministries of health should play a more active part in promoting research programmes. In her country a national institute of higher education, research, science and technology had been formed, and was expected to collaborate closely with the university and to recommend and finance research projects. The ministry itself had also taken steps to coordinate medical and health services research within its own field of competence and had even been given rather oblique access to certain development funds for that purpose.

There was, however, one major problem, for which she hoped a solution might be found within the framework of WHO. Many scientists from her country - and from other developing countries - reached eminence in institutions overseas, and their home countries were then unable to offer suitable career prospects either for them or for others aspiring to follow their example. She would like to see the setting-up of some international interchange procedure, whereby the services of such eminent scientists would not be lost to the country of their birth.
Professor SYLLA (Senegal) said that research planning did not seem to give rise to any major problems - thanks mainly to technical cooperation and, in Africa, the coordinating work carried out by the Regional Office and various WHO missions. Serious difficulties did, however, arise at three levels, namely in the adoption of operational strategies, in training for biomedical and public health research (involving a multidisciplinary approach), and in developing appropriate technology. Research structures, if they were to take account of the real situation, inevitably became very complex and difficult to manage. Among the difficulties mentioned by the Deputy Director-General, there came to mind the fact that funds allocated to research programmes were often reduced, after completion of the initial stages, in favour of other new ones in response to a healthy demand for research funding, thus producing a constraint on well-planned and promising programmes actually in progress. In that connexion, he referred to research programmes on primary cancer of the liver (a leading cause of death in Senegal) and viral hepatitis. He urged that WHO seek to ensure the provision of additional special or extrabudgetary funds for the continuation and coordination of such research, which involved clinical, biological, sociological and other studies in such a wide range of fields.

Dr BAJAJ (India) said that in his country research promotion and development programmes were administered by the Indian Council of Medical Research, which had been found to be an entirely satisfactory arrangement. He would, however, like to know whether the TCDC programme was proving to be successful and, if not, the reasons for any shortcomings.

Professor LISICYN (Union of Soviet Socialist Republics) welcomed the increased attention paid by WHO to research, particularly in special programmes, as a means of intensifying primary health care and achieving the target of health for all by the year 2000. The importance of research as a basis for health activities had emerged clearly from the reports of the representative of the Executive Board and from the remarks of the Deputy Director-General and other speakers. At the same time, WHO should not be allowed to pursue fundamental research. Research should be regarded as a basis for implementing the health for all strategy - in fact as a tool for the implementation of practical health activities. It was desirable to strengthen the coordination machinery and intensify the impact of research on programmes such as health manpower development, maternal and child health, the Expanded Programme on Immunization and promotion of environmental health. It would be worth paying particular attention, in that connexion, to the coordinating machinery at different levels - coordinating centres, committees, at the global and regional or even local level - all of which could benefit from a more systematic approach. At the same time, better use could be made of WHO links with other international organizations and bodies, such as CIOMS.

There was also room for the initiation of further programmes of research covering, for example, various concepts of public health services and elements that had emerged from the International Conference on Primary Health Care, Alma-Ata. Research programmes on public health administration, public health training and the development of appropriate technology merited particular attention.

The moral and ethical element was a most important aspect of research programmes, and one which had already generated some disquiet in the minds of research workers. A closely related subject, which needed to be studied, was the dehumanization of medicine as a result of intensive specialization, in which the doctor tended to become remote from the patient, who was regarded merely as a collection of different organs, and not as a complete human being.

The funds devoted to research, though considerable, represented only some 2% of WHO's total regular budget, and were certainly inadequate. The reductions being made in the budgetary allocations for the research components of many individual WHO programmes were giving rise to increasing concern. At the same time, however large the sums might be, the Soviet delegation considered it unwise to rely on extrabudgetary resources.

Regarding the presentation of the programme budget he considered that more detail might have been given of specific research programmes, with perhaps a list of WHO collaborating centres and their research projects.

Professor ADENIYI (Nigeria) emphasized the importance of not allowing the three elements - service, training and research - to become compartmentalized. Paragraph 6 on programme 3.1.6 (Health services research) referred to the development of training "packages" adaptable to various needs. That was a useful means of making available basic research information in the primary health care field. It was important to remember that research need not necessarily be laboratory-oriented, with the consequent serious financial burdens, but should cover also the very important social, ethical and health planning aspects.
In Nigeria the National Medical Research Council and the ministries concerned were coordinating their activities in order to provide a much-needed boost for health care in the community. The training structure also included an incentive scheme with which it was hoped to counter the problem of the brain drain, ever present in the developing countries.

Professor SPIES (German Democratic Republic) stressed the importance of science and research for the success of WHO's work. His delegation fully supported the general statement on the role of research within the work of WHO and on the declared goal of stimulating a closer relationship between health research councils and ministries of health with a view to the identification of priorities. In addition, it would advocate a closer relationship between national research councils and WHO.

It also welcomed WHO's interdisciplinary approach. The generalization of research findings, the evaluation of research programmes, the analysis of results, and development of comparable standards and norms assumed increasing importance in the work of WHO. That trend should be emphasized in the future, especially the role of evaluation and of standardization. Actual social conditions should, however, be taken into account so that the introduction of standards and new knowledge in the field of practice would be appropriate to each situation.

His delegation supported all action that contributed to the development of research capabilities in developing countries; those countries should be true partners in research rather than merely recipients of assistance. WHO should help developing countries to solve their own research problems so that they could become more self-reliant, rather than try to solve their problems for them. So far, the work undertaken on those lines had been insufficient.

His delegation also agreed with the importance of regional research programmes, but felt that they should not develop towards too great a decentralization, so that WHO's coordinating role was lost sight of.

The four distinct programme functions identified in the programme budget were of special interest, and were a prerequisite for further international cooperation. The plan of action provided an illustration of the fact that coordinated international cooperation was only possible if due consideration was given to the problems of proper information of Member States and their equitable representation in global and regional advisory committees, and in working groups and committees on specific areas of medical research. His delegation therefore welcomed the proposals for improved communication between headquarters and the regional offices and country representations, and for better coordination of scientific activities between WHO and other international organizations. It also supported the involvement of such sectors as industry, education, energy, agriculture and commerce, as described under the heading "Prospective research and development".

As regards the changes in the budget for the financial period 1982-1983, the transfer of resources provided for the African, South-East Asia and Western Pacific Regions to a more technical and material support of their research activities was understandable, and to be welcomed.

He noted increases in the research budget for cancer, cardiovascular disease and tropical disease programmes, as well as for the Special Programme of Research, Development and Research Training in Human Reproduction. For some programmes, however, allocations had been reduced to such an extent as to cause concern, in particular as regards the mental health programme.

Mr PAGÉS PIÑEIRO (Cuba), stressing that health research was an essential preliminary to action, said that WHO should not only initiate specific programmes but should undertake the responsibility of studying national policies and programmes and, when countries asked it to do so, should orientate and coordinate them.

Reference was made in the programme budget and in the Executive Board's report thereon to the advisory committees on medical research. On the basis of his country's experience, his delegation felt that the ACMR for the Region of the Americas was not playing its full role. It would like that Committee to investigate further how countries could help each other to improve their research both quantitatively and qualitatively. Such an investigation had been started in Mexico in 1977. His delegation considered that it would be useful if information on the subject could be provided to the next Health Assembly. It might perhaps show how countries proposed to build up their human resources for research and formulate their own research policies, and what impact WHO's role had had on such research. It might also indicate how far the regional offices and ACMRs had coordinated their work and the extent of any repercussions on the health of the countries.
It was known that certain WHO programmes - for example, the Special Programme of Research, Development and Research Training in Human Reproduction and the Special Programme for Research and Training in Tropical Diseases - had been successful in contributing to the solution of problems at the national level; other similar programmes should be stimulated by WHO. Some regional programmes, however, had been less successful, and their results ephemeral.

His delegation, therefore, felt that WHO should promote the national training of personnel, strengthen the resources of the least developed countries, encouraging research that would really be conducive to improving the health of their people, and help those countries to become self-sufficient. The research undertaken in countries that had already determined their research policies would serve as a pattern and stimulus for countries which had not yet started their own research programmes. WHO would develop methodology and act as a catalyst for the advance of science and technology as a whole.

Dr CABRAL (Mozambique) said that he would address himself specifically to the need to strengthen research in the Third World.

His delegation subscribed to the concern of the Executive Board as regards the dependency of most research activities on extrabudgetary funds. Great progress had been made in recent years in research capability strengthening in developing countries, but much of that had been achieved through WHO's mobilization of considerable resources and support. The financial crisis affecting various donors to research promotion funds was therefore particularly disquieting. The summary of research activities by major programme, programme and source of funds revealed, on page 88 of the proposed programme budget, the degree of dependency of research on extrabudgetary funds. Therefore, in line with the Executive Board's comments in paragraph 44 of its report on that document, his delegation expressed the hope that the Secretariat and the Director-General would continue their efforts to mobilize long-term commitments to providing such funds.

During 1980 Mozambique, with technical and financial support from the Special Programme for Research and Training in Tropical Diseases, had started institution strengthening and manpower training in the National Institute for Health, with the aim of building up a supporting infrastructure for the initiation of research activities. A research coordination group had also been established to coordinate the work of the Ministry of Health and the Medical School with regard to research. Those activities, however, were only at the initial stage, and would be at risk if external financial resources ceased coming in. Moreover, medical research had to compete with other sectors for scarce foreign currency.

Furthermore, training manpower for research and establishing sufficient institutional strength and logistic support structures for research in the Third World could take years, and would necessitate a long-term information and incentive programme. As much time was needed to generate resources for research as was needed for the research activities themselves. All those factors made assistance from WHO all the more essential, both for the continuation of successful ongoing activities and for the initiation of new ones.

Dr BULLA (Romania) expressed his delegation's support for the general orientation of WHO's research development programme towards meeting major programme needs in developing and developed countries, increasing funding of research through the regular budget and voluntary funds, and strengthening national capacities.

He then outlined his delegation's view of WHO's coordinating role at the global level. Member States and WHO in general might obtain enormous benefits from a regular, global and integrated appraisal of research development in different sectors and diseases on the grounds of efficiency and effectiveness. Such an approach, aimed at identifying lessons to be learned on a reciprocal basis, might be a way of strengthening WHO's catalytic role. A cross-sectional appraisal would reveal an impressive variety of developmental stages in the treatment and prevention of diseases, would help medical personnel to overcome their fascination with the technical progress achieved in therapy and thus provide a sounder basis for further research and progress.

The meeting rose at 11h20.
SEVENTH MEETING

Friday, 15 May 1981, at 14h30

Chairman: Dr E. P. F. BRAGA (Brazil)

PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA33.17, para. 4 (1), and WHA33.24, para. 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2) (continued)

GENERAL PROGRAMME DEVELOPMENT, MANAGEMENT AND COORDINATION (Appropriation Section 2; Documents PB/82-83, pages 84-88, EB67/1981/REC/3, paras. 40-52) (continued)

Research promotion and development (major programme 2.4) (continued)

Dr ÉLIAS (Hungary) referring to paragraphs 41, 42, 45 and 48 of the Executive Board's report on the proposed programme budget (document EB67/1981/REC/3), said that he was glad to note the increasing involvement of the Director-General and the Secretariat in the coordination and promotion of research through the global and regional advisory committees on medical research and by other means aimed at ensuring that research was highly relevant to the main goal of health for all by the year 2000.

With regard to paragraph 42, he considered that research into the health problems of the developed countries should continue, though the amounts spent on such research might seem out of proportion. It should be remembered that diseases such as cancer, arteriosclerosis and rheumatism would also be of concern in the future to the developing countries. He endorsed the allocation of 75% of voluntary contributions to research in the developing countries, as mentioned in paragraph 45, and was pleased to see that the funds were used under strict scientific peer review. Nevertheless, countries might not always have the necessary capacity to use human and material resources and a measure of criticism should be exercised. He approved the statement made in paragraph 48 with regard to national research efforts; they constituted a major source of talent and facilities of which even greater use could be made.

Dr KRUISINGA (Netherlands) said that the major programme was of the utmost importance and was essential as an instrument in reaching the goal of health for all by the year 2000 and in primary health care. He asked why the estimated obligations for 1982-1983 under the regular budget had been reduced to US$ 7 161 600, as compared with US$ 7 569 900 for the previous biennium, as it appeared from page 85 of the proposed programme budget (document PB/82-83). Funds from other sources had also apparently decreased; if allowance was made for inflation, the total decrease was 15-20%.

He asked for more specific information to be provided on the relationship between the Executive Board and the global Advisory Committee on Medical Research (ACMR). What criteria were followed in the selection of scientists to serve on ACMR? It was stated in the document that, in one of the regions, a specific proportion of the funds allocated to medical research were spent on health services research, a subject to which his delegation attached great importance. Could information be provided on which regions had indicated a percentage figure for such research and on the targets which might be set.

He endorsed Professor Bergström's plea for the assessment of research results. The benefit-cost ratio for smallpox eradication, for example, must be much greater than 100:1. That should be brought to the notice of decision-makers so that they realized the value of medical research. He thought that the efforts being made to combat malaria and in the Expanded Programme on Immunization would bring comparable benefits. Any results of cost-benefit analysis would be very useful, and he wondered whether WHO had any plans to make such analyses.

WHO might wish to consider having a central coordinating body for medical research, heading a network of State and other institutions; the idea was not new - he recalled the initiatives...
of the former Director-General, Dr Candau, and Dr Kaplan, former Director of the Office of
Research Promotion and Development. He wondered what should be the criteria used in selecting
the areas to which resources for health research were to be allocated. He had already referred
to the importance of health services research, but there was also the question of the incidence
diseases caused by the environment; morbidity and mortality data showed that the incidence
of cardiovascular diseases, cancer and psychosocial conditions was increasing. There was a
need for further study of the incidence of and morbidity and mortality due to those diseases,
in order to determine what relative weight should be given to them for balanced expenditure on
health and medical research. That was a very important point which could be made the subject
of a special document for the next World Health Assembly.

He believed that WHO should play a major role in coordinating intercountry research and
in ensuring scientific cooperation between and within countries; there was often a lack of
coordination of the research activities of universities, State laboratories, and government,
tergovernmental and nongovernmental institutions.

In the field of occupational health, cooperation with ILO should be broadened, especially
with regard to toxic chemicals, pesticides and additives. Cooperation with UNEP, FAO, UNESCO
and IAEA was also desirable.

WHO also had a duty to support research activities on energy sources. In particular, it
should look into the problem of the effects of radiation; alarming epidemiological data had
been reported from the vicinity of nuclear power stations. The problem would soon become
urgent; WHO should make a stand and use the weight of its authority.

The organizational impact of the research programmes under consideration would directly
affect expenditure on the programme to be carried out over the next decade, which were so
important in achieving the goal of health for all by the year 2000. He pleaded for more
cooperation and coordination between universities, industry, State institutions, inter-
governmental bodies such as the European Economic Community, the Council for Mutual Economic
Assistance and the United Nations system, and nongovernmental organizations. Who was going
to set priorities and decide how the research was to be carried out?

Better coordination of cancer research could be achieved by closer cooperation between
ACMR and IARC. It was necessary to decide by whom and where research on epidemiology,
prevention, early detection, therapy and after-care was to be carried out.

Dr KPOSSA-WAMADOU (Central African Republic) supported the remarks made by the delegates of
USSR and Senegal at the preceding meeting, especially the latter’s comments on technical
cooperation and biomedical research. He said that the concept of national priorities should
be given due consideration, especially by the developed countries and international organizations.
A case in point was the very high infant mortality in the Central African Republic: when
assistance had been requested in carrying out a study of that problem, the international
organization concerned had replied that it would prefer to carry out research on the pygmies
instead.

In general, he would like to see greater emphasis placed on traditional medicine; that
was complementary to western medicine, and was capable of reaching the rural population which
was largely inaccessible to conventional health services. His country would like to be
closely associated with WHO’s programme in that field. Traditional medicine was important in
all developing countries; in addition, it should also be remembered that modern medicine
tended to dehumanize the patient.

He noted the small percentage of the budget allocation to research in the biennium 1980-
1981; the position was worse for 1982-1983, so that those countries that needed research in
various fields would be at a further disadvantage. An effort should therefore be made to find
extrabudgetary sources of funds to make good the deficiencies.

Dr GURMUKH SINGH (Malaysia) asked for clarification with regard to the method of presenting
major programme 2.4. He noted from page 85 of the programme budget that there was a reduction
of US$ 464 300 in the estimated obligations for the Western Pacific Region; the explanation
given in paragraph 10 on the same page was that provision for certain research had been trans-
ferred to the individual technical programmes. His understanding was that, in programme
budgeting, each programme was given a specific objective; in fact, the objective of programme
2.4 was clearly stated on page 84; namely "to promote and collaborate in the development and
coordination of biomedical and health services research". Did the reduction in the allocation
mean that such development and coordination was to be reduced in the Western Pacific Region?
He suggested that, in future, where increases or reductions in allocations were shown in the
programme budget, some account should be given of the scope of the activities correspondingly
increased or reduced.
The programme budget under consideration was the first of its kind, so that it was inevitable that there should be some vagueness where programmes overlapped. He suggested that, in future, funds should not be transferred unless there was some real change in the scope or quantum of activities; that was the essence of programme budgeting. If there was really going to be a reduction in the research going on in the Western Pacific Region, there should be measurable indicators to show that it had reached a more than adequate level. That would be in line with the emphasis placed on the development of such indicators by countries. Was such a procedure envisaged in the WHO programme budget?

Dr MKANDAWIRE (Malawi) said that his delegation noted with satisfaction WHO's efforts to develop research programmes, especially at the country level, and the strategy stimulating closer relations between health research councils and ministries of health. In Malawi, a National Research Council had been established and a Health Research Committee set up under its aegis. The main problem was the lack of trained research workers. He hoped, therefore, that WHO would accelerate the establishment of institutions for training research workers, especially in the African Region. Finally, his delegation was concerned to see that the allocation to that Region had been reduced by US$ 37 900 for the biennium 1982-1983. Could some explanation be given for that reduction?

Mrs MAKHWADE (Botswana) said that WHO's guidance was extremely important to developing countries in enabling them to develop confidence and self-reliance in research directed towards solving their pressing problems. Countries such as Botswana lacked the capability to undertake meaningful research because of manpower, financial and material constraints. Botswana's health care delivery system therefore lagged behind, for example, in operational and applied research. Her delegation consequently supported the efforts to strengthen national capabilities. She hoped that, during the biennium, WHO would do everything possible to make ministries of health and other national institutions aware of the need to identify areas of relevant research activities.

Her delegation approved the proposed estimates, but regretted the decrease in the allocation to the African Region; what was the explanation for that decrease?

Dr MARKIDES (Cyprus) asked what progress had been made in research on haemoglobinopathies, and on thalassaemia in particular. In 1980, WHO had planned to carry out research in Cyprus in that field. What progress had been made in that research?

Dr BARAKAMFITIYE (representative of the Executive Board) said that one of the most important functions of WHO was coordination in the area of research. The fact that the Director-General had set up a number of global and regional mechanisms in the hope that they would stimulate the establishment of similar mechanisms at the national level, particularly in developing countries, showed WHO's concern for coordination. The Executive Board fully recognized the importance of coordination and followed developments closely. Priorities in the field of research had to correspond to specific problems that had already been defined at the global, regional and national levels. WHO could not become a research institute; it had to promote research activities that would help to solve major health problems and would further the achievement of health for all.

In that connexion, he mentioned that the Programme Committee of the Executive Board and the global ACMR had held a meeting in 1979 which had been attended by chairmen of regional ACMRs and at which a useful exchange of views had taken place. On that occasion he had noted with satisfaction that, contrary to preconceived ideas about research workers, they were fully aware of the ways in which their work could be used to help the population. Major health problems such as primary health care, diarrhoeal diseases, malaria, immunization and nutrition were among their main preoccupations. The delegate of Nigeria was justified in urging that research should not be confined to a laboratory because the population and the problems that were the subject of research were not necessarily found there. In other words, applied research merited particular attention. Taking into account the complexity of the problem the Executive Board considered that WHO was on the right path.

With regard to developing countries, it was obvious that they would have to define their priorities in the research field if they wished to obtain maximum benefit from existing mechanisms and funds, and would have to make considerable efforts, in which WHO should support them at every stage - as had been mentioned by the delegate of the German Democratic Republic - especially by setting up or enlarging collaborating centres and by developing their research methodology, as well as by assisting in technical cooperation among developing countries.
The Executive Board had also considered the question of ethics in the field of research, and he agreed with the delegate of the USSR that it must constantly be kept in mind, because specialization could influence the humanist concept of medicine.

Personally he did not feel that the inclusion of more details in the proposed programme budget would facilitate understanding of the very complex problems involved, but delegations' wishes had been noted and, in the mean time, some of the other points raised, by the delegate of India for instance, might find an answer in connexion with the Special Programme for Research and Training in Tropical Diseases (programme 4.1.6).

The DEPUTY DIRECTOR-GENERAL noted with satisfaction that the delegates had expressed considerable interest in research, which had become such an important part of WHO programmes at all levels, but it was extremely difficult for the Secretariat to reconcile all the different views. For example, some delegates queried reductions in the budget for research while others wished to confine WHO's activities to applied research.

The delegate of the Netherlands had outlined some interesting areas for research which would call for greatly increased resources. In reply to the question he had raised, he said that the relationship between the Executive Board and ACMR was now very close. In the past, ACMR had been an advisory body to the Director-General and it was only in recent years that it had reported to the Executive Board and to the Health Assembly, so that they were now able to have direct contacts with the chairman and members of ACMR. He nevertheless agreed with the delegate of the Netherlands that the relationship could be strengthened.

In reply to the question asked by the delegate of the Netherlands on the criteria for selecting members of the global ACMR, he said that representation was not only on a geographical basis but every effort was also made to ensure that the most important disciplines were represented. Members were expected to be internationally recognized experts in their various fields who had contributed to research at the national or individual level. In addition, they were chosen so as to reflect a balance between the developing and developed countries, whose research programmes differed considerably. Some members whose international reputation did not appear to be as high as others had been chosen because of their considerable experience in a particular field. The criteria for selection were strict and standards were extremely high.

He informed the delegate of the Netherlands that at the sixty-seventh session of the Executive Board many questions had been asked about the reduction in funds. The problem was one of presentation and there was in fact no overall reduction; on the contrary, there had been a considerable increase in total investment in research. There were also instances in which extrabudgetary funds had been committed but not paid and those sums had not been included. The Netherlands was one of the traditional donors in the area of research.

WHO would carry out cost-benefit analyses and it fully recognized their potential benefit; however, it might be premature to undertake them at the present stage. Programmes such as the Special Programme for Research and Training in Tropical Diseases and the Special Programme of Research, Development and Research Training in Human Reproduction might profitably undertake cost-benefit analyses, but in other areas it could be done at the national or regional levels. Further investigation into morbidity and mortality was being undertaken and it was part of the work of most of the divisions and units. For example, epidemiology was one of the most important aspects of cancer and mental health research. Epidemiology was the first step before any effective action could be taken.

The delegate of the Netherlands had referred to the idea of a central coordinating body for medical research, as had originally been proposed by the former Director-General, Dr Candau, and Dr Kaplan, former Director of the Office of Research Promotion and Development, who had bequeathed so many ideas to WHO. They had brought research to the forefront and had thus made it easier for their successors. One of the functions of ACMR was to be a central coordinating body, but it was extremely difficult to coordinate research at the global level, it was even difficult to coordinate it within a country. Efforts were nevertheless being made, although coordination was probably easier in countries where research was directed by the State than in those where universities took their own decisions regardless of a country's priorities.

Interagency cooperation had made considerable progress and WHO had joint coordinating bodies with UNICEF, FAO, ILO and UNESCO. There were common areas of interest but a tendency existed for each agency to consider that it had priority in a particular field. On the whole, interagency cooperation worked well, and the annual meeting of Directors-General kept the situation under review.
Research programmes for future years were planned in the various programme areas. The Research Development Committee described by Dr Sartorius at the previous meeting was working effectively and it had considerable impact on planning and coordination within WHO, probably an even greater impact than that of ACMR which was global. One of the most important tasks of the former was to give guidance and to ensure that research programmes that were becoming redundant were eliminated.

Cooperation between WHO and IARC would be commented on in greater detail by Dr Stjernswärd. In any case such cooperation would be improved in the years to come, since in many instances the original division of labour agreed upon between the two had not been easy to enforce in practice.

He shared the concern expressed by the delegate of the Soviet Union regarding basic research. WHO might in fact have to confine its activities to the application of research without involving itself in basic research. Nevertheless, the Organization had a very strong moral as well as technical obligation to encourage aspects of research in Member States, especially in the developing countries, where research activities were generally in an embryonic stage. In practice it was extremely difficult to separate basic research from applied research and to inform a government that it should concern itself with clinical research on cancer, malaria or drug testing without becoming involved in immunology, biochemistry or genetics. In particular, it was very hard to see how WHO could do anything in the field of thalassaemia and genetically provoked diseases without involving itself in all aspects of genetics.

The delegate of the Netherlands had asked what WHO could do to promote the international coordination of work by various institutions, including laboratories. Apart from the production of vaccines, it was difficult to envisage how the Organization could proceed in that field without having some small participation in basic research. It was therefore not possible to state that WHO was interested only in the applied findings of research and that it should remain inactive as far as basic research was concerned. Lists of the research centres involved, and of their programmes, could scarcely be included in the documentation submitted to the Health Assembly, but the information was available to any interested delegate. The regional offices had been extremely active in the field of research in the context of technical cooperation among developing countries, and the Regional Directors would no doubt be able to supply the Committee with information on the activities of their respective offices.

Professor BERGSTROM (Chairman of the global Advisory Committee on Medical Research) said that the global ACMR had already proposed the establishment of a subcommittee on cancer. Coordination of national efforts could be very productive; a figure of about US$ 2000 million was probably being spent on cancer research, mostly in the developed world, and the aim of the subcommittee would be to try to find cooperative schemes in which developing countries could be included using national funds so as to generate a substantial volume of activity without calling upon the regular budget.

From 1981 onwards no country would have more than one member on the global ACMR, and regional distribution was now approaching a balanced proportion. Furthermore, the chairmen of each of the six regional ACMRs were also members of the global ACMR, thereby ensuring extensive cross-fertilization. The Regional Directors were under great pressure from the advisory committees on medical research to focus resources on regional and national priorities. Discussion in the global ACMR was centred on the problem of how to meet priority needs with the very limited funds available.

Training was very much dependent upon institutions having both continuity of research and resources, and that in turn depended on the national arrangements regarding careers for research workers. In the developing countries there was a clear need for a considerable increase in voluntary contributions on the basis of long-term commitments, since it took from five to ten years to build up a strong research institution. There already were indications that such a process would take place.

Dr KO KO (Regional Director for South-East Asia) explained that the reduction of US$ 818 300 for South-East Asia shown on page 85 of the programme budget did not mean that the total sum to be spent on research in that Region would decrease. Funds had merely been redistributed for budgeting purposes among other specific programmes with research activities, such as malaria, leprosy, nutrition and health services research. The reduction of US$ 818 300 related to intercountry activities only. Funds allocated to research at the country
level were shown under the research heading in the various programmes and totalled approximately US$ 1.6 million. The amount shown in the proposed programme budget could be used for promotion and development as a catalyst to attract funds from elsewhere. In the following biennium, when the Seventh General Programme of Work would be formulated and adopted, it would be preferable to revert to the previous practice of entering the funds for all research activities under the research promotion and development programme.

As far as technical cooperation among developing countries was concerned, research in the South-East Asia Region was mostly done on a cooperative basis as a collaborative effort. The most obvious case was the malaria programme, where a major problem was chloroquine resistance in malaria parasites. A collaborative programme covering seven countries was being implemented. Liver cancer was another serious problem; nine of the 10 countries in the Region were working together on it, each country covering some specific area of research. Following the discussions at the meeting of directors of medical research councils organized in 1979, a work plan had been formulated to carry out an increasing number of research activities in the context of technical cooperation among developing countries.

Dr ACÜNA (Regional Director for the Americas) replied to questions put by the delegates of the United States of America, Trinidad and Tobago and Cuba regarding health research in the Americas. He said that the Organization was placing great emphasis on its collaboration with governments with a view to establishing career structures in research. In his opinion that could usefully be promoted within the institution-strengthening aspect of WHO's Special Programme for Research and Training in Tropical Diseases, perhaps through the Caribbean Epidemiology Centre (CAREC) which operated in close cooperation with the Government of Trinidad and Tobago and with the University.

Experience gained in promoting the identification of research coordinating units in the Member States of the Region of the Americas had proved most valuable, as some governments had shown increased interest in learning what was occurring in health research in their countries. Research workers in a number of neighbouring countries were getting to know one another and the research activities in which they were engaged, thereby strengthening their countries' overall research programme. The attempt to carry out continent-wide activities of that kind had met with budgetary problems, and the Organization was seeking extrabudgetary funds for that purpose. Even if such activities were not feasible in 1981, in 1982 it would be possible to hold a regional meeting on national research promotion and coordination. In any case the valuable comments made by delegates would make it possible to establish better coordination between the Special Programme for Research and Training in Tropical Diseases, the Regional Office, and PAHO representatives/WHO country programme coordinators. In that connexion he recognized that the Special Programme's organizational arrangements were to some extent defective in so far as it had not been able to establish closer links with governments through WHO for the purpose of keeping them appropriately informed: in fact, visits were sometimes made to countries without either the government or the WHO programme coordinator being aware of them.

Dr NAKAJIMA (Regional Director for the Western Pacific) said that in his Region, too, the reduction of the amount allocated to research promotion and development in the proposed programme budget was due to the transfer of research activities to other individual programmes. The sum shown on page 85 of the programme budget covered only the activities of the Western Pacific Advisory Committee on Medical Research and its Subcommittee, meetings such as those of the directors of national research councils, and a regional centre for research and training in tropical diseases located in Kuala Lumpur. Areas of research of regional importance included schistosomiasis, dengue haemorrhagic fever, acute respiratory infections, Pigbel (Enteritis necroticans), clonorchiasis, fish poisoning and poisonous snake bites.

Most of the research done was carried out in accordance with the principle of technical cooperation among developing countries, which involved interregional as well as intra-regional cooperation. For example, in fields such as viral haemorrhagic fever, information was constantly exchanged with the Regional Offices for South-East Asia and the Eastern Mediterranean. The spread of the virus to Europe could lead to cooperation with the European Region. The list of collaborating centres for research in the Western Pacific Region was regularly published and was available to any delegate who wished to have it.

Dr STJERNWARD (Cancer) said that Dr Kruisinga had raised a very important point about the possibility of better coordination between AOAM and IARC. That was a timely question, since the stage had been reached in the field of cancer when considerable action could be taken
in accordance with WHO’s philosophy. The delegate of Hungary had pointed out that cancer was, indeed, a problem in developing countries; in fact, a very high number of the estimated 35 million cancer patients in the world were in developing countries. At present there was a separation between the work of the two bodies, IARC covering causation and epidemiology, with related research, while the WHO headquarters Cancer unit, together with the six regional offices, covered cancer control, namely primary and secondary prevention (including detection), therapy and after-care, and related health services research. There was now enough knowledge to take active measures. Over the past 15 years IARC had done important work, and data were now collected on which relevant health action could be taken. The present separation represented an artificial splitting-off of, for example, prevention and detection from epidemiology. Epidemiology as such was not an end in itself; it should hopefully lead to results on which cancer control action could be built. Needed now were, for example, target-directed epidemiological studies on the basis of which cancer control measures could be realized.

As the delegate of Nigeria had said earlier in the day, not all research needed to be done in the laboratory; society itself could be viewed as a laboratory. For example, not enough was known about how to change human behaviour and optimally implement in the community knowledge already gained. However, enough was currently known about cause-relationship for some major cancers and relationship with life-style habits to enable active measures to be taken, applying results from research in practice. Preventive measures specific to cancers that were preventable in the countries concerned, could be implemented, leading to a significant reduction in incidence of those cancers. It would be possible to develop a pragmatic programme, in accordance with WHO’s health service philosophy, which could have a real impact if there was better coordination, as Dr Kruisinga had suggested, between IARC and ACMR. He would welcome such a development and believed that it would lead to great benefits for the cancer patients in Member States. There was no doubt that the present coordination could be improved.

The ACMR Subcommittee on Cancer that would meet in the autumn of 1981, with the mandate "to work with IARC and the secretariat of the WHO Cancer programme to develop research for the prevention of those cancers whose etiologies are known, for early diagnosis and for the optimization of treatment methods, with due regard to their efficacy and economic feasibility", was a step in that direction, in the search for better coordination.

DEVELOPMENT OF COMPREHENSIVE HEALTH SERVICES (Appropriation Section 3; Documents PB/82-83, pages 90-145, and EB67/1981/REC/3, paras 100-113) (continued)

Family health (major programme 3.2)

The CHAIRMAN said that since programmes 3.2.1, and 3.2.2 and 3.2.4 (Maternal and child health, Nutrition, and Health education) were closely linked and were all for the benefit of the family, they might be considered together and that programme 3.2.3, (Special Programme of Research, Development and Research Training in Human Reproduction) might be taken separately.

It was so agreed.

Maternal and child health (programme 3.2.1)
Nutrition (programme 3.2.2)
Health education (programme 3.2.4)

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board) said that the Board had noted that family health was one of the most important elements of primary health care. It had appreciated the way in which the activities were presented in the proposed programme budget and commended the approaches and lines of action planned to achieve the objectives. The presentation emphasized the holistic nature of the family health care concept in that it not only reflected the integrated nature of the components, but also the importance of the family in health and health care, including self-care, and the significance of social and health interactions. Attention was drawn to the attitudes and roles of all members of the family, particular emphasis being placed on the importance of women’s social and economic status as it related to women's health and the health of the family. Women’s heavy burden of work, both outside and inside the home, and their roles in child bearing and child rearing, constituted a complex situation of great concern. The major programme sought to expand its activities for improving women's health and nutrition in combination with actions to develop
social measures for supporting women, and to strengthen their roles in primary health care. Thus high priority was placed on the promotion of family planning and maternal health care. Those activities were closely related with others dealing with the promotion of breast-feeding and adequate feeding of infants and young children. Those activities were currently being expanded within the programme and would continue to expand in the future.

Activities were also to be expanded in the area of health systems research for family health, specifically in the application of the risk approach in maternal and child health and family planning care, which was being extended and developed by various WHO regions in response to the keen interest shown by more and more countries in all regions. That approach had been found to be a particularly useful managerial tool for the development of maternal and child health and family planning within primary health care, as it provided the basis for a more effective way of ensuring adequate and appropriate care for all and more care for those in greater need.

With respect to nutrition the Executive Board had recognized the close relationship between nutrition and both health and socioeconomic development. Nutrition was seen as the main factor affecting the quality of human life in most developing countries. The programme presented priority activities within the health sector's competence, including the control of nutritional deficiency diseases, the surveillance of nutritional status at community level, and an action-oriented research and development programme for strengthening nutrition-related activities as part of primary health care with focus on vulnerable groups. The programme aimed to improve the nutritional status of communities in the context of existing situations with locally available and acceptable foods. The Board had also discussed WHO's collaboration with FAO in that area, especially concerning the Codex Alimentarius, and reaffirmed its support for that collaboration.

Programme 3.2.3 (Special Programme of Research, Development and Research Training in Human Reproduction) in 1980 had involved administrators and scientists from 85 countries, including 57 developing countries. The programme concerned family planning, infertility and other aspects of human reproduction. A major part of it was the building up, in developing countries, of resources for research on the topics concerned, and the dissemination of information. Research in the programme was conducted on a collaborative basis, and related to the safety of methods of fertility regulation, the development of appropriate new technology, psychosocial aspects, operational studies, and the prevention and treatment of infertility. The Executive Board had noted, in paragraph 109 of its report on the proposed programme budget (document EB67/1981/REC/3), that the programme relied on extrabudgetary resources and that the funds shown under the 1982-1983 biennium in the programme budget document reflected hopes rather than commitments. By January 1981 it had become clear that the funds available for the 1980-1981 biennium had fallen over US$ 6 million short of those indicated in the table on page 127 of the programme budget volume. Some requests from Member States could therefore not be met, and research and development activities had had to be curtailed. Much more research on new methods of male fertility regulation could be carried out if funds were available.

In relation to programme 3.2.4 (Health education), the Board had commented on the difficulties of the activities in that field and stressed the need for increasing innovative activities and seeking new techniques using, inter alia, social psychology and behavioural science tools. That had been envisaged in the proposed programme on health education, which put more emphasis on community involvement and individual and family self-care and self-reliance, as well as on increasing links with other development sectors in such areas as the training of development workers in health subjects, and in communication and information strategies for primary health care.

In view of the complex social and economic factors influencing the problems addressed in the family health programme as a whole, the trend in that major programme, which the Board welcomed, would be towards more activities being developed as part of intersectoral approaches within the strategies for achieving health for all by the year 2000. Even more effort would be required than in the past to ensure coordination of that major programme with other health development programmes and with the programmes of other United Nations agencies and bodies, and nongovernmental organizations.

The CHAIRMAN said that since a large number of delegates would probably wish to speak on the subject of family health, he would appeal to them to confine their remarks to a review of the programme budget, as the time available was not sufficient to allow of lengthy statements.

Dr HYZLER (United Kingdom of Great Britain and Northern Ireland) endorsed the Chairman's appeal for brevity in view of the short time available and the possibility open to the Committee of taking up the major programme under item 24 of its agenda.
Professor JAKOVLJEVIĆ (Yugoslavia) said that the family health programme as a whole was very important as a core element in primary health care; as such, it was crucial to health for all by the year 2000. The family, as the basic biological, social and economic unit of any society, had been given its proper place within the approaches, with special attention to the mother as the first provider of care in the home in terms of health, life-style and environment. The major programme covered activities in over 90 countries, and it was gratifying that most of the budget would be spent on technical cooperation activities, in accordance with resolution WHA29.48.

One most important aim was to reduce maternal, perinatal and infant mortality. He endorsed the need for new approaches and new technologies directly related to the causes of maternal and infant mortality to be based on simple and inexpensive, but scientifically effective, methods. In his country, studies had been carried out of the high infant mortality in developing areas, in cooperation with the United States national institute of statistics, and it had been found that simple measures provided by front-line health workers could be more effective than hospitals or specialists. His delegation fully supported the maternal and child health programme.

He believed that extrabudgetary resources would be available, as in the past, and welcomed the increase in the regular budget. He agreed with the Executive Board (paragraph 100 of its report) that the role of the family in primary health care systems could not be overemphasized, and endorsed the Board's appreciation of the way in which the programme was presented.

Dr BORGOÑO (Chile) said that he realized the reason for the reduction in extrabudgetary funds, namely that the agencies providing them were going through a financial crisis. However, he wished to draw attention to the fact that more than half the cut was being borne by the maternal and child health programme, while others were scarcely affected, or even had their funds increased, as was the case for family planning activities and research. That situation was unacceptable in his opinion despite the importance of family planning as part of the family health programme. He therefore strongly urged that efforts be made with donor agencies and countries to maintain a proper balance, even within available extrabudgetary funds, between the various components of the major programme. He hoped that the Secretariat would do all it could to see that the agencies or countries that provided funds for family planning research, a programme in which Chile was participating, also provided funds for the other programmes, since the major programme on family health should be regarded as an integrated whole.

He emphasized the importance of the high risk concept in maternal and child care and nutrition and of its application in priority programmes.

He also noted that in several countries the neonatal component in infant mortality was rising, and in some countries, while infant mortality as a whole was decreasing, the neonatal component, especially the premature birth component, had risen to over 60% of the total. The causes of that pattern were little known; more research was therefore needed so that primary prevention could be developed to obviate the need for action at the secondary or tertiary levels.

Dr BRYANT (United States of America) expressed his appreciation of the presentation of the major programme on family health, and of the maternal and child health programmes in particular, and his support for the programme as a whole.

He wished to draw attention to recent scientific developments concerning the interaction of maternal health and fetal and young infant development that had striking implications concerning the ways in which primary health care might help to improve the health of mothers and their infants. The Secretariat had pointed out in the past that 22 million low-birth-weight babies were born every year, 21 million of them in developing countries. Those infants were mainly small for date of gestation, and not merely premature, which meant they had suffered retardation of fetal growth. For them the likelihood of perinatal death or persisting disability was much greater than for normal-for-date infants, especially for those born at term. In some countries nearly half of all deliveries were of low-birth-weight infants. What were the causes of that phenomenon, and what action could be taken? Recent findings were promising, and he wished to comment on four of them.

One of the main causes of low birth weight was infection of the amniotic fluid, which was the main cause of perinatal mortality in both developed and developing countries, but occurred most often in conjunction with maternal malnutrition, poverty and hard physical labour. Some underlying causes of amniotic fluid infection, including lack of bacteriostatic qualities of the amniotic fluid of undernourished women, were being worked out. One interesting finding was that the lack could be due to a shortage of zinc, although that still had to be proved.
Maternal undernourishment and maternal hypertension also contributed to low birth weight, and both could lead to placental abnormalities which, in turn, could lead to lower maternal blood flow to the fetus. Maternal undernourishment and maternal hypertension could act, alone or together, to result in undernourished and undersized infants.

Undernourished infants could be immunologically deficient, a condition that could persist into childhood, rendering such infants and children more than normally susceptible to infection.

Those comments had focused on the causes of perinatal mortality associated with low birth weight, but it was important to point out that those and other causes of perinatal mortality also occurred in infants of normal birth weight, so it was not enough to concentrate solely on low birth weight.

Many of the conditions referred to were preventable, and the steps of prevention, when fully understood, could most appropriately be taken at the level of primary care. It was clear that maternal health, especially in pregnancy, was crucial to the life and health of the infant. He hoped that in future applied research and field studies would link with primary care to improve greatly the care for the women and infants at risk for the problems associated with low birth weight. He urged the Organization to continue to pursue those and other important problems in maternal and child health.

Mrs HOUSSSEINI (Niger) emphasized the importance of the programme under discussion in that it related to the health of mothers and children - the two main pillars of the nation. In her delegation's view, however, programmes 3.1.3 and 3.1.4 should really be covered under major programme 3.2, since workers and the aged were also members of the family and there seemed no reason not to consider the family unit as a whole.

Her delegation was pleased to note the amount of resources allocated to family health programmes, and hoped that such allocations would increase in future.

In order to make maternal and child health care in Niger more comprehensive, family planning education had recently been started at the maternal and child health centre level. Family spacing was stressed for the elimination of the risks of pregnancies too close together, particularly malnutrition, as also the substitution of the family wellbeing concept for the traditional notion that the more children were born the better. Her Government was therefore awaiting very eagerly the beginning of construction work on the family health centre financed by UNFPA.

With reference to the Board's comments in paragraph 107 of its report, advisory committees at regional level on maternal and child health could be very useful, since each country could benefit from the experience of the others within the region concerned.

In conclusion she expressed her country's gratitude to UNICEF for the help given to Niger with regard to maternal and child care.

Professor LU Rushan (China) agreed that programme 3.2.1 (Maternal and child health) should be regarded as an important part of primary health care, since it was a key factor in the efforts to attain health for all by the year 2000. His delegation supported the proposed programme budget for that programme. In China a great deal of attention was given to maternal and child care, each district, commune or village having its own unit. Recently a campaign had been launched to give high priority to care of women in the phases of menstruation, childbirth and menopause. Priority was also given to technical help in nurseries. China hoped to benefit from other countries' experience in those fields, and his delegation hoped that WHO would arrange for further exchanges of experience among Member States, especially with regard to prenatal care.

Dr COELHO (Portugal), referring to programme 3.2.2, said that nutrition was one of the rare fields in which a multisectoral approach had been adopted. Some two years previously Portugal had established a national council on food and nutrition, under the Department of Health but with the collaboration of other ministries, to establish a national policy for food and nutrition. For that purpose a survey had been conducted based on a 10% sample population; preliminary results had revealed a situation better than had been expected, although a number of problems, stemming particularly from some very old and stereotyped dietary habits, had been noted. A large-scale campaign of health education was being conducted, with particular stress on mothers and schoolchildren. Since nutrition and maternal and child health were two national priorities, those two groups could obtain free food supplements whenever necessary. And since nutrition had such an important influence on the quality of life, Portugal welcomed WHO's efforts and supported the proposed budget increases for nutrition programmes.
Dr BAJAJ (India), referring to the major programme 3.2 (Family health), thought that some activities should have been included for the benefit of the health of men in view of the effect of that on the health and, in many cases, even the continued existence of the family unit.

His delegation generally supported programme 3.2.1 (Maternal and child health) but would like to know the extent of the proposed UNICEF collaboration with regard to the child health component. Referring to programme 3.2.2 (Nutrition), he said that India had begun a goitre control programme which included the distribution of iodized salt in the affected areas; good results had been obtained. With regard to programme 3.2.3 (Special Programme of Research, Development and Research Training in Human Reproduction), India was conducting an effective contraception programme based on laparoscopic tubectomy; his delegation commended the programme to WHO's attention. Health education (programme 3.2.4), as a component of family health care, should receive equal emphasis with the other components at the level of implementation. The Regional Director for South-East Asia had recently circulated a document in that connexion to the countries of the Region, dealing with the integration of health education in family health care. In his delegation's view, health education should be incorporated in education programmes, both formal and informal, at all levels.

Professor SENAUT (France) said it was clear, from the documents before the Committee, how much attention the Executive Board had given to the problem of family health. His delegation welcomed the proposed programme: the family, as the basic biological, psychological and social unit of any society, offered particularly suitable terrain for all of WHO's action. Family health was a particularly useful lever, when put to proper use. In that connexion, it might be well to look again at health education methods, where some re-thinking would prove worthwhile.

An excellent balance had been achieved between programmes and budget allocations and his delegation noted with satisfaction the increased allocation for the European Region.

Professor LISICYN (Union of Soviet Socialist Republics) said that WHO had come very close to defining the correct approach for solving health problems. The proposed programme budget and the records of the Executive Board's session had put forward a new approach which involved regarding the family as a whole and taking into account all the social, psychological and other factors that influenced it. Such an approach should provide the basis for defining the various programmes and budgetary allocations. It would of course be ideal to obtain, on the basis of that approach, a coherent view of the problem, i.e. the impact of family characteristics on the level of health of individual family members. The Organization was moving in that direction, as could be seen from the growing emphasis laid on the risk approach.

He expressed the hope that the risk factors and their study, as reflected in the programmes planned, would include, not only specific factors, such as accommodation and nutrition, considered singly, but family psychosocial relationships considered as a whole. In various research projects being carried out in the Soviet Union, including some at the Institute of which he was head, that factor was viewed as a determinant of the many indicators of the level of health of family members. Even with regard to fertility that indicator was used.

Another factor in the proposed integrated approach was the demographic composition of the family. Soviet research on the subject had shown that the levels of health of family members, especially the mother, differed greatly according to family size. That factor should therefore be given greater attention in the programmes under consideration.

In the evaluation of the health status of the family as a whole, more sophisticated indicators would be needed. In that connexion, his delegation welcomed the studies on birth weight, particularly low birth weight, as a factor influencing health of the child.

Another important indicator, which had been successfully studied in the Soviet Union, took the form of a health index, i.e. the absence of morbidity in relation to the number of births over a given period; that indicator was positive rather than negative, in that it looked at situations from the point of view of health rather than pathology.

The family viewed as a single unit had perhaps received insufficient attention, particularly with regard to the impact of health services where the provision of health education to the family and its effects on certain health indicators relating to individual family members were concerned. One clear indicator would be infant and perinatal mortality. Available data already showed that the number of women who attended medical institutions and the number of consultations during pregnancy had a considerable impact on perinatal morbidity.

Certain of the programmes - for example, that relating to the effects of contraception on the female reproductive system - had not been given sufficient emphasis. Nor had the question of infertility or the problem of nutrition in children, including over-nutrition.
Dr HADJ-LAKEHAL (Algeria) requested that item 23 of the agenda - Infant and young child feeding - be considered earlier in the Committee's timetable, than was at present planned owing to the considerable importance of that subject.

The CHAIRMAN thought that the topic could perhaps be considered at the Committee's next meeting.

The meeting rose at 17h30.
EIGHTH MEETING
Saturday, 16 May 1981, at 9h00
Chairman: Dr E. F. F. BRAGA (Brazil)

PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA33.17, para. 4(1), and WHA33.24, para. 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2) (continued)

DEVELOPMENT OF COMPREHENSIVE HEALTH SERVICES (Appropriation Section 3; Documents PB/82-83, pages 113-145, and EB67/1981/REC/3, paras 100-135) (continued)

The CHAIRMAN said that the slow speed which the Committee had so far achieved in its review of the proposed programme budget was causing continuing concern, since there were other important agenda items to be considered after completion of the budget review, such as the all important question of the Global Strategy. He therefore earnestly requested all members of the Committee to confine their remarks as far as possible to matters strictly affecting the proposed programme budget.

Dr HADJ-LAKEHAL (Algeria), speaking on a point of order, recalled that he had submitted a proposal to the previous meeting of the Committee, and was requesting that the discussion, under item 23 of the agenda, of the draft International Code of Marketing of Breast-milk Substitutes - a subject of great concern to a number of countries - be taken up immediately after completion of the review of the proposed programme budget. He had understood that a decision on his proposal would be given at the present meeting. In the light of the Chairman's remarks, he requested that his proposal be put to the Committee for a decision.

Dr BARAKAMFITEY (representative of the Executive Board) explained that the Board, when distributing agenda items between the main committees for discussion, had taken into consideration the relative priorities that the Health Assembly itself attributed to the various subjects, including the proposed programme budget, health for all by the year 2000 and the draft International Code of Marketing of Breast-milk Substitutes. The Board's decision to give priority to the discussion on health for all appeared logical and had been confirmed by very many statements made in plenary session. It would always be possible, if time were short, to transfer consideration of agenda item 23 to Committee B.

Dr QUAMINA (Trinidad and Tobago) and Dr WALSH (Ireland) supported the proposal by the delegate of Algeria.

It was agreed that agenda item 23 should be considered by the Committee on completion of the review of the proposed programme budget (see summary record of the thirteenth meeting, page

Family health (major programme 3.2) (continued)

Maternal and child health (programme 3.2.1) (continued)
Nutrition (programme 3.2.2) (continued)
Health education (programme 3.2.4) (continued)

Dr SIKKEL (Netherlands) noted with pleasure the overall increase of US$ 814 000 in the regular budget provision for programme 3.2.1 (Maternal and child health). It was sound and natural to develop the programme by integrating related health components, so as to emphasize
the health of the family as a whole. It was also important that the health of adolescents focusing for example on responsible parenthood by both sexes should be a component of the programme in view of the rapidly increasing number of unwanted teenage pregnancies.

He shared the concern expressed in paragraph 107 of the report of the Executive Board on the proposed programme budget (document EB67/1981/REC/3) in regard to the proposed global advisory committee on maternal and child health. For the reasons set out in the report, he too would have preferred a more regional approach. He fully approved the inclusion of activities related to improving the status of women. The goal of health for all by the year 2000 would never be achieved, until women were allowed to participate fully in development, in particular in health development.

Professor HALTER (Belgium) expressed his firm conviction that family health was one of the most important issues facing the Organization. He had already drawn attention on several occasions to the situation that could be observed in some countries where protest movements were active, where particular types of crime were developing and where unexpected forms of delinquency flourished. Those phenomena were in his opinion to a very considerable extent attributable to the disintegration of the family unit. He therefore welcomed the extension of the concept of family health beyond the stage of birth control or birth spacing - a subject which, though important, did not touch the really fundamental issues - to an integration of related health components for the improvement of family health. He fully endorsed the way in which the programme was being developed. Indeed he had been surprised to find that the programme titles had not really reflected the concern with family health as a whole from the beginning. In industrialized countries, like his own, the breakdown of the family unit had even engendered problems at the policy level, since problems, which would previously have been very largely settled within the family circle, now faced the authorities with difficult decisions, and sometimes with new problems, such as that of providing some form of pseudoprotection for the elderly. The solutions adopted to that particular problem often involved segregation and amounted to so much psychological aggression directed against the group they were intended to protect. The Organization should concentrate on studying in depth the psychological aspects of family health problems, from the family planning stage throughout life, giving particular attention to the psychological interrelationships of family members, in order to establish the reason for the breaking up of family ties, and possibly to contribute to their preservation and restoration. It was still true today that the only healthy society was one based on an intact and properly structured family unit.

In his country also, family problems had been given an important place in primary health care and in basic health care. A course in family health was to be held in September 1981, which was open to participants from other Member States and in which such traditional subjects as family planning would take second place and the principal emphasis would be placed on the family unit itself, though the course would also cover such aspects as nutrition, living conditions and behaviour. His delegation deeply appreciated the assistance of WHO and, in particular, that of the Regional Office for Europe in the organization of the course.

Dr TAMMAM (Egypt) said that maternal and child health (programme 3.2.1) was particularly important, since mothers and children were high-risk groups as was clearly evident from the high mortality rates in developing countries and from the figures for diarrhoeal and intestinal diseases as causes of death. It was generally accepted that mother and child health, and family health in general, were core elements in primary health care, which was itself regarded as of crucial importance to the attainment of health for all by the year 2000. In the light of that, he felt it right to point out to the Committee that the total budgetary provision to the Eastern Mediterranean Region under programme 3.2.1 had been reduced by 60% between 1980-1981 and 1982-1983. He also noted that the programme budget included no allocations for training and research under that programme, either at the global or regional levels. There appeared therefore to be a contradiction between the manifest needs of mother and child and the budget proposals for the corresponding programme, which he hoped would be rectified.

Dr WROBLEWSKI (Poland) wished to add a note to the important information presented at the previous meeting by the delegate of the United States of America, relating to low infant birth weight. Research results in Poland had shown tobacco smoking to be a very significant causative factor of low birth weight. Infants delivered by mothers who smoked, weighed on average 30% less. His delegation therefore advocated the inclusion of an antismoking programme in the major programme on family health.
Dr HUYOFF (German Democratic Republic) said that his country attached great importance to the family as the nucleus of a sound society. That did not of course exclude the possibility of changes in its structure and the developing countries would do well to accept that the family would lose its predominant role as the process of industrialization accelerated, and solutions to social and medical problems would increasingly have to be found outside the family structure. Nevertheless the family remained the basis of present society and his delegation therefore welcomed the proposed comprehensive approach to be taken in the programme under review, which it supported.

He was however concerned about the statement in the report of the Executive Board (paragraph 100) that "School health was recognized as an important part of family health; however, health care should be provided to families as a whole and not to separate groups of the population such as schoolchildren or workers". His delegation would not be happy to see school health and occupational medical services, for example, replaced by some form of family health system. Such a change would eliminate structures which had proved effective and beneficial to the population.

He was also not entirely clear about the meaning of the term "family self-care" used in the objectives of the major programme. If family self-care were intended as an alternative approach or as a means of obtaining a low-cost solution of the problem, his delegation would oppose it as a retrograde step.

Since more than 50% of the total allocation of some US$ 118.8 million for family health, was devoted to as many as 90 country programmes, he felt that it would have been better to show global and interregional programmes on the one hand and give more information on country programmes separately, on the other.

He also supported the view of the delegate of India that health education was increasingly important and should be an integral part of general health policies and the individual programmes.

Dr KASONDE (Zambia) emphasized the overriding importance of nutrition in primary health care. He believed that the increased provision for nutrition (programme 3.2.2) in the South-East Asia Region could be emulated with advantage by other regions, in particular the African Region. There was no doubt that the primary health care approach would provide new opportunities for effective nutrition programmes. The impression might be gained from reading the proposed programme budget that the quality of food was the only factor responsible for malnutrition. The quantity of food was, however, equally important; in many areas today there was an absolute shortage of food and the overall world outlook was bleak. Every effort should be made to ensure close collaboration and coordination with the Food and Agriculture Organization of the United Nations in that connexion and he would like to see a statement on the world food situation included in the proposed programme budget in future. He hoped that the reduced provision for headquarters under the nutrition programme, did not presage any reduction in the coordination between the two organizations. Health for all by the year 2000 could not be divorced from food for all by the year 2000.

Dr WILLIAMS (Nigeria) expressed his delegation's appreciation of the programme on family health and his pleasure at the increased provision for the African Region in the regular budget. There was no doubt that that important programme should form the corner-stone of the successful implementation of primary health care.

The health profile of mothers and children in developing and developed societies revealed a glaring disparity. The level of mortality and morbidity of both mothers and children in the developing countries was unacceptably high, although the type of social, economic and medical intervention necessary to achieve speedy and significant improvements was known.

The experience of the developing countries also showed a clearly marked socioeconomic differential in the level of maternal and child mortality and morbidity. The answer to a rapid transformation in the situation lay primarily in genuinely promoting social and economic justice and in a positive discrimination in resource allocation in favour of the poor and disadvantaged. His delegation was also pleased with the active promotion of the risk approach in achievement of cost-effective maternal and child health programmes.

It was disturbing to note that, despite the benefits of family planning to maternal and child health and in view of the availability of that service in Third World countries and the generous financial support family planning programmes had always enjoyed from the affluent countries, the number of people accepting family planning was very low. Moreover, available information indicated that family planning was more readily accepted and its use more sustained in the higher socioeconomic sections of Third World populations. He therefore suggested that
research into the cultural acceptability of contraceptives and the development of new contraceptives with fewer side effects should be intensified.

Finally, in view of the tragedy of illegal abortion in nearly all countries, he inquired what attitude WHO was adopting towards the controversial issue of abortion liberalization.

Mr WEITZEL (Federal Republic of Germany), commenting on the great importance of health education in the common effort to achieve health for all by the year 2000, expressed his delegation's support for the programme budget proposals in that field of health (programme 3.2.4).

He particularly welcomed the approach to health education which, as in the Federal Republic of Germany, emphasized primary prevention and had the family as its main target group. He noted with pleasure that the actual living and working environment of the persons concerned was given due consideration. That aspect was well recognized and expressed in programme 3.2.4 (Health Education) and should not be neglected when supporting programmes were planned at country level.

His delegation also appreciated the emphasis given in that programme to innovative strategies and to the training of health personnel. However, as a result of the necessary horizontal and vertical cooperation with other sectors, health education should also form part of the continuing education of various other professional categories outside the health sector and should become more and more integrated in training in general. His delegation would like that aspect to be adequately reflected in the guidelines for training which were to be prepared.

Dr SUVANNUS (Thailand) expressed his delegation's appreciation of the high priority accorded to family health in the programme budget. In his country, too, high priority was accorded to family health and its budget for 1982 was expected to be twice that of 1981. Thailand implemented its family health programme through the existing health infrastructure at provincial, district, subdistrict and village levels. Some 22 400 village health volunteers and 224 000 village health communicators had been trained and were playing an important role in implementing the programme. A seventh regional maternal and child health centre was being built and the national institute of maternal and child health would be completed by 1982.

Family planning was expected to reduce the population growth rate from 2.5% in 1977 to 2.1% in 1981 and, it was hoped, to 1.5% in 1986.

Thailand attached importance to education and surveillance in the field of nutrition. More than half a million pre-school children came under the nutrition surveillance system. His country was grateful for the assistance in nutritional research and action programmes provided by WHO.

His delegation supported the programme budget proposals on family health but would like to know why, when the regular budget provision was increasing, the estimated obligations under "other sources" were decreasing markedly, especially in the South-East Asia Region.

Dr HASAN (Pakistan) said that his delegation fully endorsed the programmes envisaged under family health and noted with appreciation that many activities were supposed to be carried out in conjunction with nongovernmental organizations and other agencies of the United Nations. It also noted with satisfaction that extrabudgetary resources would be forthcoming.

His delegation also agreed that family health programmes, covering improvement of maternal and child health, nutrition of mothers and children, monitoring of the physical and psychological growth and development of children, should be the core of the programmes to be planned in the context of primary health care, for the achievement of health for all by the year 2000.

As regards the plan of action for maternal and child health (programme 3.2.1), it was gratifying to note that national experts were to be included in the proposed global advisory committee as well as members of the existing expert advisory panel. Its membership should represent not only each region but should reflect the various social, economic and cultural patterns of the countries in each region.

The proposed research activities on the risk approaches in maternal and child health care, and the training of health workers in the local environment of the community to be served were all welcome approaches.

His delegation would however, like to know whether the expectations reflected in paragraph 20 under the maternal and child health programme were to be realized, i.e., whether the deficit under extrabudgetary funds was indeed only apparent, extrabudgetary funds having become available from UNFPA since the preparation of the programme budget.

His delegation also hoped that the activities for providing adequate nutrition for children, as envisaged in paragraph 12 under programme 3.2.2 (Nutrition), would include the
production of weaning foods and would also like to know whether UNICEF and FAO were collaborating in those activities and, if so, to what extent.

His delegation had appreciated the information provided by the delegate of the United States of America on low birth weight and hoped that the information would be used by WHO in cooperating with countries. His delegation also thanked the delegate of Poland for expressing the view that an antismoking campaign should form part of the major programme.

Finally, noting the considerable reduction under nutrition (programme 3.2.2) for the Eastern Mediterranean Region, he inquired whether the nutritional state of children in that Region was improving or whether the reduction was connected with the boycott of the Regional Office.

Dr DESLOUCHES (Haiti) said that the clear and complete picture of family health programmes presented by the Director-General and the approaches proposed fulfilled the expectations of his delegation, especially as regards research activities, both fundamental and operational.

His country had encountered serious problems in connexion with its family planning programme. Family planning was generally well accepted in the cities, but had met with great resistance in rural areas owing to sociocultural factors connected with the religious beliefs of a largely Roman Catholic population and with the high infant mortality which led parents to desire many children in the hope that a few would survive to provide for them in their old age in a country where social security benefits were few. Those considerations had led Haiti to integrate its family planning programme with maternal and child health programmes in the hope that, when infant mortality had been reduced, the acceptance of a small family would be achieved. He was pleased, therefore, to see those problems taken into account in the programme budget.

Dr QUAMINA (Trinidad and Tobago) said that her delegation endorsed the proposed programmes under family health both at the global level and in the Region of the Americas. It agreed with the view expressed by the delegate of China that that programme incorporated and demonstrated in a satisfactory way the ideals of the primary health care concept.

Her delegation was pleased to note the expansion of the programme to include adolescent health. In addition, while realizing that mothers and children formed a priority group in the programme, her delegation noted that they had little economic or political influence and considered that it was therefore necessary to ensure the establishment of the proper legal framework to protect their health and welfare. She saw nothing in the programme about such legal provision and hoped that it could be included in the future.

Dr WILLIAMS (Sierra Leone) said that she attached great importance to the role which could be played by schools, by both teachers and children, in nutrition and health education since a simple school feeding programme, in addition to improving the nutritional status of the schoolchildren, could form a platform for teaching the basic principles of proper nutrition and food hygiene. The children would be able to take the knowledge thus gained home to their parents, thereby influencing the nutrition of their mothers and siblings. Her delegation wondered whether WHO could take the initiative and cooperate with other agencies, including the specialized agencies such as UNESCO and FAO, with United Nations and other bodies, including UNICEF and CARE, and with ministries of health, education, etc., to work out such a programme. One important result of such a programme would be that boys would grow up to understand that men must also have nutrition education and health education, which was at present nearly always directed towards women. Village school teachers could also help to ensure full coverage by the Expanded Programme on Immunization, either through their contacts with the children or by approaching the parents.

In the area of maternal and child health and family planning, her delegation would like to see more emphasis placed on studies and management of infertility. Although the birth rate in Sierra Leone was high, infertility was also a problem and her delegation felt that more work should be done on the prevention of teenage pregnancy and abortion, and the control of pelvic inflammatory diseases and sexually transmitted diseases, especially in urban areas.

The DEPUTY DIRECTOR-GENERAL said that the high quality of the statements made and the large number of speakers showed a gratifying recognition of the importance of family health programmes and their relevance to the goal of health for all by the year 2000.

In answer to the point raised by the delegate of Nigeria on WHO's attitude to the liberalization of abortion, he pointed out that it was a subject heavily loaded with cultural,
social, ethical, religious and political bias. He was, of course, aware that the subject was of great interest to Member States, but WHO's attitude had always been a technical and scientific one, concerned chiefly with methods and medical indications: it had kept clear of the emotional controversy surrounding the subject.

Dr PETROS-BARVAZIAN (Director, Division of Family Health) thanked delegates for their constructive comments and suggestions, which had been carefully noted.

As regards the question raised by the delegate of the Soviet Union on the need to develop further positive indicators in addition to those of mortality and morbidity, especially as related to various members of the family, the Organization planned to develop the indicators of growth and development and birth weight distribution (in addition to the percentage of low birth weight) and they formed part of the indicators for monitoring the strategy for health for all.

The delegate of India had asked about cooperation between WHO and UNICEF in maternal and child health programmes. The two organizations cooperated through the UNICEF/WHO Joint Committee on Health Policy in which members of the Executive Boards of WHO and of UNICEF took part. The Joint Committee met once every two years and decided on specific programme policy issues and priorities in the field of child health.

As regards the comments made, in particular by the delegates from Egypt, Thailand and others, relating to extrabudgetary resources and their concern that those funds for 1982-1983 were less than those for 1980-1981, she pointed out that the funding cycle for the extra-budgetary resources and for the regular budget were different. Therefore, when preparing the regular budget the Secretariat was not able to indicate exactly the level of funds that would be available from extrabudgetary sources. If a decrease was shown in the tables, that meant that funds had not yet been committed to the programmes and one could only hope that they would become available later.

The delegate from the German Democratic Republic had asked what was meant by the expression "family self-care". She shared his concern that the idea should not be misinterpreted. As used in paragraph 1 of the major programme narrative, it was meant to indicate that the family should be supported through organized health care systems and other sectors so that it could play a role in the prevention of disease, in the promotion of health and in the humanitarian care of the sick.

Several delegates had mentioned the need to place more emphasis on the prevention of low birth weight. The Secretariat was well aware of the need and was developing a programme, though more resources were needed.

The subject of adolescence had been mentioned several times. It was currently an emerging programme. In the past, because of the very high levels of mortality in younger age-groups, less attention had been paid to adolescents, but it was now being recognized in more Member States that, as future parents, they formed a key group in terms of establishing healthy behaviour patterns.

Finally, the delegate of the USSR had asked about the effect of various contraceptives on the reproductive system. She would ask the Director of the Special Programme of Research, Development and Research Training in Human Reproduction to comment on important studies in that field in due course.

Dr BEHAR (Nutrition), referring to the comment made by the delegate of Zambia, said that he regretted that the impression had been given that food shortages were not considered to be a frequent cause of malnutrition; that had not been the intention, and it was recognized that many areas were suffering because of such shortages.

The delegate of Sierra Leone had inquired about cooperation with the organizations of the United Nations system and others in providing nutrition education through the schools. Provision was made in the programme budget for close cooperation between WHO and FAO, UNICEF, UNESCO, the World Bank, and other bodies, through the ACC Sub-Committee on Nutrition as described in paragraph 14 under programme 3.2.2. The ACC Sub-Committee, a very active body, was concerned precisely with determining how the multisectoral programme could be dealt with by the different agencies.

While food availability was indispensable, it was recognized that alone it would not ensure proper nutrition; severe malnutrition had been observed in areas where food shortage was not a problem or where there were even food surpluses. A great deal could be done to prevent malnutrition directly through the health services; the primary health care approach offered new opportunities for attacking the problem where the main cause was not shortage but inappropriate practices.
The two approaches that had been adopted were thus intersectoral cooperation and ensuring that the direct responsibility of the health sector at the national level was not neglected.

Special Programme of Research, Development and Research Training in Human Reproduction (programme 3.2.3)

Professor LUNENFELD (Israel) commended the Director-General on the way in which the proposed proposed programme budget had been oriented towards a global strategy, linking practically all programmes with primary health care and including in them the trilogy of service, training and research. While approving the proposed programme budget in general, his delegation considered that the budgetary policies of international organizations should take account of the economic situation and limited resources of some Member States.

His delegation also fully endorsed the view expressed by the Director-General that the Special Programme of Research, Development and Research Training in Human Reproduction was one of the two "flagships of pride" of WHO. In particular, it was pleased to see the increasing activities in the area of male and female infertility; the strategy adopted in research on that problem consisted of a series of logical steps, which he enumerated. His delegation also endorsed the collaborative approach followed in that and other areas of the Special Programme, so that studies carried out at national level would be strengthened by the coordination provided by the Programme. Standardization of methods was particularly important as also the training of research personnel. His delegation was therefore pleased to learn that a training workshop on male reproduction and infertility, specifically for scientists from the African and Eastern Mediterranean Regions, had been held in a collaborating centre in a developing country; that illustrated the emphasis in the programme on technical cooperation among developing countries.

Only one delegate had referred to health of adolescents, although they accounted for 20-25% of the population of Member States. With reference to maternal and child health (programme 3.2.1) his delegation noted with satisfaction that reproductive health in adolescence had been included, according to paragraph 15 of the narrative, since the health of that age-group would determine largely the health situation in the immediate future and by the target date of the year 2000. Adolescents were also important because of their roles in community participation for health; the adolescents of today would be the health care providers of the 1990s. His delegation was surprised that the budget allocated to that part of the programme was relatively small. He wondered whether that was due to the belief that adolescents were relatively healthy and whether WHO was sufficiently aware that traffic accidents, suicide, drugs, and teenage pregnancies were the main health hazards for adolescents. Should not provision be made for studies on, and services for, that population group? According to paragraph 15 of the narrative, activities for promoting reproductive health during adolescence were to be expanded during 1982-1983; it was therefore difficult to understand why the provision for global and interregional activities under programme planning and general activities (programme 3.2.0) and maternal and child health (programme 3.2.1) for that period was lower than for 1980-1981. In addition, no funds whatsoever from the regular budget were allocated to adolescent health for 1982-1983.

Dr FJAERTOFT (Norway) said that his delegation endorsed the Executive Board's appreciation (paragraph 100 of its report) of the way in which the major programme on family health had been presented, endorsed the view that family health and family planning should be an integral part of primary health care, and agreed with the objectives of the Special Programme. No priorities had been assigned to those objectives, however, but his delegation assigned the highest priority to devising improved approaches to the delivery by health services of family planning care.

It was necessary to consider whether inadequate techniques, nonavailability, or socioeconomic and cultural barriers were the most important obstacles in the way of successful family planning. Why did only a minority of women of reproductive age practise family planning? Why was there such a high discontinuation rate? Was it really mainly due to dissatisfaction with available methods or to inadequate information and health education? Family planning techniques and methods with a reasonably low incidence of side effects were available, yet the utilization rate was too low. His delegation considered that it was the methods of family planning promotion that needed improving, together with the acceptability of the various family planning methods already available.

His delegation had noted with satisfaction the proposed budget increase for the Special Programme of Research, Development and Research Training in Human Reproduction, and hoped that the socioeconomic, cultural and behavioural problems related to the promotion of family planning would be given high priority within that programme.
Dr EL GAMAL (Egypt), referring to paragraph 7 of the narrative for the Special Programme, and to the work mentioned in it on prostaglandin suppositories for the termination of pregnancy and on a plant product for the same purpose, wondered whether it was advisable for WHO to become involved in such a controversial subject.

Mr WEITZEL (Federal Republic of Germany) said that his Government had contributed DM 2.5 million to the Special Programme in 1980, the agreement on that contribution having been concluded in December of that year; as a consequence, the funds had become available to the Programme at the beginning of 1981. Those funds were intended to enable the Programme to undertake new commitments. However, because of other urgent requirements for funds, it was not possible for a cash contribution to be made to the Programme in 1981, although it was his Government's intention to make further contributions in the future, subject to parliamentary approval and to the performance of the Programme. That was a reflection of the great importance attached by his Government to the Programme. It was essential for it not merely to promote research, but also to ensure that the research results were applied in practice.

Professor ARAUJO (Cuba) expressed his thanks for the continued support from WHO for research activities in Cuba on human reproduction.

Reverting briefly to the matter of the health of adolescents noted by the Board, in paragraph 101 of its report, he added that the very profound social changes resulting from changes in society made adolescents, as a group, of increasing importance. They were also a high-risk group, because they matured earlier, became active participants in society at a very early age, and were subject to the influence of the mass media. As a result, WHO should pay greater attention to that population group in the near future, and particularly to the psychosocial factors acting upon them. The problems of adolescence were universal in character.

Dr LIU Xirong (China) said that his delegation considered research development and training in human reproduction to be of great importance; the Special Programme was absolutely essential, and his delegation supported its continuation. The Chinese Government paid great attention to the subject, and especially to its family planning aspects; a special committee of ministers had been set up to deal with them. The objective was to ensure the provision to the masses of simple, effective and cheap means of contraception, and also to keep the quality of sterilization operations under review. China and WHO had cooperated in research development and training in human reproduction, and that cooperation had yielded good results. Family planning was the subject of great attention in many countries, and scientific workers in China were willing to learn from the experience of other countries in finding the best methods of controlling reproduction. He hoped that WHO would increase its support of activities in that field and would encourage the exchange of experience on it among both developed and developing countries.

Dr KASONDE (Zambia) expressed his strong support for the Programme. He was concerned to note that, as mentioned in paragraph 109 of the Executive Board's report, there had been a shortfall in extrabudgetary funds. What efforts had been made, since the programme budget document had been issued, to secure such funds? Increasing interest was being shown in natural methods of fertility control: why should they be excluded from the programme of activities? Work had been going on for a number of years on vaccines against pregnancy; did the results justify the continued expenditure? Finally, he was glad to see that attention was being paid to infertility and looked forward to the development of a prevention programme in that field on the basis of the evidence being collected in the studies currently in progress.

The CHAIRMAN said that he had found the discussion most interesting, especially in the light of what had happened at the World Health Assembly in 1952; at that time, family planning had barely existed and the mere discussion of the question had seemed likely to give rise to a crisis. Many countries had even threatened to withdraw from WHO if it dared to enter the field.

Dr KESSLER (Director, Special Programme of Research, Development and Research Training in Human Reproduction), referring to the request by the delegate of the Soviet Union for more research on the impact of contraceptives on the reproductive system of women, assured him
that such research, as well as that on the impact of contraceptives on other organ systems was an important part of the Special Programme. The Programme's work on infertility, referred to by delegates of the Soviet Union and of Sierra Leone had been described by the delegate of Israel.

The delegate of Nigeria had called for further studies on the cultural acceptability of contraceptives. That comment had been noted, although such studies were already part of the activities of health services and psychosocial research in the Programme. The same applied to research on the delivery of family planning by health services and the integration of family planning into primary health care, mentioned by the delegate of Norway. One of the limiting factors in health services research was the lack of expertise and facilities; workshops for training in that area had been organized by the Special Programme, as part of the Programme's other major objective, the promotion of national self-reliance by collaborating with national health authorities in building up health manpower.

In reply to the delegate of Egypt, he said that research on prostaglandins and on plant products for the termination of pregnancy was carried out in response to requests by Member States that provided abortions under their national health services and that wished for safer, simpler and less costly techniques than those currently available.

The delegate of Zambia had referred to natural methods of family planning; those were not excluded from the Programme but were being actively studied. The studies in progress included an assessment of natural family planning methods currently available, research on new techniques that would facilitate determination of the fertile period, and studies on the teaching of natural family planning methods by lay-workers within the context of primary health care.

The delegate of Zambia had also asked about the efforts being made to raise funds; the Director-General and the staff of the Programme had continued their discussions with Member States. In 1980, more than US$ 18 million had been made available; for 1981, however, pledges amounted only to US$ 12.9 million, but it was still hoped that additional contributions would be made, so that progress would continue and the increasing demands of Member States be met.

With regard to vaccines for fertility regulation, progress had been made, but it was slow; that was an entirely new area of therapy and great care had to be taken at every step. It was hoped that the first trials on human subjects might be undertaken in 1982.

In reply to a question by Dr KPOSSA-MAMADOU (Central African Republic), he explained that the research on other birth control vaccines mentioned at the end of paragraph 7 of the narrative related to vaccines against pregnancy; it had not been possible to pursue other promising lines of research because of shortage of funds. As far as birth control vaccines for men were concerned, research in that area was lagging even further behind than that on vaccines for women.

Mental health (major programme 3.3)

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board) said that the three medium-term objectives of the major programme were given in paragraph 1 on page 132 of the proposed programme budget (document PB/82-83). The Executive Board had approved the proposed activities, which paid special attention to underprivileged and vulnerable groups, such as the handicapped, the elderly, and children being brought up under slum conditions. The Board had also recommended that the psychosocial consequences of unemployment and underemployment should be included. The promotion and coordination of research on mental health should be concentrated on the establishment of effective methods and strategies for preventing and controlling the most common mental and neurological disorders leading to disability, such as organic cerebral disorders (associated, for example, with infections, parasitoses and malnutrition), epilepsy, mental retardation, schizophrenia, and recurrent depression. Such research should lead to practical methods capable of being applied in the health system, including primary care. Training guidelines and simple equipment that could be used by primary health care workers should be developed.

Emphasis should be placed on the prevention of alcoholism and drug abuse, and on WHO's activities in connexion with the lists of drugs under the international conventions on narcotic and psychotropic substances. The Director-General was requested to seek additional funds for those activities. The implementation of the programme activities during the biennium was based, inter alia, on the network of national and regional coordinating groups which had been established in recent years, and on the ever-increasing number of collaborating centres.
Dr BARREIOS E SANTOS (Portugal), expressing his delegation's pleasure at the inclusion in resolution WHA33.31 of the comments on workers' health which it had made to the Thirty-third World Health Assembly, said that his Government took the keenest and most constant interest in the living and health conditions of migrant Portuguese workers and, by extension, in the psychosocial development of their children. According to the most recent count there were almost 150 000 such children, and a startlingly high proportion of them had psychological problems. It should be borne in mind that by the year 2000 those children would be on the threshold of adulthood. Relevant factors included: date of arrival in the host country; the children's age; transformation of the traditional values of their country of origin; latent xenophobia encountered in the host country; and inability to adapt to the school system. Those factors were reflected in the reaction, on the one hand, to the society of origin - the family - and, on the other, to the host society - the school. There was often an inferiority complex that hindered progress and integration into the new community, mistrust, aggressivity, morbid oversensitivity and inability to accept criticism or advice - seen by the child as mockery or even racism. Such was the result of the strongly negative psychosocial factors involved when people found themselves at the meeting point of two cultures.

A few weeks previously he had taken part in a workshop organized by the European Science Foundation on the psychopathology of migrant transplantation. At that workshop the conclusion had been reached that migrants and their children suffered from no specific psychopathology, but from a feeling of insecurity in relation to the community.

His Government was concerned about the medium- and long-term repercussions of the children's psychosocial development. Accordingly, given that the promotion of sound psychosocial development was one of the basic approaches of the mental health programme as presented in the programme budget, his delegation wished to see due weight given to the psychological reaction of immigrant children - from the point of view of both research and the organization of appropriate care.

Dr BAJAJ (India) said that his delegation supported the major programme. It was most grateful to Dr Sartorius, Director, Division of Mental Health, for his recent visit to India and the advice he had given. A mental health bill was being revised in India at the moment, and would shortly be submitted to the Indian Parliament.

He asked whether any further results were available from studies on the treatment of epilepsy.

Professor JAKOVLJEVIC (Yugoslavia) said that his delegation attached particular importance to the second objective of the major programme - namely, increasing the effectiveness of general health services through appropriate utilization of mental health skills and knowledge. Mental health was still dealt with in many countries by a specialized service unconnected with prevention. There was a need for changes in medical education, including postgraduate training, which at present gave too little place to the prevention of psychiatric, neurological and psychosocial problems. Without such training there could be no improvement in the effectiveness of the general health services in the field of mental health.

The fact that insufficient attention was generally given to the psychosocial aspects of overall development resulted in such problems as juvenile delinquency, violence, and the abuse of alcohol and drugs. There had been considerable research in that field, but there was still a wide gap between the knowledge obtained and the preventive measures being undertaken. Accordingly his delegation strongly supported further activities, including research, which might lead to a better understanding of the psychosocial aspects of overall development and serve as a basis for a long-term policy for preventive action.

His delegation much appreciated the excellent presentation of the mental health programme.

Dr HIDDLESTONE (New Zealand) said that his delegation appreciated the detail in the programme budget document and, as in recent years, the presentation of the mental health programme as a whole. There was, however, one matter for concern. Despite the emphasis in the Executive Board's report on the importance of alcohol-related problems, the budgetary provision in that respect was, he felt, somewhat inadequate. Was there perhaps an assured source of extrabudgetary funding? After Dr Kessler had described substantial changes in the extrabudgetary funding for his programme, there was a need for reassurance that there was no uncertainty regarding the financing of that important work.

Dr ALSEN (Sweden) said that the problem of alcohol abuse had always been of great concern to the Nordic countries, on whose behalf he was speaking. It was their hope that the
financial contribution they were making over the coming two years would strengthen the programme and enable it to form its own profile. Two full-time posts at headquarters would be financed from that contribution. The programme was in a transitional phase, which might explain the very low level of funds allocated to it; but he wished to stress the desirability of improving the programme's financial situation in every way possible.

The presentation of the programme on alcohol-related problems under major programme 3.3 was insufficiently detailed to show how it was related to other programmes. Alcohol abuse was a problem which demanded social as well as medical intervention, and involved many facets of society. There was much to be gained from coordinating the alcohol and drug abuse programmes, at least in regard to treatment and the training of personnel. There should be close cooperation with the programmes on psychosocial aspects (possibly with special emphasis on the problems among young people) and with the primary health care and maternal and child health programmes (particularly in view of the serious consequences for the child if its mother indulged in alcohol abuse during pregnancy). It was important to achieve a proper balance between the medical and welfare aspects, and a well-planned and consistent social policy was essential if the programme was to achieve lasting success. Cooperation with the United Nations agencies and other governmental and nongovernmental organizations was also essential. It was vital to combat alcohol abuse in order to achieve health for all by the year 2000.

Miss BELMONT (United States of America) said that her delegation had been glad to hear the representative of the Executive Board comment on the need for additional efforts on drug abuse. It had been somewhat disappointed that the proposed programme did not appear to reflect resolution WHA33.27, urging greater stress on drug abuse within the context of country programmes, but continued to hope that governments would recognize the importance of dealing with the growing problems of drug abuse in their national health programmes. It endorsed the comments made by the delegate of Bolivia during the general discussion, to the effect that the problem of drugs was always a problem of health.

Dr EL GAMAL (Egypt) said that his delegation would like to see mental health services included in primary health care. Many psychological conditions could be dealt with easily if detected early. Moreover, many diseases contained a psychological element. A project which was being carried out in Egypt on that subject in collaboration with WHO was giving very encouraging results. His delegation hoped that the project could be developed further within the mental health programme.

Features which, to his mind, had been generally neglected were the poor conditions of psychiatric hospitals and the unsatisfactory condition of inpatients in those institutions, the lack of efficient personal care and abuse of patients.

Professor SENAULT (France) recalled that his delegation had always shown keen interest in the mental health programme. Speaking earlier on the subject of workers' health, he had referred to the psychosocial repercussions of unemployment. He was pleased to note that WHO was giving attention to that problem; its recommendations would undoubtedly be very valuable to countries where there was serious unemployment.

In regard to alcoholism, he had been struck by the lack of impact of the many educational campaigns. Such campaigns had been conducted in several countries, but they did not seem to lead to any real reduction in alcoholism. Perhaps the methods employed were not the best or most appropriate.

Professor ÖZTÜRK (Turkey) expressed his delegation's full support for the objectives, plan of action and targets of the major programme, as described in the programme budget.

Although the Executive Board's report appeared, justifiably to his mind, to have emphasized problems related to alcohol and drug abuse, he had found the presentation by the Board's representative and the text of the programme budget itself more comprehensive. This vitally important programme was appropriately ambitious.

As stated in plenary session by Professor Doğramaci, the chief delegate of Turkey, violence and terrorism should be seriously considered as a major subject for research.

Many programmes relating to family health, human reproduction, health education, and so on, could not be implemented effectively without due weight being given to the psychosocial and mental health aspects and collaboration with experts in those fields at global, regional and national levels.

Regarding the budget, it seemed to him that, in view of the alarming figures resulting from epidemiological research on problems related to mental health, including alcohol and drug abuse, and given the very dynamic WHO Division of Mental Health, the budgetary allocation was
far below what it should be. There was reason to believe that the situation was no better at national level, particularly in the developing countries - where mental health problems were just as serious as in the developed countries, if not more so. If there were no improvement in budgetary allocations by WHO or at the national level over the next 20 years, at the turn of the century it would be necessary to launch a programme of mental health for all, and by that time it might be too late.

Dr KASONDE (Zambia) noted with satisfaction the threefold increase in the proposed allocation for the African Region. He further commended the initiative taken by the African Region in establishing a mental health action group, involving Botswana, Kenya, Lesotho, Rwanda, Swaziland, the United Republic of Tanzania, and Zambia. He implored the Secretariat to do all possible to facilitate the work of that and similar groups. The primary health care approach seemed ideally suited to the prevention and treatment of mental illness. Expert guidance, however, was particularly important in the field of mental health; special attention should therefore be given to supporting countries' efforts in preparing that type of guidance for primary health care workers.

Useful literature had been produced on primary health care, and no doubt similar material would be prepared on primary maternal care and other primary care. It would be helpful if guidance on mental care was included in all the literature.

Mr WEITZEL (Federal Republic of Germany) commented briefly on the distribution of tasks and funds between WHO and the United Nations Fund for Drug Abuse Control (UNFDAC). Drug abuse took various forms but was a global problem and in the long run would only be tackled successfully by concerted action at international level. Of the three main aspects of drug abuse - namely illicit cultivation and manufacture, illicit trade and smuggling, and illicit use - it was in fighting the illicit use of drugs that WHO was most competent to act. Control measures relating to illicit cultivation and manufacture and to illicit trade and smuggling were the responsibility of UNFDAC. On the other hand, measures to prevent drug abuse, and - still more - measures to treat drug addicts (who were to be regarded as sick people), as well as relevant research activities in the fields of prevention and treatment, fell within the purview of WHO. Accordingly they should be at least partly financed from WHO funds rather than wholly by UNFDAC as shown, for instance, for projects MNH 018, 069 and 093 (pages 135 and 136 of the programme budget).

Dr HASAN (Pakistan) said that his delegation was most gratified to see the programme to be undertaken and hopeful of the impact it could have in many developing countries, including his own, which were rapidly passing through the industrialization and urbanization processes. The stress to individuals caused by changing political and socioeconomic conditions was such that psychological and behavioural abnormalities were creeping into communities. Such abnormalities should be studied, and methods of monitoring them should be developed; but those methods needed to be within the comprehension of the category of staff working in basic health units.

Drug dependence was an increasing problem in his country, and his delegation noted with satisfaction the due attention given to it in the programme budget for 1982-1983. It also valued the cooperation of WHO in that field; WHO collaborating centres had been established, and from time to time WHO staff members visited Pakistan, where their presence boosted local efforts to prevent drug dependence and rehabilitate addicts.

His country had ratified the international conventions on narcotic drugs and psychotropic substances and had appreciated WHO's activities for the prevention of drug abuse. Dr Khan of WHO had been visiting his country in that connexion and had been arranging workshops in various developed countries in which his country had participated. The result had been an increased insight into the problems involved and the methodologies that could be employed to tackle them.

Professor HALTER (Belgium) said that Belgium took a keen interest in the major programme on mental health; it had participated in a number of discussions on its various aspects, and fully endorsed its aims. He had said earlier that family health would be one of the major problems of the 1980s, and the same was true of mental health. All around could be seen behavioural changes in individuals and disturbances of various kinds, sometimes of a nature to require action by the authorities, sometimes merely examples of distress or unhappiness - or at least denoting the lack of wellbeing of those concerned. It was clear that such situations were often due to the living conditions of the victims and the presence in their environment of factors leading to emotional disturbances. Such instances should not be overlooked.
when considering the various types of pollution of the environment, and when considering the effects of external factors on individual behaviour, attention should always be directed towards the possible psychological effects. It was important to note that the doctors dealing with such cases were mainly psychiatrists, people who were accustomed to dealing with mental illnesses, while the psychologist, on the other hand, often had no medical training. Thus there was often a divorce between the attitudes of the two groups. It might be useful to encourage faculties of medicine to train medical psychologists, as well as medically trained psychiatrists, in the same way as they trained medical specialists in other fields, such as toxicology. Medical psychologists could form part of health teams, helping communities to develop harmoniously, with a view to the general wellbeing. There was an urgent need to train people who were alert to the psychological effects of the various factors. He had recently watched a television programme dealing with accidents in nuclear power stations, in which one lady, when asked if she had received any dangerous doses of radiation, had replied that she had not, but that she was a psychological wreck living in constant fear because she had no confidence in the safety measures that were being taken. That was a vivid example of the psychological harm that could be done by modern living conditions. One reason why insufficient attention was paid to such problems was that there was a shortage of doctors capable of viewing the individual in his general health context and analysing his psychological behaviour.

Professor LISICYN (Union of Soviet Socialist Republics) said that his delegation supported the proposed major programme on mental health. It noted, however, that the allocation of funds from all sources continued to diminish; in fact, the total funds available had dropped to US$ 7.7 million, and allocations for activities at the global and interregional level had been decreased from almost US$ 3 million to some US$ 844 000. Moreover, the programme presented seemed rather modest in view of the complex nature of the topics involved. His delegation hoped for a more detailed presentation in the future, at least in the Executive Board's report.

In view of the multidisciplinary nature of mental health activities, the programmes should perhaps be considered from two points of view - a review of the mental health programmes as such, and a review of related aspects in other WHO programmes - in order to give a broader picture of WHO activities in that field.

In addition, WHO should concentrate on defining the basic concepts involved, given the importance of the premises underlying the strategy. Certain of these concepts were unclear and controversial. A more precise definition of psychosocial factors was called for. He also hoped that WHO could formulate more clearly its position with regard to psychosomatic medicine, given the recent major developments in that field relating directly to mental health programmes. Attempts should also be made to predict developments in psychosocial, medical and biological research, particularly for the 1990s and beyond, when planning mental health programmes. There should be emphasis on medium-term programmes, and some attempt to outline long-term programmes, with a clearer delineation of genetic and biological studies.

The programme should clarify the priorities for implementation. For example, in matters such as research the significance of alcoholism should receive due attention not only as a clinical problem but in its broader medicosocial context.

Alcohol and drug dependence problems were related and, in his view, presented a considerable challenge. However, these problems did not feature sufficiently in the lists of projects for the biennium 1982-1983.

With regard to the organization of psychiatric care, WHO should be thinking not simply in terms of the equivalent of primary health care but also in terms of mental health care at the secondary and tertiary levels.

WHO should be following up the research it had successfully begun some years ago on the epidemiology of mental disorders, which were becoming more prevalent in many countries.

Dr KFOSSA-NAMADOU (Central African Republic) fully supported the view of the delegate of Belgium on the need to train medical psychologists as well as medically trained psychiatrists. The behavioural example he had given was in line with what could be noted every day in the Central African Republic. He urged the need to reduce the temptations to consume alcohol. WHO should make firm recommendations to all countries, and particularly to developing countries, where such recommendations might have a favourable effect on government decisions. It might also be possible to organize special anti-alcohol days - on the line of the antismoking campaign. In the African countries the producers of alcoholic drinks had been known to encourage young people to drink by organizing entertainments and offering cases of liquor as prizes. Such practices should not be tolerated.
Dr ROGWONSKI (Poland) said that during an informal meeting organized by Dr Lambo on 12 May 1981 he had already put forward his delegation’s views on the part of the mental health programme that was of particular interest to Poland - the programme on alcohol-related problems. His statement was included in the report of that meeting. He wished to reiterate the high priority his Government gave to controlling the ever-increasing consumption of alcohol in Poland. As several other delegations had stressed their wish to see that part of the programme strengthened, he suggested that additional funds should be allocated to the programme from the Director-General’s Development Programme or from extrabudgetary resources.

Dr DIA (Mauritania) said that his delegation was in general satisfied with the major programme - in particular with paragraph 9, on promotion of the use of appropriate technology. Mauritania, like other Third World countries, was very anxious to send its children to school - but there were some dangers involved. Measures should be taken to ensure that all the children - even those who did not continue after two or three years of schooling - could find employment; otherwise the school might become merely a recruiting ground for delinquents, alcoholics and drug addicts.

Everyone recognized the importance of mental health - yet the budget had been reduced; more funds were being allocated to the campaigns against alcohol and drug dependence - but mental health involved far more than that. In malaria control there was a precise target: to kill the mosquito and destroy the parasite; in the mental health programme, on the other hand, there was no definite target. To devote large sums to the fight against alcohol was to adopt a piecemeal approach. The delegate of France had said that his country had difficulties in fighting alcohol abuse - but that was only to be expected in a country that prided itself on producing the best wine. Alcohol was a vague and ill-defined psychosocial problem, as the delegate of the USSR had implied. Clearly-defined targets and terminology were needed. The family approach might be the best, since mental troubles often began early in life. In the developing countries of Africa doctors and public health officers were not always conscious of mental health problems, and were wary of psychiatrists who dealt with the mentally disturbed. At the national and local levels mental health was regarded as a luxury and relegated to second place; there were very few psychiatrists, for instance, in Angola, Mali, Mauritania, Niger and Upper Volta. And yet only a small infrastructure was needed, and very modest means would suffice. He had himself been able to do useful work alone in Mauritania even in rather primitive conditions with unsophisticated assistance. Training in psychiatry should be included as an integral part of the curriculum at medical and nursing colleges. Suitable treatment already existed for a number of well-known conditions; it should be fearlessly applied.

The DEPUTY DIRECTOR-GENERAL said that, with respect to the misgivings expressed about cuts in the budget for a number of programmes, he wished to point out that the levels of appropriation as indicated in the programme budget did not represent the degree of interest of WHO. Moreover, sometimes the distribution of the appropriations made it difficult to appreciate what was the total budget for a given programme. The tendency in WHO was that once a programme had been introduced it was allowed to proceed under its own impetus. There had been a steady increase in the goodwill, funds and resources in general amassed by the Organization. Most appropriations had increased. For example, about 10 years ago the level of the budget for the mental health programme had been very low. Since then there had been steady growth, and five years earlier the Director-General had been asked why that budget had doubled within only a few years. WHO was very pleased with the vitality and quality of the programme, since mental health was a most important area affecting the whole life of the individual.

He had noted with interest the views of the delegate of the Soviet Union concerning psychosocial studies.

Another question raised was why the programme was presented in only three pages. In earlier years such a presentation might have taken up 30 pages, and would undoubtedly have been much harder to follow in terms of clear language. The Secretariat had been urged to be succinct, and the aim now was to present the programme in a manner that made it clear for delegates.

If the delegate of Mauritania could stay on after the Health Assembly and study the analysis of the mental health programme he would be able to appreciate its substantial growth, particularly in terms of WHO’s function as a coordinator and catalyst. When a number of countries and regions showed great interest in a programme it was not necessary to budget as at an earlier stage. Several years ago very few medical schools in Asia and Africa had had
mental health departments, but now nearly all of them had. It was WHO’s function so see that the academic and scientific world accepted a new discipline and developed it to the benefit of all. The same applied to the regions, most of which had well-defined mental health programmes. Thus less work needed to be done at headquarters, the essential task being carried out at the national and regional levels.

The Director-General would be the first to ask for a higher budget level if he believed any programme was suffering from lack of funds. He hoped that, during the forthcoming debate on that subject, delegates would fully support the Director-General’s proposals, which were modest enough in terms of the usefulness of the programmes concerned.

Dr SARTORIUS (Director, Division of Mental Health) said he was grateful for the continuous help countries were giving to the mental health programmes at national, regional and global level. The modest increase in budgetary allocation had been applied to the regions having the most developing countries, confirming the growing awareness of those countries of the importance of mental health programmes. WHO had always been aware of the need for close collaboration between mental health and other programmes - something which had been successfully done with regard to family health, care for the aged, road traffic accidents, and other topics. There needed to be more interprogramme collaboration, of course, involving other social sector services as well.

The problem of migrants mentioned by the Portuguese delegate was acute in European countries. WHO had coordinated a number of studies dealing inter alia with ways of helping children of migrant families; he would be pleased to provide relevant information and publications to those interested.

The problem of epilepsy, mentioned by the delegate of India, was accorded priority, since it affected some 15 million persons throughout the world. It was felt that action could be best carried out at country level, as appropriate technology was becoming more readily available and treatment costs were low: the annual cost of drugs per patient, for example, was merely some US$ 2.

Referring to the Yugoslav delegate’s observations, he agreed that it was essential not only to speak of care for mental disorder in the context of general health care but also to bear in mind that all health problems called for a psychosocial and humanitarian approach. This point also mattered in connexion with the concerns about the dehumanization of medicine, mentioned at the Committee’s sixth meeting by the delegate of the Soviet Union, and with the fact that, while medical expenses increased, satisfaction with treatment in many settings diminished. In that connexion, a manual would shortly be produced with a view to introducing measures to deal with psychosocial aspects of medical care and training.

The growth in alcohol-related problems mentioned by several delegates, including those of New Zealand and Sweden, was something to which WHO was paying increasing attention. Unfortunately, the funds available for suitable programmes had been modest, and WHO was grateful to the Nordic countries for help in enabling a basis to be laid for an expanded programme, although it would be up to countries themselves to help in developing local programmes. A strong element in such programmes, of course, must be prevention, including education. The obtaining of budgetary and extrabudgetary funds would be a major difficulty; however, some of the programmes already undertaken had produced evidence that might be useful in mobilizing resources. With the help of the United States Government a review had been made of alcohol prevention activities in a number of countries, and a project had been launched to explore community responses to alcohol-related problems. With regard to the comments made by the delegate of the Central African Republic, he hoped that the question of combating alcoholism could be developed further during the 1982 Technical Discussions.

The programme on drug dependence should be closely linked to that of alcohol-related problems. The difficulty was that some countries dealt with the two sets of problems separately, for religious and other reasons, and would doubtless continue to do so. It was hoped, however, that WHO could approach them in a combined programme; he hoped to be able to report on developments in that connexion during the next biennium.

Referring to the observation by the delegate of Egypt on the provision of mental health care in the context of primary health care, he was pleased to report that a specific project involving several developing countries had been coordinated by WHO showing the high frequency of mental health problems and the way in which help could be given as part of primary health care. He agreed that neglect of care provided to chronic mental patients and those in mental hospitals remained a matter for concern, and that the emphasis on outpatient care meant that the needs of this group of patients were often inadequately attended to.
WHO was grateful for the programme support given by France, the United States of America and many other countries.

The question of violence, mentioned by the delegate of Turkey, was an example of a problem broader in scope than the mental health programmes alone. As a result of collaboration with the Netherlands Government a workshop on the psychosocial aspects of violence had been held and the report could be made available. It was hoped to continue with work in that area.

WHO was proud to have taken part in a programme, referred to by the delegate of Zambia, which had involved seven African countries and had come about as an expression of the national commitment of those countries to developing mental health programmes in the spirit of TCDC. The bilateral and other forms of assistance provided by some European countries under that programme were noted with gratification.

He appreciated the remarks made by the delegate of the Federal Republic of Germany concerning the United Nations Fund for Drug Abuse Control, and hoped that the expression of support for the treatment component of programmes financed by UNFDAC would be reiterated to the United Nations Commission on Narcotic Drugs when the latter came to decide on the allocation of UNFDAC funds.

The delegate of Belgium had referred to the possibility of training in a discipline of psychological medicine. Such training would be valuable. In that connexion he wanted to report that WHO had developed brief courses, for the inclusion of such training in schools of public health in several countries.

With regard to the important comments made by the delegate of the Soviet Union, a programme of major importance had been launched, with the support of the United States and some other governments, aimed at establishing accepted common terminology in mental health disciplines. In that connexion the use of the term "psychosomatic disease" had been avoided by WHO because it could imply that some diseases could be only physical, whereas in fact all diseases had psychological as well as physical components. WHO had been looking at possible ways of including, in medical training, appropriate instruction in ways of recognizing and dealing with the non-physical aspects of disease.

With regard to the observations made by the delegate of Mauritania, it was probably necessary both to continue programmes dealing with mental health in general and to look at the various specific aspects which gave rise to mental health problems, such as those related to alcohol.

Propylactic, diagnostic and therapeutic substances (major programme 3.4)

Drug policies and management (programme 3.4.1)
Pharmaceuticals and biologicals (programme 3.4.2)

Dr Mork (representative of the Executive Board), Chairman of the Board's Ad Hoc Committee on Drug Policies, said that in January 1981 the Board's Ad Hoc Committee on Drug Policies had informed the Board of the situation and progress made in the development of the drug policies and management programme, as well as the proposed objectives and global strategies recommended by the interregional working group for the implementation of that programme.

The Ad Hoc Committee on Drug Policies had expressed concern at the present situation of the action programme on essential drugs at country, regional and global levels, and the constraints it had encountered. In view of the complexity of the programme, the Ad Hoc Committee had expressed its appreciation of the results so far obtained by the Secretariat in implementing resolution WHA31.32. Action on all operative sections of the resolution had begun, and a global strategy had been formulated by a working group at a meeting in New Delhi in December 1980.

The Ad Hoc Committee considered that problems related to the marketing and pricing of pharmaceutical products were an urgent matter which, however, required further study, owing to the complexity of the subject matter and to the limited availability of reliable information.

The Board recognized the importance of the establishment of the action programme on essential drugs to accelerate the implementation of the programme at country level, in view of the relevance of essential drugs in health care and, particularly, the programme's importance as one of the crucial components of primary health care. The Board had been informed that a set of information sheets for prescribers and guidelines on drug management were being prepared. The Board had welcomed that important contribution to the implementation of the action programme on essential drugs.

The main strategies highlighted by the Board with regard to the development and establishment of national drug policies, consonant with country health needs and resources, were: technical cooperation among developing countries in pool procurement of essential drugs; local formulations; quality control; exchange of information and expertise; manpower development;
and collaboration with other United Nations agencies such as UNICEF and UNIDO, as well as with the pharmaceutical industry.

The Board had also reviewed the area of pharmaceuticals as presented in the programme budget for 1982-1983. The main activities for the biennium were to promote drug quality assurance in developing countries through the establishment of quality requirements for pharmaceuticals and the preparation of international chemical reference substances; the development of basic tests for quality control to be carried out at the peripheral level; the evaluation of the application of the WHO certification scheme on the quality of pharmaceutical products moving in international commerce, and continuation of efforts to assure proper use of that scheme; and the continued selection of international nonproprietary names for pharmaceutical substances.

With regard to the biologicals programme, the Board had noted that a major component was the establishment of international reference materials for biologicals in order that their biological activity might be expressed in international units. It was noteworthy that over 11,000 reference materials were distributed by four international laboratories each year and that, of the 85 countries requesting them, 50 were in the developing world. Another important component was the formulation of requirements for the manufacture and control of biologicals, which made a significant contribution to technical cooperation among developing countries. Such requirements kept abreast of developments in technology through reformulation at appropriate intervals. The establishment of standards and formulation of requirements were approved at the annual meetings of the Expert Committee on Biological Standardization, budgetary provision for which had been made from the regular budget in both 1982 and 1983. Assistance from UNDP allowed the biologicals programme to assist the Expanded Programme on Immunization in the quality control of vaccines used in WHO programmes.

In view of the importance of the action programme on essential drugs, the Board had requested the Secretariat to prepare a comprehensive progress report for consideration by the Executive Board at its sixty-ninth session and by the Thirty-fifth World Health Assembly.

A summary record of the Board's discussion of the item was to be found on pages 132 to 137 of document EB67/1981/REC/2. Since the Executive Board's sixty-seventh session the Director-General had made arrangements at headquarters to develop a detailed plan of action on essential drugs covering all the components referred to by resolution WHA31.32, with special emphasis on action at country level.

The meeting rose at 13h10.
NINTH MEETING

Monday, 18 May 1981, at 9h30

Chairman: Dr E. P. F. BRAGA (Brazil)

PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19,1 of the Agenda (Resolutions WHA33.17, para. 4 (1), and WHA33.24, para. 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2) (continued)

DEVELOPMENT OF COMPREHENSIVE HEALTH SERVICES (Appropriation Section 3; Documents PB/82-83, pages 137-145, EB67/1981/REC/3, paras 119-135) (continued)

Prophylactic, diagnostic and therapeutic substances (major programme 3.4) (continued)

Drug policies and management (programme 3.4.1) (continued)
Pharmaceuticals and biologicals (programme 3.4.2) (continued)

Dr BAJAJ (India), referring to paragraph 4 under the major programme on page 137 of the proposed programme budget (document PB/82-83), asked how it was proposed to strengthen the WHO certification scheme on the quality of pharmaceutical products moving in international commerce, by virtue of Article 21 (d) and (e) of the Constitution, and how it was intended to apply the scheme to developing countries.

With regard to programme 3.4.1 he said that his delegation thought it important that WHO should provide some guidelines on the establishment of testing laboratories for drug safety and efficacy. Regarding programme 3.4.2, he asked whether the bulletin Drug Information was distributed to regional offices or to individual countries direct.

With regard to the oral poliomyelitis vaccine mentioned in paragraph 20, he wondered whether killed vaccine could be reverted to if the oral vaccine proved ineffective, and, if so, whether the killed vaccine's potency was affected by factors such as heat.

Professor WON MANGER-KOENIG (Federal Republic of Germany) said that discussions during the current Health Assembly had underlined the great importance attached to the need for ensuring supplies of safe and effective drugs, which, although not strictly a component of primary health care, would be a vital factor in the attainment of health for all by the year 2000. It was important to bear in mind, in that connexion, the economic aspects relating to the rationalization of national drug policies and procurement and to the establishment of the action programme on essential drugs. Unfortunately, implementation of resolution WHA31.32, at all levels, had been slow - a matter which had been commented on by the Executive Board at its sixty-seventh session. No doubt there would be a secretariat report available for in-depth consideration at the next Health Assembly; but his delegation would welcome immediate steps to implement the resolution at all levels.

His delegation shared the concern expressed at the lack of action concerning drug supplies, particularly since his country, as a donor, had declared its readiness to cooperate in suitable schemes. Moreover, it feared that the envisaged reduction in headquarters posts in that field might have a negative effect.

Although there was no reference in the documents, there seemed to be a proposal concerning the establishment, in addition to the good manufacturing practices and drug quality certification scheme, of a new evaluation scheme for pharmaceuticals with certification of scientific approval; whether it would be European or global, he did not know. Perhaps the Secretariat could indicate what was being planned, and outline the financial implications. Any such scheme would no doubt be the subject of a background document which could be circulated for consideration at the Thirty-fifth World Health Assembly. Clarification was important in order to avoid misunderstanding and duplication, as well as conflicts with national programmes and legislation. The matter had, of course, global and not merely European implications.
Professor LUNENFELD (Israel) agreed with the observations made by the previous speaker. With regard to programme 3.4 the Division in question was one of the most important in WHO, but its work was often taken for granted. Safe and effective vaccines, sera, antibiotics and other products were an essential part of primary health care; without them, the concept of health for all by the year 2000 would be meaningless.

It was encouraging to note that during 1980 more than half of the biological standards distributed had gone to scientific and health personnel in the developing world. Quality control was a task for specialists and therefore costly. Less than 20% of Member States could afford their own system and had to rely on WHO studies. Production and quality control were constantly changing, particularly the development of biologically active products, prepared by genetic engineering, such as recombinant DNA synthesis. WHO must keep a close watch on those activities in order to ensure that safe and effective products continued to be made available for health programmes. It must also constantly monitor production and make up-to-date information continuously available. For that purpose, WHO should collaborate fully with the food and drug administrations of Member States.

Dr KLIVAROVÁ (Czechoslovakia) fully supported the programme presented - in particular, the continued work on the model list of essential drugs, under programme 3.4.1, and the drug safety and efficacy programme under 3.4.2. The drug information circulars, especially, were appreciated in her country. She wondered, however, why there was no mention of the side effects of drugs - surely an essential aspect of work on drug safety. She recalled that WHO had laid considerable emphasis on that aspect in the past, and that an institute in Sweden had been entrusted with responsibility for work in that field.

Dr BEAUSOLEIL (Chana) said he was gratified to note that all the programme components were now being carried out, although implementation was slow in relation to the programme’s importance and should be accelerated. Most countries had now made their selections of drugs for health care; but many of them, including Ghana, had not yet been able to draw up rationalized drug safety and distribution policies. The Regional Office could not always meet requirements, and headquarters had to be relied upon. But headquarters, because of demand pressure, could not always respond promptly enough. Therefore, the proposed increase in staff was welcome; it was hoped that the increase would enable both headquarters and the regional offices to provide a swifter response. The costs involved should be attributed to technical cooperation rather than administration.

The Drug information bulletin was extremely useful, and in that connexion he endorsed the remarks of the delegate of Czechoslovakia. He hoped that efforts would be made to resume the former frequency of circulation.

Dr SIKKE (Netherlands) said that essential drugs formed the corner-stone of primary health care, and the action programme should receive high priority, particularly for the African Region, where 80-90% of the population had no access even to essential drugs. His delegation endorsed the view expressed by the Executive Board’s Ad Hoc Committee on Drug Policies regarding the situation of the programme. It was regrettable that, two years after the adoption of resolution WHA32.41, no appropriate management structure had been developed and no realistic plan of action proposed. He hoped that a detailed progress report would be available for consideration by January 1982. The problem was indeed complex, but the complexity should be deemed a challenge. The programmes should be integrated at regional level, with strong coordination at headquarters. If drugs were not available there was no point in training paramedical staff in their use, and it was impossible to provide adequate services at local level. The Expanded Programme on Immunization showed what WHO could do in prophylaxis by developing appropriate techniques and quality control methods and providing information, in close cooperation with countries and regions. The proposed budget increases of some US$ 140 000 for collaboration with countries in the action programme (DPM 010) and US$ 50 000 for the development of quality control tests (PHB 008) were far too modest in relation to the high priority rightly accorded to the action programme. He would like to have further information about the present situation of the programme.

Dr H. SYLL (Guinea) said that, with the development of primary health care in Guinea, the quantities of drugs required far exceeded the estimates in the three-year development plan. Because of the lack of on-site dispensing facilities, all drugs had to be ordered, and the demand could not be met by one laboratory alone. Therefore, the reference to bulk
purchasing was welcome; his delegation would like to know how the system was organized and how access to it was obtained.

He wondered whether a regional pharmaceutical industry could be established in the African Region with a view to solving supply problems. Countries such as Guinea, as consumers of pharmaceutical products, were anxious about drug safety and effectiveness; he was glad, therefore, to note that regional quality control laboratories were under consideration for the countries of South America and for the Western Pacific Region, and wondered whether one was being envisaged for the African Region also.

Dr WILLIAMS (Sierra Leone), referring to the need for availability of simple but essential drugs for primary health care, said that her country had taken advantage of the joint WHO/UNICEF programme and drawn up a list of requirements according to the list of 40 essential drugs and 10 vaccines. Supplies were to begin in 1982. However, she hoped that WHO could help in decentralizing medical stores with a view to keeping them closer to the periphery. In that connexion, there was a need for trained storekeepers and for packaging in smaller units.

Native medicines were widely used, and it was hoped that WHO could help in setting up arrangements to ensure their safe and appropriate use.

She expressed concern about the appearance in some publications sent to developing countries of advertisements for drugs which had been banned in their countries of origin.

Dr HAUGSBØ (Norway) said that the Nordic countries, on whose behalf he was speaking, had supported the concept of essential drugs during discussions in plenary session. They had made various contributions to the action programme, and would continue to provide technical know-how.

The exchange of information among countries concerning drugs was an important topic. Some exchange did exist among drug regulatory agencies; such exchanges should be strengthened, and should include the developing countries.

The Nordic countries supported a strengthening of the WHO certification scheme on the quality of pharmaceutical products, as outlined in the proposed programme budget. On the other hand, the effectiveness of the existing scheme could have been greater had exporting and importing countries given it more attention. Other international activities in the same field should be taken into account.

Professor ADENIYI (Nigeria) supported the views expressed by the delegates of Ghana, Guinea and Sierra Leone, and stressed the importance of making information available to the African Region. The African countries were particularly anxious that the safety and efficacy of the drugs they received should be ensured. A code of conduct should be established for the open market in which they had to deal. In that market, it was possible to sell drugs banned elsewhere; there had recently been trouble in the United Kingdom because an Englishman had bought a drug in Africa which had given rise to blood dyscrasia. It should also be borne in mind that Africans' genetic constitution was such that certain drugs were unsuitable, especially for children - and yet they were indiscriminately advertised and sold.

WHO's responsibility in regard to quality control could not be overstressed; perhaps the Organization should also consider the establishment of a code of ethics for the sale of drugs.

Dr ISLAM (Saudi Arabia) congratulated the Secretariat on its excellent work in the vitally important field of prophylactic, diagnostic and therapeutic substances; the programme received the full support of his delegation.

Saudi Arabia had used the updated WHO model list of essential drugs as a guide when preparing its first essential drugs formulary, which would be updated regularly; it looked forward to the proposed updating of the WHO lists.

Unfortunately, because of the present situation regarding the Eastern Mediterranean Regional Office, the countries of the Region had not been able to meet to discuss problems and coordinate efforts related to the drug policies and management programme. Nevertheless, the seven Arab countries of the Gulf area were combining their efforts in an intercountry health body - the Council of Ministers of Health of the Arab Countries of the Gulf Area, set up six years ago. Joint procurement of drugs had commenced four years previously and it had proved so successful that it was being expanded.
His delegation noted with satisfaction the proposed increase in the estimated obligations for collaboration with countries on the action programme on essential drugs (DPM 010). He asked why the proposed programme budget did not include any funds for a survey of drug utilization in developing countries, although it was stated that several regional studies would be carried out.

His delegation strongly supported WHO's efforts to ensure the quality of pharmaceuticals and biologicals. Developing countries, especially those depending on imported drugs, had become dumping grounds for low-quality, unsafe drugs that could not be sold in the manufacturing countries. Saudi Arabia had taken action to stop the practice by re-registering all drugs, vaccines, pharmaceuticals and biologicals so as to eliminate unsafe products, and it only permitted the importation of drugs that satisfied its registration requirements. In private pharmacies, drugs could only be sold by registered pharmacists and the list of drugs available on prescription had been expanded.

A new drug quality control laboratory had been established in Riyadh. Since Saudi Arabia and other Arab countries in the Gulf planned to set up more pharmaceutical manufacturing plants, he urged WHO to expedite distribution of the practical guidelines for pharmaceutical formulation plants in developing countries.

His delegation fully supported the proposals to supplement the existing information services by the creation of a standing committee on drug regulation and information, and to introduce international regulations concerning the labelling and advertising of pharmaceutical products moving in international commerce.

Paragraph 19 under programme 3.4.2 referred to problems that had delayed preparation of the WHO requirements concerning blood products. He asked what those problems were.

Dr CABRAL (Mozambique) said that a subregional meeting on drug policies had been held at Beira in April 1981, and almost all the countries from subregion III of the African Region had taken part. The meeting had opened up new areas of short- and long-term cooperation in the countries of the subregion.

Referring to paragraph 131 of the Executive Board's report on the proposed programme budget (document EB67/1981/REC/3), he said that the developing countries did not want to see their populations used as guinea-pigs. He acknowledged that the discovery and trial of new drugs were useful, that the countries in which the trials were conducted could benefit from them if they helped to acquaint their pharmacologists and clinical research workers with trial methodology, that countries undertaking drug quality control activities could learn a lot from control trials, and that trials of new drugs had to be carried out in areas in which diseases were prevalent. However, most developing countries had no legislation on ethics concerning experiments involving human subjects, and no means of control. WHO should therefore define and give widespread distribution to information on codes of ethics, and issue warnings on the subject, particularly to Third World countries. Furthermore, WHO should seek ways of ensuring the international control of the application of such codes of ethics, and assist Member States to ascertain whether the health of their populations was in danger because of unconsidered trials of new drugs.

Professor JAKOVLJEVIČ (Yugoslavia) expressed his delegation's support of the programme on prophylactic, diagnostic and therapeutic substances. With regard to drug policies and management, his delegation recognized that any formulation of comprehensive national drug policies was a long-term task and should constitute part of the overall development of health and the economy. WHO's role in helping countries to formulate such policies was extremely important. Technical cooperation among countries had proved successful, and should be further developed.

He had noted with satisfaction that, in accordance with resolution WHA31.32, the action programme on essential drugs was becoming operative.

The WHO certification scheme on the quality of pharmaceutical products moving in international commerce fulfilled a need, but at the same time developing countries should be helped to set up their own drug quality control laboratories. His delegation strongly supported the introduction of international regulations on the labelling and advertising of pharmaceutical products moving in international commerce.

His delegation, like several others, was in favour of the proposal to hold a consultation on oral poliomyelitis vaccine.

Dr ALSÉN (Sweden) noted that paragraph 127 of the Executive Board's report stated that the Regional Office for Europe was working on plans to improve and expand the
certification scheme on the quality of pharmaceutical products. Rational drug use meant that the right drug should be given for the right purpose to the right patient in the right dose for the right period of time, and to achieve that goal it was first necessary to ascertain which drugs were both efficacious and safe. Such an assessment called for scientific resources, inter alia in the form of trained personnel, but in the majority of countries scientific resources were scarce. He therefore suggested that, in order to make the most effective use of available scientific resources and to facilitate rapid transfer of knowledge concerning new pharmaceutical substances, WHO should further develop the certification scheme. In particular, WHO should explore the possibility of scientific assessment, under its auspices, of the pharmacological, toxicological, pharmaceutical-chemical and therapeutic effects of drugs. A drug should be approved in the light of the evidence available at the time of assessment, if the data provided showed that the drug was effective and safe when properly used, and that it met satisfactory quality standards. In addition, the drug should be accompanied by adequate and reliable information on its use. Such a scheme would require a network of specialists to assess the drugs, a secretariat to coordinate the work, and an expert committee to decide concerning approval; it should be simple, flexible and rapid. It was not intended to replace national drug approval mechanisms, but to assist them, particularly in the developing countries. Since the proposed scheme laid no obligations on Member States or on any other body, it could avoid the problems that arose when attempts were made to harmonize national drug legislation or to set up a supranational mechanism. In view of the limited resources available, it was essential to try new approaches.

He proposed that the Regional Office for Europe should look into the possibility of conducting a feasibility study whose results would permit a decision to be taken on whether or not to proceed.

Professor SYLLA (Senegal) said that the fact that the drug policies and management programme gave a comprehensive analysis of the technical and administrative aspects of several systems was undeniably a step forward. The programme budget took into account drug policy and management problems studied by the Regional Office for the Western Pacific in March 1978, as well as the recommendations of the Technical Discussions at the Thirty-first World Health Assembly. It also reflected the results of the discussions in the Regional Committee for Africa on management processes, in September 1980. Furthermore, the debate had shown that the programme was relevant to both developing and developed countries. His delegation therefore hoped that Committee A's discussions would clarify the role of United Nations bodies such as UNDP, UNIDO and UNICEF, that of international institutions such as the Red Cross and Medicus Mundi Internationalis, as well as that of certain countries that had assisted in setting up manufacturing plants in Africa - for example, France, Belgium, the Federal Republic of Germany, and Italy.

Keeping in mind prophylactic and health care objectives, the following practical approaches were the most appropriate for many countries in Western Africa: firstly, the collection and updating of statistics on drug consumption; secondly, the establishment of systematic inventories of stocks, at least every six months, which should not present difficulties for products on the list of essential drugs. If those practical approaches were used it should be simple to find solutions on the basis of financial possibilities and epidemiological parameters proposed by WHO - such as the definition of the ten principal diseases resulting in consultations, hospitalization, and the highest mortality rate. WHO had of course also used other parameters in elaborating its list of essential drugs.

In the absence of widespread acceptance of WHO's recommendations, present results could be considered encouraging at the primary health care level where drugs were provided from restricted lists in village pharmacies and from standard packs in health stations and medical areas. It was also encouraging to see that hospitals received drugs that were on standard lists of essential drugs. WHO's recommendations had had a bearing on pharmaceutical studies at university level; during the current university year new subjects such as management processes in general, accounting and health economy, had taken their places alongside the traditional courses on technology, preparation and control. Nevertheless, the difficulties were considerable, and at the present stage it was sufficient to express satisfaction that the problems had been recognized and to emphasize the need to make increased budgetary provisions.

Dr ADANDÉ MEWEST (Gabon) said that his delegation considered the question of prophylactic, diagnostic and therapeutic substances to be of crucial importance for the formulation of strategies for health for all by the year 2000, since drugs were one of the basic components
of primary health care. The Executive Board had undertaken an exhaustive analysis of the question at its sixty-seventh session. His delegation supported the approaches and objectives outlined in the proposed programme budget.

In Gabon the Government promoted free treatment and drugs for the public sector for both in- and out-patients. It also offered encouragement to the private sector, which was responsible for setting up pharmacies at the intermediate level and for drug stocks at the periphery. Private companies outside urban areas were encouraged to set up their own health structure, including a pharmaceutical component.

Essential drugs were selected so as to provide drug lists adapted to the central, intermediate and peripheral levels, taking into account the needs of the patients and the expertise of the health workers responsible for administering the drugs.

The Government also attached great importance to TCDC. Joint purchasing of drugs could only be effective if policies at the national level were well formulated and there was a unified purchasing policy; in certain countries there were three sources of supply, and consequently three purchasing policies. In addition, the countries involved must undertake to ensure the smooth functioning of the body responsible for purchasing drugs, especially by paying their contributions promptly and regularly.

His Government had also taken steps to control the importation, marketing and manufacturing of drugs. A foreign drug company that had recently been authorized to manufacture drugs in Gabon had had to fulfil certain obligations, for example, give priority to the essential drugs listed by the Ministry of Public Health, provide the State with facilities for drug quality control, and assist national institutions in promoting the processing and use of local medicinal plants.

With regard to the supply of drugs, inadequate roads and transport systems often proved an obstacle to efficient distribution. Close international and intersectoral cooperation in that field should help to promote national transport policies that would facilitate the distribution of drugs.

Dr COELHO (Portugal) said that his delegation attached the greatest importance to the programme, which was one of the most challenging areas in the health care delivery system. Experience in Portugal had shown that, because of the many difficult problems involved, the question of prophylactic, diagnostic and therapeutic substances required much time and effort both at the national and international levels. As in many other countries, there was a generalized overconsumption of drugs resulting not only from overprescription by doctors but also from abusive self-administration by the population, with a notably negative impact on health expenditure. There were two main reasons for the phenomenon: firstly, lack of adequate education of physicians both at the undergraduate and postgraduate level; secondly, lack of information, considerably aggravated by an aggressive and uncontrolled advertising policy. The adverse effects of the indiscriminate use of powerful and potentially harmful drugs were well known.

He called for urgent action to define a national drug policy covering the establishment of provisions for the rationalization of drug utilization, the elaboration of adequate information and educational programmes, and the implementation of appropriate quality assurance methodologies. In view of the importance of the problem, his delegation expressed its concern at the considerable decrease in the budgetary allocations under major programme 3.4.

Dr KASONDE (Zambia) fully supported the major programme in general and the drug policies and management programme in particular. He expressed concern at the continuing lack of essential drugs in many countries, including Zambia. Despite the fact that the action programme had been conceived in 1977, formulated in resolution WHA31.32, and endorsed in resolution WHA32.41, the situation regarding the supply of drugs remained far from satisfactory, and had been complicated by the alleged dumping of expired or otherwise unsuitable drugs. While acknowledging WHO's achievement in producing a list of essential drugs, he drew attention to the resulting problems. For obvious reasons the pharmaceutical industry was unenthusiastic, and as a result when a listed drug was out of stock a country might be offered other drugs on more favourable terms, thus making it impossible to adhere to the list. When an administration proposed a list of essential drugs as part of its primary health care programme and was then unable to provide the drugs listed, it suffered loss of credibility.

His delegation endorsed the view expressed in paragraph 120 of the Executive Board's report; the time had come to launch the action programme on essential drugs with the
objective of ensuring the regular procurement and distribution of essential drugs, of the right quality, to all countries and communities. In that connexion, he had understood that WHO and the pharmaceutical industry had initiated a dialogue, and he would like to know what progress had been made, and whether the tactics so far adopted were regarded as adequate to produce results before the year 2000.

Dr BELCHIOR (Brazil) emphasized the importance of the bulletin Drug Information - a valuable source of knowledge on drug assessment within the international scheme for monitoring adverse drug reactions, offering the possibility of keeping abreast of the decisions of national authorities on the withdrawal of specific drugs, or on restrictions on their availability, on grounds of safety or efficacy. He congratulated WHO on issuing such a valuable publication; he hoped that it would be expanded and given wider distribution.

Dr GUERRERO (Colombia) suggested that, for the purpose of guaranteeing an appropriate supply of essential drugs, WHO should consider the possibility of establishing a revolving fund for such drugs, with particular reference to tuberculosis, leprosy and malaria. The object should be to obtain more advantageous prices in the light of the volume of purchases of high-quality products. A basis for the establishment of such a fund could be supplied by the experience already gained with the fund for the Expanded Programme on Immunization, which had produced excellent results and had reduced the cost of vaccines purchased under it.

Dr HIDDLESTONE (New Zealand) said that the programme under consideration represented a curious paradox. There was a record of good endeavour and yet, to some extent, disappointing achievement. The acrimonious controversy on essential drugs of a few years ago had given way to cooperative discussion and action - a tribute to the honest broker role played by WHO.

But what was hindering progress? A clue had been given by the excellent introduction by the representative of the Executive Board. There seemed to be a lack of progress in respect of the first of the objectives of the major programme - namely, to promote and collaborate with Member States in the formulation of national drug policies. It might well be that there was a need for greater activity and endeavour by both headquarters and the regions to assist in the development of effective national drug policies. The action programme on essential drugs should be a beneficial spur to the development of such policies, and he felt that, through that endeavour, progress would be achieved.

Dr ALBORNOS (Venezuela) said that in his country there was a sound control of pharmaceutical products, but the supply of some products posed problems because of their price. Technical cooperation among developing countries regarding technology in that area could be valuable. An example of what he had in mind was the effort being made by the Andean Pact countries with regard to the distribution of certain essential drugs by concentrating their manufacture in specific countries. Such an arrangement could help to overcome the shortage of certain drugs which had to be made available if the goal of health for all was to be achieved.

Dr CASTELLON (Nicaragua) said that the advance of primary health care programmes and the extension of their coverage were intensifying the problems associated with drug supply and the difficulties involved in formulating a world or regional strategy in that respect. His country therefore supported the work being done in the Region of the Americas regarding the dissemination of information on drug efficacy and quality control.

Dr M'DAHOMA SOILIHI (Comoros) endorsed the suggestion of the delegate of Colombia concerning the establishment of a WHO revolving fund. Quality testing should be sufficiently simple and inexpensive for the benefit of the poorer countries.

The DEPUTY DIRECTOR-GENERAL, after noting that the question raised by the delegate of the Federal Republic of Germany had already received an answer from the delegate of Sweden, said that the Director-General, fully aware of the importance of the action programme on essential drugs, had provided financing from the limited resources available in the Development Programme in 1979, 1980 and 1981. After the launching of the programme on essential drugs it had been hoped that extrabudgetary funds would be attracted from the developed countries, but so far there had been little success.

With regard to the question of a revolving fund, it had been suggested that it could be dealt with in - or similarly to - the Revolving Fund for Teaching and Laboratory Equipment for
Dr FAUTORUSSO (Director, Division of Prophylactic, Diagnostic and Therapeutic Substances) noted that several delegations had commented on the WHO certification scheme on the quality of pharmaceutical products moving in international commerce. That system had been approved and recommended to Member States in 1975 by resolution WHA28.65. The Secretariat had produced a brief document giving the text of the scheme, an important element of which was the agreement by importing and exporting countries to exchange information on drug control. The document contained a model certificate and a list of the countries which had agreed to participate, showing the administrations responsible for implementing the scheme and the reservations which certain countries had formulated; it was available to any delegations which wished to have it.1

Reference had been made to the need to strengthen the certification scheme. One way of doing so might be to extend the certification of product quality so that it covered product safety and efficacy - in other words, the scientific evaluation of the effects of the drug. The Swedish delegation's proposal would therefore certainly be taken into account, and the Secretariat would see how it could be incorporated in the scheme.

The delegates of Nigeria and Sierra Leone had expressed a widely felt concern that products which had been withdrawn from the market in exporting countries could be exported to some countries which did not have very strict control mechanisms. However, if the importing country requested a certificate in accordance with the WHO scheme, that situation ought not to occur, since the authorities of the exporting country would make it known that the product concerned was not accepted or, if it had been accepted, that it had been withdrawn; if it had never been registered, as could happen in the case of products used against tropical diseases which did not exist in the exporting countries, the reasons why it had not been registered ought to be stated. Thus the problem could to some extent be solved by the certification scheme, which should be reinforced at the level of both exporting and importing countries. The more the importing countries requested such certificates, the more the exporting countries would strengthen their capacity.

The delegate of India had inquired, with reference to paragraph 4 under the major programme (page 137 of the budget document), how Article 21 of the Constitution was to be applied. First of all it should be borne in mind that in the 1970s, when the certification scheme had been discussed at the Health Assembly, consideration had had to be given to the question as to whether a recommendation or a regulation was required. The Health Assembly had at that time decided that a recommendation was appropriate. At the moment the text was such that it could easily be applied as a regulation, even though it seemed to function quite satisfactorily as a recommendation. The Director-General would be submitting a report on the subject.

In the developing countries there was a need to strengthen the capacity of the authorities to control the quality of pharmaceutical products. The delegates of India and Guinea had asked what support WHO could give to national control laboratories. That support had been given for quite some time, and took the form of seminars for staff training - some of them with the financial support of the Danish Government - and advisory services. At the moment simplified tests for quality control were being elaborated - tests which seemed to meet the needs of the developing countries. There was, as far as the Secretariat was aware, no plan for a regional drug control laboratory in Africa.

Dr KAPRIO (Regional Director for Europe), replyng to the delegate of the Federal Republic of Germany, said that the Regional Office for Europe had been requested by the Director-General to use its scientific know-how to explore new approaches in technology assessment, including drug evaluation. Both scientists and governments were interested in giving WHO greater

opportunities to develop future activities. New developments were not always readily acceptable and specific forms of approach would have to be sorted out before governments and industry could be formally consulted. However, the work was well in hand and the matter would be considered by the Regional Committee for Europe in Berlin in September 1981, when it was to discuss drug policies and management in the European Region. The additional document that had been requested would be prepared for submission to the next Health Assembly.

Dr WANANDI (Action Programme on Essential Drugs), replying to the question raised by the delegate of the Netherlands regarding the status of the action programme on essential drugs, said that, as the Chairman of the Executive Board's Ad Hoc Committee on Drug Policies had already mentioned, the broad objectives and strategies had been discussed at the interregional working group meeting held in New Delhi. Owing to the complexity, delicacy and sensitivity of the programme, the Secretariat felt that it needed adequate time in which to complete its work before carrying out projects at country level. In the past two or three years about 30 countries had been visited for the purpose of ascertaining how the programme should be conducted. A step-by-step approach was required and great care had to be exercised to ensure that the initial approach was correct. The New Delhi meeting had developed a comprehensive strategy, and the Global Programme Committee had given instructions that a plan of action should be developed as to how the policy and strategies endorsed by the Health Assembly in resolutions WHA31.32 and WHA32.41 should be implemented. The plan of action was now ready and would be submitted first of all to the Global Programme Committee for endorsement at the end of the current month so that agreement could be reached on the internal arrangements to be made before further commitments could be entered into. Factors such as resources and manpower requirements would of course be taken fully into account. A complete report would be submitted to the Executive Board's session in January 1982 and to the Thirty-fifth World Health Assembly.

In reply to the point raised by the delegate of the Federal Republic of Germany regarding donors and the pharmaceutical industries, he said that since 1978 several industries in different countries had offered support for the programme regarding the provision of essential drugs on favourable terms. WHO was working in collaboration with UNICEF on the subject and the programme had been jointly endorsed by both agencies, with a start to be made in the African Region. As soon as an appropriate mechanism for drug purchasing was available, and as soon as the legal aspects had been analysed and the financial problems settled, collaboration with the pharmaceutical industry would be initiated. An essential prerequisite would be to know the quantities involved and the payment procedures envisaged. Further work on these points needed to be done, and a full report would be available in 1982. Furthermore, there was a need for donor countries to pledge financial support for the programme.

In reply to the delegate of Saudi Arabia, he said that, for the sake of simplicity, provision for drug utilization studies had been included in the figure of US$ 200 000 for collaboration with countries on the action programme on essential drugs (DPM 010) shown on page 141 of document PB/82-83.

The delegate of Ghana might be glad to know that, despite the disestablishment of three posts, the Director-General had given full support to the new programme, and personnel requirements would be discussed at the next meeting of the Global Programme Committee. In any case more funding for the programme was needed.

Dr DUNNE (Pharmaceuticals) said that several delegates had raised the question of exchange of information on the safety and effectiveness of widely available drugs. It was recognized in the Secretariat that without an adequate inflow of technical information it was impossible for Third World countries to contemplate effective drug policies. The Secretariat assured all delegations, including Ghana, that the Drug Information bulletin would be produced within the capacity of the Secretariat. WHO was grateful to the many drug regulatory authorities that collaborated in the production of the bulletin. With reference to the point raised by the delegate of India, he said that the bulletin was distributed to all governments of Member States, to drug regulatory authorities, and to teachers of medicine in Member States. In many countries local translations were made.

With respect to drug monitoring, he said that 23 national centres were participating in the WHO international adverse-reaction monitoring programme. Valuable work was being done in the WHO collaborating centre in Sweden in collating the data submitted. However, the project had now been in progress for 13 years and many new approaches to drug surveillance had been introduced in the interim. In 1982 it was hoped to review these developments to ensure the programme had relevance to a far greater number of countries.
Two questions had been asked about ethics in the drug field. The delegate of Nigeria had raised the question of the ethics of advertising; the need for restraint in the advertising of pharmaceutical products in international trade was referred to in the programme, partly in response to concern registered within the United Nations General Assembly. Industry itself had now responded positively to the challenge, the International Federation of Pharmaceutical Manufacturers' Associations having drafted the first international code of pharmaceutical marketing practices. A measure of self-regulation within the industry was clearly an essential element in any endeavour to realize satisfactory standards of drug advertising throughout the world.

The delegate of Mozambique had raised the question of the ethics of clinical trials in developing countries. It was crucial that drugs for diseases endemic in the developing world be tested within the communities at risk. WHO was an important sponsor of such research and the Organization had developed its own rules of procedure to ensure that appropriate ethical standards were observed. Proposed studies were not only reviewed from an ethical standpoint within the Organization; it was also necessary for researchers to show that the plans had been approved by an institutional review committee within the country concerned and that the responsible government department had been notified.

International guidelines for ethical review of research involving human subjects were now being developed within the Organization in conjunction with the Council for International Organizations of Medical Sciences. A consultative document was in an advanced state of preparation, and it was hoped that that would adequately cover the sensitive issues involved.

Dr ACUNA (Regional Director for the Americas) said that the revolving fund in the Americas for the purchase of vaccines and other materials should contain US$ 4 million in order to meet the needs of the various countries. The fund had been established with contributions of US$ 1.8 million from various Pan American Health Organization sources, together with a special donation of US$ 0.5 million from the Netherlands, for which the Organization was most grateful. Thus, of the needed total of US$ 4 million, US$ 2.3 million were in hand. The fund was so managed that vaccines representing a total expenditure of US$ 6 million were bought every year. That reflected the time it took for a country to place an order, for WHO to process the order and obtain the vaccine, and for the requesting government to pay for it.

In accordance with the decision of the Member States of PAHO, local currency could be used in part payment in many cases, to the extent corresponding to direct expenditures by the Organization in local currency in the country concerned. Furthermore, in 1980 the Regional Committee had asked for a study of the possibility of extending the use of the revolving fund to other essential supplies in the Expanded Programme on Immunization, such as needles, syringes and all the components of the cold chain that were equally essential. In addition, it had been proposed that other drugs and supplies should be purchased for specific priority programmes, such as drugs for the malaria and leprosy control campaigns, and oral rehydration preparations for the control of diarrhoeal diseases. There was a difference between referring to essential drugs or medicaments from the list of some 200 substances established by WHO, and to the specific priority programmes established by the Member States at the Health Assembly and in the regional committees. He was referring exclusively to the drugs for the specific programmes previously mentioned.

Dr PERKINS (Biologicals) said that the delegate of India had asked about the use of killed poliomyelitis vaccine. That vaccine was in very short supply and, as far as quality control was concerned, it undoubtedly needed a cold chain. The delegate of Israel had raised an important question relating to the development of biologicals in recombinant DNA, or genetic engineering. Rapid and impressive progress was being made in that field, which would affect all countries. It was hoped that a meeting would be held in 1981 or 1982 to consider the suitability of WHO biological standards to control biological materials made in that way.

Replying to the delegate of Saudi Arabia, he said that, since the publication of the international Requirements for the collection, processing and quality control of human blood and blood products,1 four meetings of groups of experts had been held to discuss plasmapheresis, the use of albumin solutions, cryoprecipitates and immunoglobulins. The reports of those groups of experts had now been combined in a nonserial publication that would soon be available and would be sent to governments.2

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2 Collection, fractionation, quality control, and uses of blood and blood products, Geneva, World Health Organization, 1981.
Dr SANKARAN (Director, Programmes of Traditional Medicine and Essential Surgery) referred to the questions raised by the delegates of Sierra Leone and Gabon about the use of traditional medicinal plants, particularly in primary health care. In the past three years steps had been taken to use national resources and expertise in that field. Five collaborating centres had been recognized, with which contractual technical and scientific agreements had been signed. They were the Istituto Italo-Africano in Rome, the first to be recognized, in 1978-1979, the Mexican Institute for the Study of Medicinal Plants, the College of Pharmacy at the University of Illinois, Chicago, the Ayurvedic Institute at Jamnagar, Gujarat State, India, and the parent collaborating centre, the Academy of Traditional Chinese Medicine in Beijing, China, with the Xi-Yuan Hospital and the orthopaedic institute.

In the African Region the Regional Office was finalizing agreements with four centres (one in Ghana, one in Mali and two in Nigeria), and it was hoped that they would shortly be signed. The delegate of Sierra Leone would be able to get help from those four centres. Eight specialists doing basic work in pharmacology, field plant biology, public health and traditional herbal research, and pharmacognosy had been recommended as experts in the African Region from Ghana, Madagascar, Mali and Nigeria, and had been nominated by the Director-General as members of the expert panel in the African Region. A meeting of directors of the collaborating centres was planned for the third week in November 1981.

DISEASE PREVENTION AND CONTROL (Appropriation Section 4; Documents PB/82-83, pages 146-195, and EB67/1981/REC/3, paras 136-171)

Communicable disease prevention and control (major programme 4.1)

Dr BARAKAMFITIYE (representative of the Executive Board) said that the Executive Board had noted with satisfaction that the WHO global medium-term programme for communicable disease prevention and control, covering the biennium, focused on disease problems that were of major socioeconomic relevance to the world community and could be largely controlled through the use of existing technology within the framework of primary health care activities. The advances made in epidemiology, immunology, vaccines, chemotherapy and other preventative and control techniques should help to improve the health of large populations, and particularly of the young. The programmes had been divided into three categories: (1) diseases preventable by existing vaccines; (2) non-parasitic diseases whose prevalence, or the mortality from which, could be controlled to varying degrees by therapy or other methods (such as diarrhoeal diseases, sexually transmitted diseases, etc.); and (3) vectorborne diseases.

The Board had noted how the global and regional advisory groups were providing valuable technical guidance on policy and strategies, and on continuous evaluation of progress, for those programmes. Those reviews gave an assurance to Member States and funding agencies that the resources allocated were being judiciously used.

The WHO expert advisory panels and the network of WHO collaborating centres on communicable diseases were part of a vast machine that was helping to develop new technology and improve existing technology, and was supporting operational research to improve delivery of services. In particular there was emphasis on the development of simplified and rapid diagnostic laboratory techniques for the use of different levels of primary health care and a major training programme would continue to operate both regionally and interregionally.

In addition to the advisory and technical work, the Board had advocated greater efforts to improve managerial capabilities, since the obstacles in controlling such diseases as malaria or tuberculosis, or those met with in the Expanded Programme on Immunization or in diarrhoeal disease control, were often managerial rather than technical. The Board therefore endorsed the effort in such programmes to give a special place to the training of managers and trainers to support health workers at all levels.

For programme 4.1.1 (Epidemiological surveillance) the weak point was still the lack of experienced epidemiologists to undertake surveillance activities, and consequently the management of existing resources was still inadequate. It had been noted that WHO would continue to support the training of epidemiologists through its regional programmes.

The Board also took note of WHO's current efforts to draw up guidelines, including guidance on laboratory services and personnel protection.

In discussing programme 4.1.2 (Malaria and other parasitic diseases), the Board had noted with satisfaction the measures taken to improve the epidemiological situation and reorient the malaria control programme.

In the presentation of the programme activities it was essential to prepare realistic plans based on the level of endemoeendemicity of malaria, on the manpower and financial resources
available, and also on the identification and analysis of technical, administrative and operational problems, including political and administrative aspects of malaria control and eradication. The research component of the malaria control programme was being developed in the Special Programme for Research and Training in Tropical Diseases.

With regard to the other parasitic diseases covered by the programme, it was noted that WHO proposed to continue its cooperation with other international organizations and multilateral and bilateral agencies, with a view to reducing morbidity and mortality from the major endemic parasitic diseases of schistosomiasis, lymphatic filariasis, onchocerciasis, African trypanosomiasis, Chagas' disease, leishmaniasis, and intestinal parasitoses. Chemotherapy, vector control, improved water supplies and sanitation all had a part to play, and there must also be emphasis on health education, technical training and community participation in disease-prevention activities. Research efforts would be continued in the search for new solutions to specific problems.

The main components of programme 4.1.3 (Bacterial, viral and mycotic diseases) were diarrhoeal diseases control, tuberculosis, acute respiratory infections, sexually transmitted diseases, leprosy, human plague, cerebrospinal meningitis, etc.

With respect to the diarrhoeal diseases control programmes, the Board had concentrated mainly on its immediate aim, to reduce infant and childhood mortality from diarrhoeal diseases through greater emphasis on early treatment of acute diarrhoea with oral rehydration therapy and proper dietary practices. Such therapy must be made available in at least 25% of all childhood diarrhoea cases in the developing countries by 1983. Efforts would continue to develop programme strategies and activities aimed at appreciable reduction in morbidity from diarrhoeal diseases. The Board had noted, with respect to the budget presentation, that the modest amount provided in the regular budget represented a significant increase over the previous biennium. The programme presentation itself underlined the importance given to management training and to a wide range of technical aids for technical training. The Board had noted with satisfaction that UNICEF was cooperating in the development of local facilities for producing oral rehydration fluids. On the research side much was expected from the testing of a newly developed typhoid vaccine, and important progress was expected in developing rotavirus and cholera vaccines and new drugs for the treatment of diarrhoea. Noting with satisfaction the development of the diarrhoeal diseases control programme, the Board had adopted resolution EB67.R4, which changed the title "Special Account for the Cholera Programme" to "Special Account for Diarrhoeal Diseases including Cholera".

Regarding tuberculosis, the Board had noted that the obstacles to tuberculosis control often appeared to be organizational rather than technical, and in the programme for 1982-1983 the emphasis would be on managerial techniques. The activities would include advisory service to governments on reorganizing and monitoring tuberculosis programmes, collaboration in the training of programme managers at intermediate level, and research on operational problems. In view of the negative results of the South Indian trial of BCG vaccines to prevent tuberculosis, the programme provided for research to determine the effectiveness of BCG vaccines for infants and young children in tropical areas. It was agreed by the Board that BCG was still an important weapon in preventing the disease in uninfected individuals - in other words, as a general rule, in infants and young children. In accordance with resolution WHA33.26, a review of the tuberculosis situation in the world would be presented to the Thirty-fifth World Health Assembly, in 1982.

The programme on acute respiratory infections would focus on those affecting the lower respiratory tract in children - since, unlike the upper respiratory infections, they were responsible for high mortality rates. Special attention would be given to health services research for the development of practical guidelines on the clinical management of acute respiratory infections in children at primary health care levels, especially in developing countries. A technical advisory group was being established to review the data from various investigations in progress, and to recommend control strategies adapted to the prevailing epidemiological situation.

It was noted with regard to leprosy that intensive research would continue under the Special Programme for Research and Training in Tropical Diseases, and would deal with chemotherapy - to determine the most effective, simple and inexpensive means of treating leprosy, and with immunology - with the long-term aim of producing a vaccine. Meanwhile the programme continued to emphasize management, training and evaluation problems associated with control programmes.

The Board had discussed the problem of sexually transmitted diseases and how to provide effective treatment and control services, especially for the large segment of the population
without any access to competent centres and laboratory diagnostic services. The programme would continue to promote clinical, bacteriological and operational studies to help develop a simplified approach to control which would largely eliminate the need for laboratory examinations and could therefore be applied by the peripheral health services. With that methodology, which was within the means of most developing countries, 80-85% of sexually transmitted disease cases could be given effective treatment by the primary health care services without referral to the next higher echelon. The Board had advocated continuance of global and national surveillance of resistance to antibiotics among the agents of sexually transmitted diseases and the setting-up of appropriate and economic treatment regimens.

With reference to viral diseases, he said that their real repercussions on public health were not yet clear, particularly in countries without appropriate laboratory installations and monitoring systems. The Board believed that the WHO programme should try to determine their importance in public health, support national monitoring systems, develop simplified techniques of laboratory diagnosis, and promote national capabilities of dealing with endemoidemic outbreaks through the primary health care services. The Board had been pleased to note the promptness with which WHO had taken measures in cooperation with Member States to stem recent outbreaks of Lassa, Marburg and Ebola fevers, and to reinforce those activities by training national personnel to deal with such epidemics. It had also noted the development of influenza surveillance and the monitoring of vaccine requirements. The studies on the development of a vaccine for dengue haemorrhagic fever, which would be of vital importance to the South-East Asia and Western Pacific Regions, were being followed with great interest.

In the veterinary public health programme, efforts were concentrated on preventing, through the peripheral services, the most important zoonoses, such as rabies and foodborne diseases, including salmonellosis, echinococcosis, hydatidosis and brucellosis. There was particular reliance on direct collaboration with countries and on the network of zoonoses control centres. The Board had been particularly interested in knowing how research results had been used in practical control activities.

In the discussion on programme 4.1.4 (Smallpox eradication), it had been noted that in 1980-1981 the activities were financed solely from voluntary contributions. However, a programme for post-eradication surveillance and research had been formulated for the proposed 1982-1983 budget in compliance with resolution WHA33.4. That programme accounted for a significant portion of the regular budget increase for headquarters, global and interregional activities. The Director-General's appeal for extrabudgetary funds had resulted in two positive responses but no firm commitment, and the Board had expressed the wish that the particular attention of the Assembly be drawn to his appeal. The six laboratories still retaining stocks of variola virus would be visited by WHO inspection teams during the coming year. In February WHO was informed that all variola virus stocks in China, where one of the six laboratories was situated, had been destroyed.

The Board considered that programme 4.1.5 (Expanded Programme on Immunization (EPI)) was one of WHO's most important programmes. For the 1982-1983 period the specific target was 50% coverage of the target population by immunization services by the end of 1983. Information systems were being strengthened to provide estimates of the immunization coverage currently being achieved. For example, in the Eastern Mediterranean Region about 20% of children in their first year of life were receiving a third dose of DPT and poliomyelitis vaccines, and 18% a measles immunization. It was hoped that coverage estimates from all regions would be available for inclusion in a comprehensive review to be presented to the Board and the Health Assembly in 1982. Recent studies had indicated that about US$ 3 was required to immunize a child fully against the EPI target diseases. Of that, $2 - mainly covering staff salaries and operating expenses - was expected to come from national budgets. It might be possible to provide the remaining $1, mainly covering the transport of the vaccine and the cold chain, by external funding. The fact that most of the resources to support the programme were national emphasized how far national commitment was essential for success. The Board had also stressed that management and management training must remain a major concern. The EPI continued to concentrate on the quality control of vaccines, and expected to receive support from the United Nations Development Programme to strengthen regional quality control capacities. The EPI Global Advisory Group joined with the Advisory Committee on Medical Research in endorsing the continued use of BCG within the programme, and in recommending that research on the effectiveness of BCG vaccine continue to receive priority.

Programme 4.1.6 (Special Programme for Research and Training in Tropical Diseases) had expanded considerably and had been discussed at length by the Board. Up to the end of 1980, the programme had supported over 1000 projects in national establishments in 78 Member
countries, with obligations of over US$ 52 million. The percentage of that support going to developing countries where the diseases concerned were endemic had risen from 29% in 1977 to 55% in 1980. The proposed programme budget for 1982-1983 reflected the resolve to continue to increase the involvement of developing countries with problems of endemic diseases and direct research and development activities along the most appropriate lines. Since the programme was financed mainly from extrabudgetary resources its activities would have to be adapted to the amount of money actually obtained. Thus far 23 governments, including six developing countries where such diseases were endemic, and a number of organizations, including the World Bank, UNDP and WHO, had contributed over US$ 70 million to the programme.

Programme 4.1.7 (Prevention of blindness) would focus on the planning and implementation of national programmes geared to local needs and resources. The programmes would be based on existing simple technology to combat blindness, particularly blindness of infectious and nutritional origin, as well as the restoration of sight to the curable blind, and would be directed to providing essential eye care as an integral component of primary health care. Apart from regular budget funds for the programme in each region, voluntary contributions had been provided for the development of the programme in the South-East Asia and Western Pacific Regions. Similarly, extrabudgetary funds had been made available to strengthen the central core staff, which had enabled the programme to include operational field research in its activities.

Programme 4.1.8 (Vector biology and control) continued to constitute an important component in the prevention and control of communicable diseases in most countries, and was largely based on a strategy incorporating pesticide application with environmental management. The main emphasis would be on the local development of vector control strategies most suited to the prevailing socioeconomic, epidemiological and environmental conditions. Thus national staff would have to play a greater role than in the past, and a special effort would be made to strengthen the operational expertise and capability of countries with endemic disease problems by training manpower at all levels and ensuring that technical information was provided for their use. Vector control was often impeded by the lack of relevant information on vector bionomics. Action would be taken to initiate, coordinate and support research on that subject, and to develop improved pesticide formulations, application equipment and environmental management methods.

The meeting rose at 12h35.
TENTH MEETING

Monday, 18 May 1981, at 14h30

Chairman: Dr E. P. F. BRAGA (Brazil)

1. ORGANIZATION OF WORK

The CHAIRMAN informed the Committee that, at its meeting at midday, the General Committee had recommended that the Committees should extend their working hours. It had also decided that either agenda item 21 (Health for all by the year 2000), or agenda item 23 (Infant and young child feeding), should be transferred from Committee A to Committee B but had left it to Committee A itself to determine which of the two items it would transfer. He pointed out that since the Global Strategy for health for all by the year 2000 was related to the programme budget, item 21 could only be discussed after completion of the examination of the latter.

He invited comments on which item should be transferred.

Dr ALSÉN (Sweden) said that the draft International Code of Marketing of Breast-milk Substitutes (in item 23) and the Committee's efforts to establish it formed an integral part of the activities for family health, which in turn were an essential component of health for all by the year 2000. Family health had already been discussed by Committee A. To transfer item 23 to Committee B would mean a break in continuity. The Swedish delegation would therefore prefer item 21 to be transferred to Committee B; that item had several aspects which converged with the items being discussed by Committee B.

His delegation also hoped that Committee A would abide by its unanimous decision to take up item 23 immediately on concluding its consideration of the programme budget.

Professor ARAUJO (Cuba), Professor AVRAMIDIS (Greece), Dr BEAUSOLEIL (Ghana), Dr HYZLER (United Kingdom of Great Britain and Northern Ireland) and Dr IBRAHIM (Egypt) supported the view of the Swedish delegation.

Dr BORGÓN (Chile) said that, in his view, it was most important that Committee A should discuss the global strategy. He therefore proposed that agenda item 23 should be transferred to Committee B and that the Committee should decide by a vote.

Professor HALTER (Belgium) said that, while appreciating the point made by the delegate of Chile, he considered that Committee A should discuss the draft International Code of Marketing of Breast-milk Substitutes. However, he agreed that the decision should be taken by a vote.

The CHAIRMAN then put to the vote the proposal of the delegate for Chile that agenda item 23 be transferred to Committee B.

The Chilean proposal was rejected by 71 votes to 7, with 7 abstentions.

The CHAIRMAN announced that, as a result, item 23 would be discussed in Committee A and item 21 transferred to Committee B.
Communicable disease prevention and control (major programme 4.1) (continued)

Epidemiological surveillance (programme 4.1.1)
Smallpox eradication (programme 4.1.4)
Expanded Programme on Immunization (programme 4.1.5)

Dr BORGONO (Chile) referring to programme 4.1.1 (Epidemiological surveillance) said that, although the budget regularly included an allocation for the Committee on International Surveillance of Communicable Diseases, that Committee had last met in 1976. He wished to ask the Director-General to reconvene it in 1982 to consider amendments to the International Health Regulations (1969) for submission to the Health Assembly, and to review the progress made in evaluation programmes and the need to strengthen national surveillance systems. It was necessary also to consider or reconsider which diseases needed to be kept under surveillance globally or regionally.

Noting that no extrabudgetary allocation for the Expanded Programme on Immunization (programme 4.1.5) had been included for the Region of the Americas for either the current or following biennium, he inquired whether there were in fact no funds for that programme for the Americas, or whether the omission was an oversight.

Dr WILLIAMS (Nigeria) said that the Expanded Programme on Immunization was one of the major items in the budget and one to which African countries attached great importance within the context of primary health care. It offered tremendous hope of rapidly and significantly reducing the burden of ill health and the high level of mortality from communicable diseases, particularly among young children in the Third World.

The plan of action for the programme in the programme budget was balanced and realistic, but he noted that there was a reduced appropriation from extrabudgetary sources for the forthcoming biennium. His delegation would welcome further efforts by the Director-General to make up the deficit in the total financial commitment, at least to the level of that of 1980-1981.

It would be naive not to temper the initial enthusiasm and expectation the programme had generated with some measure of realism, caution and disappointment at the moment of implementation. The programme in many Third World countries with well-known infrastructural deficiencies had been attended by serious problems, particularly in the area of cold storage and transportation of vaccines, data collection for evaluation of the programme, as well as the repair and maintenance of equipment. There were far too many vaccine failures which could adversely affect the total credibility of the programme. That deficiency would certainly be overcome through development and strengthening of the managerial capacity in the operation of the programme. Nevertheless, Nigeria would like to see more research and support devoted to the development of heat-stable vaccines for the particular situation in the Third World countries. While it was desirable to focus attention on the programme's quantitative targets, it was equally important not to overlook the qualitative aspects. Nigeria was taking the necessary steps to monitor vaccine potency and to ensure that only potent vaccine was used.

His delegation commended the excellent working relations and partnership in Nigeria between WHO and UNICEF; that had significantly contributed to the progress - even though it was limited progress - which the programme had achieved in his country.

Professor LUNENFELD (Israel) said that his delegation wholeheartedly supported the objectives outlined for major programme 4.1.

In spite of dramatic advances, infectious disease was still a factor in Israel's mortality and morbidity pattern, with accompanying economic and personal results. In the period 1973-1975, Israel's death rate from infectious and parasitic diseases had been more than twice that of Sweden and Norway and other Western countries. Although progress had been made since 1975, communicable disease control and prevention remained an important element in the public health process in his country. The newer exotic virus diseases also constituted...
public health problems for Israel as had been exemplified by the epizootic of Rift Valley fever in 1977, 1978 and 1979, which had arrived from neighbouring countries and regions. The occurrence of Rift Valley fever had necessitated a large-scale preventive programme, including massive immunization of large animals and human beings at risk, as well as extensive surveillance and monitoring activities. Ebola virus from the Sudan and other haemorrhagic fever viruses from Iraq had also recently appeared, thus stressing the importance of regional cooperation in epidemiology and public health.

The widespread problem of hepatitis A and other enteroviruses was still a major cause of morbidity in Israel with important implications for water and food supply, as well as for general sanitation. Effective surveillance and skilfully applied public health practice were still the backbone of communicable disease control.

In collaboration with the WHO Regional Office, Israel planned to add killed poliovirus to the basic live poliovirus immunization in areas where repeated introduction of wild poliovirus by travellers from neighbouring countries had resulted in continued occurrence of sporadic cases of poliomyelitis. The successful experience in Gaza and the West Bank in almost eliminating poliomyelitis by the combined application of oral and killed vaccines would be useful in other areas at risk.

Rubella immunization of 12-year-old girls had been routine in Israel since 1972. The programme was being expanded after a major epidemic in 1979 had led to some 1500 abortions to prevent the rubella syndrome. The basic programme was being expanded to include immunization of seronegative women immediately after pregnancy and those attending family planning clinics. It was hoped to add rubella vaccination to the routine child immunization programme.

The newer technologies in vaccines would have important public health effects in the coming years, particularly as the pneumococcal and meningococcal vaccines could be applied more widely. Progress in hepatitis vaccines would also be important in future public health planning. Pneumonias due to pneumococci still constituted a major risk, particularly in view of a growing elderly population and as the risk of antibiotic-resistant strains increased.

Surveillance and treatment for the prevention of waterborne bacterial and viral diseases was of great importance in a country which used such a high proportion of its basic water supply and where recycling of sewage water was a widespread practice. Food and environmental sanitation remained essential mainstays in the prevention of infectious diseases, as were sewage collection and treatment, garbage collection and disposal, and health education to increase public consciousness of the importance of sanitation. Much remained to be done in those respects in Israel, although there had been good progress in the past decade.

His delegation, therefore, endorsed the budgetary proposals for major programme 4.1, which took into account an increased allocation of funds at the national level.

Dr IBRAHIM (Egypt) thanked WHO for the efforts it had put into the prevention and control of disease. On the occasion of the International Year of Disabled Persons, 1981, she would have liked to see greater stress placed upon disabling infectious diseases which could be prevented by immunization. Poliomyelitis, despite the enormous effort which had been made to prevent it, still represented the main cause of locomotor handicaps in children. The children affected needed considerable efforts on the part of rehabilitation centres and were a serious economic burden on countries. Her country, therefore, was laying particular stress on immunization against poliomyelitis, which, although it had almost vanished from most of the developed countries, still affected her own. She therefore urged that particular effort should be made to ensure that poliomyelitis vaccination was undertaken in all countries.

Dr SADRIZADEH (Iran) said that, since the control of communicable diseases was primarily dependent on international cooperation, early case detection, the application of preventive measures, immunization, and health education, the main budgetary allocations should be devoted to those elements.

Stress should be placed on legislation embodying stricter regulations making the reporting of certain communicable diseases compulsory, promoting the standardization of diagnostic criteria, continuous cooperation by WHO with Member States in the development of training programmes - which might be very fruitful and would be highly appreciated - and a further development of epidemiological surveillance in order to monitor the trend of communicable diseases, especially of those that were preventable.
Dr LOCO (Niger), speaking on Appropriation Section 4 as a whole, referred in particular to the control of onchocerciasis and of cerebrospinal meningitis. Regarding onchocerciasis, he suggested that WHO, as the executing agency for the Onchocerciasis Control Programme (OCP), should, with the agreement of the Joint Programme Committee, transform the programme from a vertical to a horizontal one that would include malaria, schistosomiasis, and trypanosomiasis, which were prevalent in Africa and hampered economic development.

In connexion with cerebrospinal meningitis, he informed the Committee that Niger had built and equipped a centre for research on that disease and on schistosomiasis in the framework of the Organization for Coordination and Cooperation in the Control of Major Endemic Diseases (OCCGE). The meningitis section was already operative and Niger hoped that WHO, in cooperation with OCCGE, might help to make that centre a reference centre for the Region. He also hoped that the Secretariat of OCCGE might be enabled to participate in the work of the Health Assembly or of the Regional Committee for Africa. That would help to direct research in specialized institutions towards practical applications.

Regarding control of diarrhoeal diseases, he indicated that, with the support of Belgium, Niger was about to start the manufacture of oral rehydration salts.

In conclusion, his country supported the proposals for Appropriation Section 4.

Professor AVRAMIDIS (Greece) said that his delegation approved of the programme on communicable diseases. In connexion with the Expanded Programme on Immunization, he noted that in paragraph 6 (page 166 of document PB/82-83), reference was made to the establishment of protocols for the investigation of cases of poliomyelitis in fully immunized children. He recalled that a survey on that question had been carried out by WHO in which it had been shown that just over 100 cases of poliomyelitis had been caused by oral vaccines in the United States of America and similar cases had occurred in several European countries in the period 1961-1973. He asked whether the proposed protocols would be similar to those used in that survey and wondered whether in future the Sabin vaccine should be replaced by the Salk vaccine.

Dr HOPKINS (United States of America), said that his delegation considered that emphasis in communicable disease prevention and control should be directed towards the recognized priority areas, especially for developing countries in tropical zones. There were, however, two areas that deserved a higher priority than they were given in the proposed programme budget. First, schistosomiasis should be given special emphasis now that greatly improved drugs were available for mass treatment; secondly, efforts to control nosocomial, or hospital-acquired, infections deserved a higher priority in many countries.

As regards epidemiological surveillance, his delegation believed that technical assistance and cooperation could not be overemphasized; it especially endorsed the stated preferred approach of "learning by doing" in the context of local communicable disease programmes.

His delegation also endorsed the post-smallpox-eradication activities as detailed, and wished to commend the Expanded Programme on Immunization for the clarity and programmatic content of the material presented on that item.

Dr ODDO (Italy) said that his delegation was satisfied with the results achieved by the communicable disease prevention and control programme. Factors that had markedly reduced the incidence of such diseases in recent years included immunization and the prophylactic use of antibiotics and chemotherapy; nevertheless, infectious diseases remained important, since morbidity from that cause remained high and sometimes even at traditional levels. In that field, however, advantage could be taken of scientific and pharmacological progress, which had provided new vaccines and prophylactic products. The question therefore arose of enabling society to benefit from rational prevention and control activities.

In the view of his delegation, WHO had an essential part to play in promoting communicable disease control; the good results so far obtained justified more intensive efforts at all levels. The undoubted success of the smallpox eradication campaign showed the results that could be obtained when an effective means of prophylaxis was available and all the necessary resources were mobilized.

His delegation was following with interest WHO's activities in monitoring the world epidemiological situation with regard to communicable diseases such as influenza, salmonelloses and acute respiratory infections, as well as the three diseases covered by the International Health Regulations (1969). That enabled countries to take appropriate preventive measures, when necessary. In addition, it was clear that, the better national surveillance was developed, the more complete and up-to-date would be the international information.
WHO's work on developing guidelines for the application of standardized methodologies in epidemiological investigations and in laboratory research for the testing of new prophylactic products was also of great importance. Expanded immunization campaigns constituted another field in which WHO should continue its activities. It was necessary to ensure that all Member States possessed the necessary vaccines and prophylactic products; they should also themselves organize the training of the staff for those campaigns and the evaluation of the results obtained.

His delegation fully supported the programme for communicable disease prevention and control.

Dr FEDOROV (Union of Soviet Socialist Republics) approved of the division of communicable diseases into three groups, as described in paragraphs 4 to 7 under major programme 4.1; that was extremely useful from the point of view of national and international campaigns, and of prophylaxis, as well as from that of the development of intersectoral collaboration. He was pleased to note that WHO was continuing to place special emphasis on the Expanded Programme on Immunization, epidemiological surveillance, the Special Programme for Research and Training in Tropical Diseases, and the control of virus infections.

Smallpox eradication was only briefly considered in the proposed programme budget. Special attention should be given to further scientific research on the different viruses of the smallpox group, and especially monkeypox virus; it was possible that the gradual reduction in the immunity of the population as a result of not vaccinating against smallpox might increase the danger to man from those viruses. His delegation also noted the theoretical and practical significance for the Member States and for WHO of the experience gained in the campaign for eradicating smallpox. That experience should be analysed immediately by those who had participated in that campaign, not by historians.

His delegation noted the success of the Expanded Programme on Immunization, but considered that the programme budget document failed to deal adequately with the problems of the organization of the production and quality control of vaccines at the regional level, as well as those of the links between that Programme and other programmes, notably for primary health care.

Dr PARADE (France) endorsed the remarks of the delegate of the Soviet Union with regard to the division of communicable diseases into three groups; that classification would enable those responsible for health at the international level to design and define the appropriate control strategy and to use the appropriate techniques. The need for strict epidemiological surveillance was emphasized in programme 4.1.1. In that connexion, it would be desirable to strengthen WHO's support of, and collaboration with, the Organization for Coordination and Cooperation in the Control of Major Endemic Diseases (OCCGE) in West Africa and the Organization for Coordination in the Control of Endemic Diseases in Central Africa (OCEAC); those organizations played a major role in their respective subregions in collecting and disseminating epidemiological information and in taking practical steps for the control of communicable diseases.

The Expanded Programme on Immunization (programme 4.1.5) was fundamental to the attainment of health for all by the year 2000. For 1982-1983, however, the percentage increase in the funds available under the regular budget for that programme was appreciably less than that for the budget as a whole. Did the budget allocations really reflect the importance of the programme? In addition, no figure was given for the project for quality control of vaccines, while the figure for 1980-1981 was US$ 563,000; had the activities concerned been transferred to the regions? It appeared from the remarks made at the previous meeting by the representative of the Executive Board that they would be financed from outside sources, and especially by UNDP, which was reassuring.

Dr BAJAJ (India), referring to paragraph 6 under programme 4.1.1 (Epidemiological surveillance), asked whether the Weekly epidemiological record would be available through the regional offices, as well as from headquarters. The Expanded Programme on Immunization (Programme 4.1.5) had his delegation's support; he nevertheless requested WHO to expedite the programme of poliomyelitis vaccine distribution in the rural areas, where the majority of the population lived, especially since the disease was one of the greatest causes of disability.

Dr WILLIAMS (Sierra Leone), commenting on the Expanded Programme on Immunization, said that, in Sierra Leone, coverage with the third dose of DPT and poliomyelitis immunization was still relatively low. While it was easy to obtain full community participation in some areas,
elsewhere communities were indifferent and coverage therefore low. Could WHO assist by undertaking studies to determine the reasons for that state of affairs? Remedial procedures could then be undertaken. Her delegation would also like WHO's views on the immunization of ill children, and on means of changing the views both of health personnel and of the community on that matter; that would help towards achieving the high coverage necessary to reduce the morbidity and mortality due to the diseases covered by the programme.

With regard to health education, which was essential if the programme was to be successful, use should be made of village workers, such as agricultural extension workers, social welfare workers, and village teachers. How should such integration be undertaken?

Professor SPIES (German Democratic Republic) said that the major programme was an excellent one and very well structured; the fact that it covered one of WHO's oldest fields of activity might make it difficult to introduce new features. It was perhaps clear from a reading of programme 4.1.0 that more courage was needed in an approach to new activities in the field; that would help in speeding up progress, and perhaps also in preparing the Seventh General Programme of Work. The structure of the programme should reflect, not merely technical groupings, but also the need for WHO to coordinate and promote activities so as to achieve a more rapid progress towards solving the problems involved.

If the major programme as a whole was considered, it would be seen that it was one of the biggest from the point of view both of the proportion of the regular budget allocated to it and that of other sources of funds; that reflected the great interest of many bodies outside WHO.

The importance of primary health care and of the Declaration of Alma-Ata had not been adequately emphasized; in fact, the control of communicable diseases was a major part of such care, and that should be reflected in the programme.

With regard to epidemiological surveillance and control, many institutions in the world could make a contribution, for example by holding training courses; it was not just a question of the two epidemiology courses mentioned in the plan of action (paragraph 4). If necessary, institutions in the German Democratic Republic could assist in that way. Epidemiological surveillance was an integral part of primary health care in the development of health care systems in order to reach the goal of health for all by the year 2000. The experience of the German Democratic Republic was interesting in that context; a State Hygiene Inspectorate had been set up to cover the whole country, especially from the point of view of comprehensive surveillance, prevention and control of infectious diseases, and the coordination of the multi-sectoral approach in that field.

The same was true for the Expanded Programme on Immunization. A large potential was available in Europe that could be used for the benefit of the entire WHO programme; it was strange, therefore, that Europe played such a small part in it. It was not that European countries needed funds for research, but that they should undertake more activities in collaboration with the developing countries and the other regions.

The achievements of a comprehensive immunization programme could be lost if there was no surveillance. For example, if a measles vaccination programme covered up to 90% of the young age-groups concerned, it was only a question of time - say, 5-6 years - before there would be enough members of those age-groups who were not protected for the spread of measles to be once again possible. All gaps in such vaccination programmes should therefore be filled.

With regard to smallpox eradication, he believed that general surveillance and preparation for accidents was not enough; a comprehensive research programme was also necessary to cover other poxvirus infections, and especially monkeypox. Surveillance of other widespread poxviruses should always be carried out, and especially in relation to animals coming into close proximity with man.

He agreed with the proposed activities, and with their implications from the point of view of the International Health Regulations (1969).

Dr NDIKUMANA (Burundi) said that the programme for the control of communicable diseases, together with that on essential drugs, constituted the basis of primary health care. Communicable diseases were the main cause of illness in the countries of the African Region and therefore imposed the greatest burden on the health budgets of those countries.

The Expanded Programme on Immunization was absolutely essential to the maintenance of health, and provided a model of the necessary management process; it was in course of being implemented in Burundi. The secret of the success of that programme lay in the training courses for vaccinators; he hoped that those would be continued. One problem associated with the programme was that vaccines were becoming increasingly expensive; was it really so that the
cost per immunized person was only US$ 37. A problem that arose in the poliomyelitis immunization campaign was the very low coverage achieved in Burundi, which amounted to only 20-30%; he hoped that WHO would be able to assist in solving that problem.

Professor HALTER (Belgium) said that one problem remained in connexion with the eradication of smallpox, namely the possible existence of stocks of variola virus in laboratories which had been involved in the testing of material from smallpox patients. In Belgium, he had called for an inspection of such laboratories in order to determine whether such unrecorded stocks existed. How many laboratories were officially entitled to hold stocks of the virus? Was WHO aware of the results of investigations aimed at finding and destroying virus stocks which might exist as a result of negligence in certain laboratories?

Also in connexion with the smallpox eradication programme, he had pleasure in announcing that Belgium would make available to WHO 1 000 000 doses of smallpox vaccine, thus bringing the total for 1981 to 1 500 000.

In Belgium, as in most industrialized countries, a series of immunization campaigns against various diseases had been organized. He was particularly concerned, however, with immunization against mumps. What was the expert view on promoting immunization against that disease? Mumps was a benign disease of children, and complications were rare. He would like an opinion on that question, especially in view of the large number of immunizations currently carried out and the risks associated with them.

Dr HASAN (Pakistan) said that his delegation attached great importance to the Expanded Programme on Immunization; he particularly appreciated the efforts being made by the Regional Director for South-East Asia to ensure the training of middle-level health workers and with regard to training for the managerial process involved. His delegation was also grateful to UNICEF for their assistance with the programme. WHO should cooperate, however, by providing technical expertise so as to help countries to develop their own vaccines; many had the capability to do so, and Pakistan was already producing certain vaccines though it needed assistance in the production of others.

WHO should place adequate emphasis on developing the methodology for achieving complete coverage by poliomyelitis and DPT vaccines in the 50% of the population that was the target for the biennium. That was the crux of the problem in countries where the literacy rate was low, the fertility was high, and the main concern of parents was to find food for the family.

Dr HYZLER (United Kingdom of Great Britain and Northern Ireland) said that his delegation endorsed the communicable disease prevention and control programme, and supported the view of the delegate of the Soviet Union with regard to the value of grouping diseases for the purpose of formulating prevention and control strategies. That grouping was also to be commended for the pragmatic approach that it embodied.

Reference was made among the approaches for the major programme (paragraph 5) to immunization against rubella; in that connexion, it was essential to bear in mind the importance of preventing congenital malformations caused by that disease. Rubella vaccination should therefore be given high priority in the formulation of immunization strategies.

With regard to paragraph 7 of those same approaches, due emphasis should be given to intersectoral collaboration; that was essential in dealing with the ecological aspects of vectorborne diseases.

The WHO publication on the vaccination requirements for international travel had appeared in 1981 in a new format, and gave information on methods of avoiding contracting communicable diseases. It provided a fund of valuable information both for doctors and health workers. He congratulated those responsible for that publication. 1

One of the major benefits of the eradication of smallpox was that vaccination against the disease was no longer necessary; the removal of the requirement for such vaccination had been recommended by the Global Commission for the Certification of Smallpox Eradication and endorsed by the World Health Assembly in 1980 by resolution WHA33.4. Unfortunately, some countries were still requiring smallpox vaccination of travellers entering their territory; his delegation was concerned by that state of affairs, as was the entire medical profession in the United Kingdom, where doctors were reluctant to carry out a vaccination that was totally unnecessary and could cause serious reactions.

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1 Vaccination requirements for international travel and health advice to travellers, Geneva, World Health Organization, 1981.
Dr QUAMILA (Trinidad and Tobago) thanked the representative of the Executive Board for his helpful and detailed review of the subject and wished to place on record her delegation’s support for the programme on communicable diseases as set out in the programme budget. Her delegation was convinced that epidemiological surveillance was the corner-stone of the programme. It was a question of identifying needs and ordering priorities on a global, regional and country basis. She commended the usefulness of the Weekly Epidemiological Record and expressed her appreciation of the relevant information contained in the regional and subregional bulletins supported by the Pan American Health Organization. Meaningful participation of primary health care workers in the collection, transmission and appreciation of epidemiological information depended on the inclusion of epidemiology as a basic science in the curriculum of medical students, nurses and other health workers. Her delegation further noted with appreciation that the Director-General had included a meeting on safety measures in microbiology in the programme. She also wished to thank WHO for the excellent training programme in support of the Expanded Programme on Immunization and to record the fact that her country now had a measles vaccine available.

Dr BEAUSOLEIL (Ghana) endorsed the role and importance of health laboratory services in epidemiological surveillance as set out in programme 4.1.1. The document had not convinced him, however, that the development of public health laboratories had been given quite the attention it deserved. He asked what was proposed in that context. He agreed with the observations of the United Kingdom delegate regarding the implementation of the International Health Regulations (1969).

His delegation had noted the call for self-reliance in regard to the regional promotion of vaccine production (programme 4.1.5). It should be borne in mind that experience of local production showed that locally produced essential drugs were not always available in the quantities and quality required. Moreover, they were often more costly than those procured from outside the country. Accordingly he wished to sound a note of caution. Local production should be promoted only when it was certain that the resulting product would be cheaper than its imported equivalent and that it would be satisfactory in respect of quantity, quality, safety standards and efficacy.

Lastly he had the impression that funds for the purchase of vaccines for the Expanded Programme on Immunization were not available from the regular budget but only from extra-budgetary sources. He wished for a clarification as to whether that was in fact the case.

Dr KLIVAROVÁ (Czechoslovakia) asked for a reply to the question she had put at the previous meeting in connexion with the side effects of drugs as an integral part of the activities on drug safety (programme 3.4.2).

Her delegation supported the major programme on communicable disease prevention and control, mindful of the success achieved in eradicating smallpox. It also supported the post-eradication programme formulated in resolution WHA33.4. Immunization programmes were being implemented systematically in her country and the sharp decline in the incidence of the diseases concerned fully justified the measures taken; there had been no cases of tetanus, diphtheria or poliomyelitis for 20 years. Her country also had collaborating centres on streptococcal diseases, influenza, arboviruses and tuberculosis. In addition it was very interested in the possibility of developing simple methods for the diagnosis of viral diseases, including influenza, which she believed to be a major problem throughout Europe.

Professor AYRES (Portugal) said that her delegation fully supported the programme on communicable disease prevention and control, which were of interest to developed and developing countries alike. Although the objective was the reduction of morbidity and mortality due to such diseases, due attention should be given to the new epidemiological situations, especially the ever-increasing danger of infectious diseases for which the growing use and abuse of evermore sophisticated technology for the diagnosis and treatment of many diseases was responsible.

Her delegation attached the utmost importance to the role of epidemiological surveillance in pursuit of those programmes, and as a corollary, to the role of the epidemiologist. Epidemiologists were badly needed in Portugal as in many other countries represented and her delegation accordingly commended WHO’s efforts to promote their training. No less important was the training of general practitioners and other health workers in epidemiology and related fields.

With regard to the Expanded Programme on Immunization (programme 4.1.5), she stressed first the need to eliminate erroneous ideas and to educate health personnel and whole communities in immunization. That would cost money. Secondly, it was essential that the quality of
vaccines be properly controlled. Many countries were unable to produce their own vaccines and had to rely on imported vaccines.

Finally her delegation wished to know the position with regard to the inclusion of rubella vaccine in the Expanded Programme on Immunization.

Dr TAMMAM (Egypt) said that in his delegation’s view immunization against communicable diseases was valuable not only for the part it could play in preventing such diseases but also for its role in the reduction of infant mortality resulting from serious diseases complicating an underlying disease. He instanced observations carried out in Egypt of a general reduction in infant mortality from diarrhoea since 1978 when compulsory measles immunization had been introduced. A similar reduction in infant mortality from diarrhoea had been noted where oral rehydration solution had been used in the treatment of dehydration.

Dr MÜLLER (Netherlands) recalled that several delegates had mentioned the use of inactivated poliomyelitis vaccine in combination with or instead of live oral vaccine for the control of poliomyelitis, and that the delegate of Sierre Leone had stressed the problem of obtaining adequate immunization coverage. The subject was of great interest to the Netherlands, where it was felt that research in that field was urgently needed. His Government was contributing financially to the Expanded Programme on Immunization in order to stimulate such research, and it would like to see an investigation made into the possibilities of incorporating inactivated poliomyelitis vaccine in DPT vaccine. It would further be interested in knowing whether two doses of such a vaccine during infancy would provide acceptable levels of protection against the four diseases. Inactivated poliomyelitis vaccine was at present considerably more expensive than oral vaccine, but if produced on a large scale, it might not remain so. It had the merit of greater stability under tropical conditions and would be easier and less expensive to deliver if the health services had to contact the children only twice rather than three times.

Dr ROGOWSKI (Poland) voiced his delegation’s appreciation of the progress achieved in WHO’s communicable disease control programme. It viewed with satisfaction the presentation of the chapter in the programme budget document and the statement of the representative of the Executive Board. It further welcomed the substantial increase in the budget allocation for disease prevention and control.

He noted that the results of the Chingleput, India, trial of BCG vaccine had cast some doubt on the protective value of BCG. In that connexion an evaluation had been made in 1980 of a controlled longitudinal BCG trial in Poland covering the years 1966-1977. The results confirmed previous findings that BCG did protect tuberculin-negative individuals. The protective value of the BCG strain used in Poland was calculated to be 65% and full protection lasted for 6 years, with a gradual diminution of protection thereafter. He hoped that the Polish findings would restore some of the confidence previously accorded to BCG vaccine.

Dr LADNYI (Assistant Director-General) thanked the Committee for their comments and assured them that all their observations had been duly noted and would be taken into account in implementing the relevant programmes. WHO had given great attention to smallpox and the Expanded Programme on Immunization, and without going into detail, he was happy to confirm that all possible measures had been taken in regard to the conservation of the smallpox virus. Only five laboratories in the world kept the strains and the most stringent safety precautions were taken and regular checks by WHO experts were carried out. Every possible provision had been made to ensure that nothing should stand in the way of further research, and there were no budgetary, technical or political barriers to a continuation of the work needed on monkeypox and other orthopox viruses.

Questions had been raised as to future policy on vaccine supply for the Expanded Programme on Immunization. He wished to make it clear that the regular budget of WHO provided no special funds for the purchase of vaccines; however, the method used for smallpox had been to route vaccines through UNICEF and voluntary agencies, for instance, and that was an example to be followed.

Dr ZAHRA (Director, Division of Communicable Diseases) said that the Secretariat was most grateful for the constructive comments made in the course of the discussion. As various speakers had pointed out, the re-orientation of the major programme aimed to reflect its vital role as one of the elements of primary health care. That role had been highlighted at the International Conference on Primary Health Care, Alma-Ata, 1978. The aim was to develop strategic approaches to diseases or groups of diseases which unquestionably gave rise to problems, and on which it was hoped to make a global and regional impact in terms of mortality and morbidity reduction.
Another emphasis in the programme, alluded to in particular by the delegates of Trinidad and Tobago and of Portugal, was the key role of epidemiological surveillance services, which unfortunately remained weak everywhere. That, too, had been stressed at the Alma-Ata Conference. Without strong epidemiological services it was impossible to improve surveillance management, since those services were the managerial tools employed at all times in surveillance evaluation and accounting. He wished to assure delegates of the increased attention being paid to training in epidemiology, at national and regional level. "Learning by doing" must be the watchword in order to strengthen such services.

The delegate of Ghana had asked for a clarification of the linkage between that programme and laboratory services. The programme reflected a keen interest in the development of rapid simplified diagnostic techniques such as those now being evolved in collaboration with the large network of WHO collaborating centres. The translation and utilization of those simplified techniques within the laboratory services was part of another programme, concerned specifically with laboratory services, and might for that reason not have been brought out very clearly in the presentation of the programme. It was hoped that in future programme budgets the linkage would show up better.

The rapidly changing pattern of communicable diseases had been referred to directly or indirectly by the delegates of Chile, Portugal, India, Israel and Iran, who had highlighted the importance of keeping up to date, particularly where an epidemic potential was involved. Such was the case with Rift Valley fever, an important zoonosis, and with various other hemorrhagic fevers, requiring the maintenance of epidemiological vigilance.

The Chilean delegate had raised the question of the frequency of sessions of the Committee on the International Surveillance of Communicable Diseases which was one of the obligations of the Organization under the International Health Regulations (1969). The Committee's main function was to review the application of those Regulations and other related legislation; in each biennium, in fact, financial provision was made by WHO for a session. However, the Committee had decided at its nineteenth session that in future it should meet only as necessary, and not on an annual routine basis, the Director-General having it within his discretion to decide when and where to convene each session as he considered it necessary. He assured the delegate of Chile that - in addition to the obligations under the International Health Regulations (1969) and distinct from those obligations - the question of reviewing the changing pattern of communicable diseases did receive the Organization's periodic attention. Furthermore, the medium-term programming up to the end of 1983 had been preceded by the type of review the delegate of Chile had in mind. In the programme budget for 1980-1981, provision was made for a meeting to review priority communicable diseases control programmes.

In connexion with the delegate of Niger's remarks about cerebrospinal meningitis, he could assure him that there was a good liaison with various centres, including the OCCGE, and that collaboration related to the outlining of new developments in diagnosis, therapy and prevention, through consultations and training meetings, would be maintained with his country and with others.

Regarding the United States delegate's reference to the control of nosocomial infections, he said that there was close collaboration with the Center for Disease Control in Atlanta. In the programme attempts were being made to highlight the concept of prevention and to promote techniques for better hospital and laboratory management, with emphasis on improved training programmes for nurses and other hospital staff.

In reply to the question from the delegate of France, as to whether the budget truly reflected the importance of the communicable diseases programme, it was fair to say that no budget would be adequate for so important and diversified a programme. However, by reformulating the programme around problem-solving and problem-oriented activities, and with the guidance of advisory groups, it had been possible to attract relatively large funds from other sources. That method had succeeded well in relation to priority programmes of technical cooperation, such as diarrhoeal disease control and the Expanded Programme on Immunization, and it was hoped to extend it to the prevention of blindness and acute respiratory infections.

In connexion with the delegate of Trinidad and Tobago's reference to safety measures in microbiology, he said that three courses on that relatively new subject were being held in the Region of the Americas, two were planned for 1982 in the South-East Asia Region, and there would be others.

He had been most interested in the recent BCG trial which the delegate of Poland had reported on, and which confirmed the recommendations of the ICMR/WHO Scientific Group and the WHO Study Group which had met after the BCG trials in India.1 Present evidence suggested

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that BCG did have the ability to protect the uninfected and the young, and explained why it formed part of the Expanded Programme on Immunization.

Dr ACUÑA (Regional Director for the Americas) said that it was difficult to answer directly what proportion of the budget was allocated to a given activity. To convey the picture in its totality, he needed first to provide the frame and the canvas; only then could the rest be sketched in. The frame and the canvas represented the infrastructure and the health services structure of a country as a whole, on the basis of which the regional office helped each country to draw up its programme.

In reply to the delegate of Chile he said that the extrabudgetary funds devoted to disease prevention and control in the Americas, up till April 1981, had amounted to US$ 24 503 000, or 13.5% of total allocations. It was worth noting that that was slightly below the authorized percentage for 1980-1981, which stood at 14.7%. However, he was hopeful that for the next biennium larger sums would be forthcoming, and that the percentage devoted to disease prevention and control could be raised.

He thanked the delegate of Trinidad and Tobago for her kind remarks on the epidemiological bulletins which reached her country from CAREC and PAHO. The value of the bulletins depended entirely on the accuracy and timeliness of the information they contained. He was pleased to note that the bulletins had acted as an incentive to some of the countries in the Region to issue similar bulletins of their own.

Dr HENDERSON (Director, Expanded Programme on Immunization) wished to make it clear that even if a comment failed to elicit a reply, it would nevertheless be taken into account in the implementation of the programme. The comment by the delegate of Nigeria in regard to the need for strengthening programme management applied equally well to many of the programmes in the developing world. Although WHO could be an active partner, it was essentially a national responsibility to overcome most of the problems described. The delegate of Greece had asked whether the protocols envisaged by WHO for the investigation of cases of poliomyelitis in persons who had received poliovirus vaccine would be similar to those used in the United States of America. The aim in the present case was to arrive at protocols which would be suitable for use in the developing countries so that simple methods could be used to determine whether the vaccine had lost its efficacy or whether the observed number of cases in immunized individuals was within the expected number. The protocols would therefore be less sophisticated than those used in the United States of America.

Replying to the delegate of the USSR, he said that a great deal of work was being done in all the regions to strengthen the quality control efforts of laboratories already in existence at regional level. It was hoped to supplement that by activities at global level in the form of certification of individual laboratories as being qualified to perform quality control tests at the global level. The programme, which it was hoped would attract UNDP support, would reach the active implementation stage in 1982. In regard to the link between the Expanded Programme on Immunization and primary health care, he said that if Member States failed to adopt the health for all strategy, the Expanded Programme on Immunization would be unlikely to succeed. The principal action in that Programme had to be concentrated at the national level and in fact two-thirds of the Programme's resources were expected to come from that level. Such resources were only likely to be provided by countries which had made an overall commitment to primary health care.

The programme was ready and willing to examine with India problems arising over the delivery of poliomyelitis vaccine in the country and to work for their solution.

The delegate of Sierra Leone had raised the question of varying coverage rates in different communities. WHO was certainly interested in working with individual countries to determine the reasons for the acceptance or non-acceptance of vaccines, but very often the problems related to specific issues in specific communities and no generalized approach was possible. Recently completed work in the Gambia had shown that many children in the programme in that country had received immunization because they had visited a health facility for a reason relating to illness. It was strongly recommended that illness should not be regarded as a contraindication to immunization unless the child was found to be gravely ill, especially in the developing countries where the risks of vaccine-preventable diseases far outweighed the risks of adverse reactions to vaccines associated with any illness which a child might have at the time of its visit to a medical facility. It was not yet clear how that point could best be got over to the medical profession as a whole in the developing world.

The problem of integrating schoolteachers, agricultural extension workers, etc. in the Expanded Programme on Immunization applied equally to primary health care in general and required a
creative and intensive effort on the part of all concerned. Replying to a remark by the delegate of the German Democratic Republic, he said that the European Region had contributed enormously to the programme with its experts and its expertise and an information system was being developed within the Region which should facilitate determination of what the appropriate budget level might be.

The currently used immunization cost figures, referred to by the delegate of Burundi, were US$ 3 per immunized child (gross costs), but it was certainly true that worldwide inflation had greatly altered the picture since the original estimate was made. It was also true that specific costing studies had revealed wide variations in the costs - from under US$ 2 to as much as US$ 10 - and the figure of US$ 3 per immunized child had been retained on the ground that it was generally accepted and understood. It might be altered later in the decade on the basis of further costing studies. The problem of achieving adequate individual coverage was one that was common to all immunization programmes and was normally only solved after 3-5 years of training, evaluation, retraining and re-evaluation.

He did not propose to comment on the cost-benefit ratio in relation to either mumps or rubella vaccines. National decision-makers should contact those authorities which could assist them in arriving at the relevant cost-benefit determination in regard to the individual vaccines, neither of which was included in the global Expanded Programme on Immunization.

A point arising from what the delegate of Belgium had said was whether there was a limit to the number of different vaccines that could be administered. No such limit was accepted by the Expanded Programme on Immunization. Whenever a country found a positive cost-benefit ratio in favour of a vaccine it should add that vaccine into its immunization programme.

WHO was in general very well satisfied with the assistance being received by Pakistan from bilateral and regional donors in regard to vaccine production. Methods for improving immunization coverage were being developed at national level and such work was extremely promising.

In regard to the question of oral or inactivated poliomyelitis vaccination raised by several delegations, the advent of new production methods had raised hopes that effective inactivated vaccines could be produced at costs which could be afforded in the developing world. At present, however, the costs of inactivated vaccine were high and the Expanded Programme on Immunization therefore recommended the continuing use of oral vaccine. In spite of evidence that it was less effective in the developing than in the developed countries, its efficacy rate was still 90% or above in the developing world. An active research programme, assisted in particular by the Government of the Netherlands, was attempting to define better the respective roles of oral and inactivated vaccines in the control of poliomyelitis. Interesting observations in the Middle East had revealed failures of both oral and inactivated vaccines, the causes of which had not yet been established.

**Malaria and other parasitic diseases (programme 4.1.2)**

**Vector biology and control (programme 4.1.8)**

Professor ÖZTÜRK (Turkey) said that malaria was a serious problem in Turkey, as evidenced by the epidemics of 1976, 1977 and 1978. The substantial international help accorded to Turkey had enabled the incidence of 115,000 in 1977 to be reduced to 29,000 in 1979 - a result that might be regarded as satisfactory in view of the difficulties encountered, although the threat of an epidemic was always there. The Ministry of Health and Social Assistance had decided that malaria control measures necessitated close coordination between the health services and other public services.

He announced that an international centre was to be opened during the next year, where students would receive practical training. The first group of students would be arriving in 1982, after attending a course on malaria in Italy.

Dr SADRIZADEH (Iran) said that malaria was under effective control in most areas in his country. In the south, where the problem of vector resistance to insecticides was serious, the introduction of the insecticide propoxur and close integration with the health services had been helpful in bringing the disease under control. Nevertheless, the risk of malaria was always present, both in areas of vector resistance to that insecticide and in areas of western Iran which had been subject to military action.

He was particularly concerned about finding a replacement for insecticides such as propoxur, if resistance developed. Fenitrothion had been tried but it had proved too toxic to spraying operatives due to the shortage of water for washing. Information would be welcome on the methods to be used to counter resistance, the time and equipment required.
Professor TUCHINDA (Thailand) said that the 1979-1980 season saw the simultaneous occurrence of the mass migration of refugees from Democratic Kampuchea into Thailand and increasing agricultural and gem-mining activities along the border, at which time failures of the successful therapeutic regime of pyrimethamine-sulfadoxine against Plasmodium falciparum began to be observed.

After discussion at the national malaria conference in 1980, a plan to deal with the situation at the border between Thailand and Democratic Kampuchea was formulated which was submitted for comment to the Regional Office and to WHO headquarters. The plan made provision for greatly increased numbers of supervisory personnel, intensified antivector measures and the introduction of a new antimalarial, mefloquine. It was hoped that vigorous implementation of the plan would prevent the spread of pyrimethamine-sulfadoxine resistant malaria to other parts of the country and to neighbouring countries.

Professor JAKOVLJEVIĆ (Yugoslavia) said that malaria still represented an extremely serious problem with an incalculably adverse effect on the health of populations. Antimalarial measures necessitated in the first place a political decision to implement an appropriate programme with sufficient priority, after which there were technical and administrative problems to be solved. Although antimalarial programmes obviously came under the head of primary health care, some discussion of the form of integration would be required, in order to ensure that antimalarial activities were not prejudiced thereby. He hoped that the study group to be convened in 1982 would concern itself with that aspect. Antimalarial cooperation had been very well illustrated by the Seventh Asian Malaria Conference, which had provided useful guidelines for the development of national malaria programmes. His delegation fully supported the need for constant vigilance expressed by the Executive Board, to prevent the reintroduction and resurgence of malaria in previously free areas.

Dr CANDAU (Brazil) said that his country continued to be seriously preoccupied by the possibility of reinfection by Aedes aegypti and the consequent threat of yellow fever and dengue fever; increased surveillance and control activities were therefore being carried out throughout the country. An even greater reason for concern, however, was the endemic jungle yellow fever already present in the country and the progressively greater proximity of the areas in which it occurred and where A. aegypti already existed.

The vastness of his country, the length of its coasts and frontiers and the intensification of traffic and travel, both international and within the country, represented a constant threat of reinfection with A. aegypti. The existence of jungle yellow fever in other South American countries as well and the presence of A. aegypti in some of them constituted a regional problem which required an intercountry coordination of efforts.

A hundred years ago anxiety had been expressed that yellow fever might be spreading from south to north. Brazil was preoccupied at the present time about a movement of A. aegypti and of yellow fever in a southward direction. Even countries that were not at risk should be prepared to cooperate in a joint programme to eradicate A. aegypti from the Americas.

Dr BAJAJ (India) said that increasing oil and other prices had necessitated modification of his country's antimalarial plan. A further problem that had arisen was the resistance of the parasite to malarial drugs. In spite of WHO's collaboration with the national authorities, reinfection remained a serious problem. It had also been found that mosquitoes were becoming resistant to insecticides, a problem which affected other diseases also.

Dr HOPKINS (United States of America) said that his delegation accepted and approved the objectives and approaches set out in the proposed programme budget. He wished, however, to emphasize in particular the urgency of the situation in regard to malaria in South-East Asia, where large population movements in 1979 and 1980 had exacerbated the problem by introducing a multiple-resistance strain of Plasmodium falciparum, a problem which merited greater attention from the world community before those strains became more widely disseminated. The International Drinking Water and Sanitation Decade presented an unusual opportunity to achieve greater control of guinea-worm disease.

Dr ODDO (Italy) said that the publication by WHO of "Information on Malaria Risk for International Travellers" had been of great practical value and the Ministry of Health had circulated about 50 000 copies to health authorities and travel agents. Nevertheless, even more complete and reliable information would be useful both to the countries in which malaria remained endemic and to visitors to them, so that antimalarial plans could be updated and the
reintroduction of malaria into malaria-free countries prevented. The progressive spread of the resistance of *P. falciparum* was a disquieting problem and the efforts already made to promote intercountry and interregional coordination should be intensified.

The extraordinary increase in air traffic and in the number of international travellers, the opening of new international highways, the intensification of demographic movements, the exchange of populations between endemic and nonendemic areas were so many factors favouring the spread or reintroduction of a disease that seemed uncontrollable in the short term.

His country, which had effectively eradicated malaria, was still highly vulnerable and viewed the progressive deterioration of the worldwide malaria situation with grave concern. In the light of this, it had played a leading part in the field training of technical personnel in the conception, planning, application and evaluation of antimalarial programmes, based on the new global strategy guidelines.

The Ministry of Health, in conjunction with the Turkish Ministry of Health, and with the support of the Regional Office for Europe and headquarters, was planning an English-language course on malaria starting in February 1982, for a small group of doctors, entomologists, and sanitary engineers, followed by periods of training in the field in south-eastern Turkey. He hoped that Italy's example would be followed by other Member States in the European Region with suitable teaching staffs and experience, since there was a critical shortage of specific knowledge in that particular complex and difficult field of human pathology.

Dr Hasan (Pakistan) said that the endemic countries, of which his own was one, had already given malaria high priority, but their programmes had not worked as well as could be expected, although not for any lack of training of the health workers involved or of political commitment on the part of national leaders. Among the reasons, operating singly or in combination, were changes in mosquito response to insecticides and in their bionomy, man-made changes in the course of development that created new breeding-places, and lack of resources that made it impossible to provide the health workers involved with a career structure offering the necessary incentives for the careful performance of the difficult work involved.

His delegation had some reservations about the integration of antimalaria activities in primary health care, fearing that they might be overshadowed by other, easier activities, such as those under the Expanded Programme on Immunization, or the treatment of simple ailments. It therefore welcomed the recognition, in paragraph 5 under programme 4.1.2, of the need for further study.

Because so many factors were involved in malaria control, his delegation considered that the proposed action programme should be accompanied by intensified research promotion for the development of a vaccine. Examination of the proposals under research promotion and development (major programme 2.4) and immunology (programme 4.2.5) had failed to reveal any such intention and his delegation hoped that, at least under the Special Programme for Research and Training in Tropical Diseases (programme 4.1.6), the matter would be kept in the foreground of attention.

Malaria, as one of the main causes of morbidity and mortality in many parts of the world, had great economic impact but efforts to control it had often engendered discouragement in countries which had embarked on eradication and then had to lower their sights and envisage control, with varying success - even at that level - and no clear prospects of greater success in the future. For those reasons, his delegation hoped that WHO would give more attention to the malaria action programme in all its aspects.

Professor Spies (German Democratic Republic) expressed his appreciation of the formulation of the programme but noted much discussion throughout the programme narrative on the pros and cons of various strategies and approaches. His delegation considered that the whole tenor of the programme militated in favour of the primary health care approach which the Organization should encourage in the light of its experience that the problem could not be solved by drugs or by technology alone. There had been frank recognition that unsuccessful programmes owed their failure to lack of continuity, poor management and lack of follow-up, which had led to a resurgence of the disease accompanied by new difficulties in the scientific and technological fields. Experience in Europe and Asia had shown that a multisectoral approach combined with full community involvement and appropriate technology could succeed with malaria as with some other communicable diseases.

In preparation for long-term malaria control programmes, the development of health infrastructure should take precedence over field research on the intensity of endemo-epidemicity (paragraph 8 of the narrative). It was easy to recognize the dimensions of the problem accurately enough; on the other hand, without development of the infrastructures, left
Weaken from colonialism as they were throughout Africa in particular, in parallel with the spread of scientific and technological expertise and without the development of the general lines of a suitable division of activities between the community and the health services, success could not be expected.

Despite lack of direct experience with the malaria problem in the field, his Government was prepared to take part in research on the biological aspects of the disease, its pathology, chemotherapy and so on.

As regards the presentation of the programme budget, he would like to know what were the differences in the Organization's strategies as to malaria and other parasitic diseases, vector biology and control and the Special Programme for Research and Training in Tropical Diseases (programmes 4.1.2, 4.1.8 and 4.1.6 respectively) that justified the separate presentation of activities that belonged and, he hoped, was implemented together.

Dr M'DAHOMA SOILIHI (Comoros) appealed for the assistance of the international community in undertaking a malaria eradication campaign which in his country, consisting of four islands, had good prospects of success. The disease had already been eradicated from certain islands of the Indian Ocean, so that the continued hyperendemicity of the Comoros was a constant danger. It had been estimated that such a campaign would cost US$ 10 million over 10 years, of which WHO could provide $ 400 000; the remainder had still to be found. It had been estimated that every member of the Comorian working population of 200 000 lost 12 days' work every year, so that, at a conservative estimate of one dollar per day, the country - a potential tourist paradise - was losing $ 2.4 million a year, or nearly three times the sum required for malaria eradication. The cost-benefit ratio was therefore very positive.

As regards immunization against malaria, he would like to know the prospects for a vaccine becoming available in the near future and why research on the subject did not appear among the many immunological research activities that were included in the programme budget.

Dr ISLAM (Saudi Arabia) endorsed the establishment of the malaria action programme at global level (paragraph 2 of the narrative) and subscribed to the primary health care approach and integration of the programme into that of the general health services. That integration should be gradual in order to permit the fulfilment of certain prerequisites which included strengthening of the health infrastructure and training of health workers in malaria diagnosis, treatment and control. In his country, where the change from a vertical to a horizontal programme had been effected (paragraph 5 of the narrative) political commitment had proved rather less of a problem than community involvement. Planning and evaluation were carried out jointly on a biannual basis by the central, regional and local health authorities. Activities were implemented at the local health level, with the participation of health centres and local hospitals. Health education of the public had been emphasized and community participation in the vector control activities had been encouraged. In order to ensure a multisectoral approach a cooperative committee had been established on which the Ministries of Health, Agriculture and Water, and Municipal and Rural Affairs were represented. Training of staff at all levels and particularly of physicians, laboratory technicians and health educators in all aspects of the malaria problem had been found to be of major importance. Applied field research included regular endemicity surveys and, during the current year, there was to be a nationwide health infrastructure survey. Precautions taken to prevent the importation of resistant falciparum malaria included routine blood tests for immigrant workers from countries where that form of the disease was known to exist and a survey to be conducted among the pilgrims during the 1981 pilgrimage. Intercountry cooperation where areas of endemicity existed along the frontiers should not be neglected and his Government was cooperating in vector control and treatment activities with the Government of Yemen along their common border. The recommendations of the 1982 study group and the 1983 scientific group (paragraphs 10 and 11 of the narrative) were awaited with interest.

Both the urinary and intestinal forms of schistosomiasis, distributed as the oasis or dry valley types, were to be found in his country. The dosage forms for the new antischistosomal drugs mentioned in paragraph 24 of the programme narrative had been established and field research on dosages for Saudi Arabian populations was in progress. The new drugs would probably be introduced into mass campaigns in the next few months. Thus oral treatment was replacing treatment by injection. While the major thrust in schistosomiasis control was to be on chemotherapy (paragraph 16 of the narrative), snail control should also receive attention. He had found no mention in the programme statement of snail control research, despite its importance. A field research project on biological control was to be conducted jointly with the Government of Denmark in his country during 1981. Training should be a major thrust in the Organization's schistosomiasis programme also.
Leishmaniasis was becoming more and more of a public health problem. The cutaneous form was being found even among foreign residents in the endemic foci and some cases of the visceral form were starting to appear. Significantly, the cessation of spraying activities for malaria vector control had been followed by an increase in the number of cases of cutaneous leishmaniasis. The approach adopted included the establishment of a control unit and the carrying out of spot surveys all over the country. A conference to sensitize the medical profession to the problem had been held in 1980 with participants from the three medical schools, other countries and WHO. Health education of the public had begun in order to minimize contact with the vector. In research, a cooperative effort, involving the Ministry of Health, medical schools and the National Centre for Science and Technology, was being made to reveal as many as possible of the unknown factors concerning the epidemiology, immunology, diagnostic methods, therapy and control of the disease in Saudi Arabia.

Dr PARADE (France) expressed his pleasure in the conviction shown in the statement of the political and administrative approach to the malaria action programme (paragraphs 4, 5 and 6 of the narrative). He agreed that political commitment and community involvement were nearly as important for success as the technical content of antimalaria programmes. He informed the Committee that a training course on malaria similar to the one mentioned by the delegate of Italy, but for French-speaking participants, was planned at the University of Aix-Marseilles.

He particularly welcomed the continuation of the Organization's well planned and appropriate programme in African trypanosomiasis (paragraph 28 of the narrative) at a time when only 6 of the 45 million people exposed to the disease were under surveillance. That programme could well be intensified in view of the spectacular results that could be expected.

Professor LUNENFELD (Israel) expressed his delegation's appreciation of the clarity of the programme presentation.

His delegation particularly welcomed the almost three-fold increase in the total provision for vector biology and control in the Eastern Mediterranean Region.

The health hazards of the environment and workplace constituted important problems of modern society. Complex chemical technology and the production of chemicals and their use in agriculture and industry called for greater public health emphasis on those fields.

The epidemiology of environmental health hazards called for the use of new skills and information to resolve the conflict between the demands of modern economies, technology and rapid transport and those of health concerns. Vigilant and up-to-date public health practice was essential in such conditions.

Despite major advances over the years in water, sewage, garbage and vector control and in food safety, there was room for improvement in his country, as was also the case with the control of air pollution, chemicals in the environment and exposure to radiation and noise and other environmental health issues requiring supervision and control by the public and private sectors. There was also a growing need for surveillance, education, regulatory action and prevention in relation to the health hazards implicit in the development of agriculture and of the plastics, building materials and other industries.

His delegation would also welcome research on the potential insect vectors and small-mammal reservoirs of Rift Valley fever to determine their role in the maintenance and transmission of the disease with a view to its control. He would like to know whether such research was planned and, if so, whether the financial provision was considered adequate.

Dr LADNYI (Assistant Director-General) thanked the speakers for their comments on the programme. He gave an assurance that, over and above the amounts indicated in the programme budget, the Director-General and the Regional Directors would mobilize additional funds for the control of malaria and parasitic diseases and for vector control, as in the past. The question of scientific research on malaria and other tropical diseases would be discussed later under programme 4.1.6 (Special Programme for Research and Training in Tropical Diseases).

Malaria remained a problem in most of the countries of Asia, Africa and South America. The Director-General and the Secretariat were doing their utmost to promote disease control programmes in countries but they were aware that the technical, economic and other measures currently feasible fell far short of what was required to ensure success in the near future. However, results from the Special Programme for Research and Training in Tropical Diseases gave grounds for hope of finding new weapons for the war against malaria, other parasitic diseases and vectors.
There had been comment on WHO's administrative structure and the fact that malaria control, malaria research and vector control were the responsibility of three separate divisions at headquarters, but he was convinced that this arrangement in no way contributed to difficulties in solving the malaria problem in the field. If the division concerned with vector control dealt only with malaria, then it would of course form part of the Malaria Action Programme, but that was not the case since vectors played a leading role in the transmission not only of malaria but also of a number of other diseases, bacterial and viral.

Dr ACUNA (Regional Director for the Americas), replying to the delegate of Brazil, said that the problem of the proliferation of Aedes aegypti and the danger it represented for the spread of yellow fever, dengue and similar diseases, had been debated almost yearly in the Regional Committee for the Americas and a very large number of resolutions had been adopted stressing the importance of the eradication of that vector. Acting on those resolutions many governments in the Region, especially those in the Caribbean, had made tremendous efforts at very high cost in achieving and maintaining the eradication of that vector from considerable areas of their territories. More recently, however, a few countries had slackened their efforts because they considered them unproductive for the expense involved, until a concerted simultaneous effort could be decided upon by all countries of the continent. That was the situation. It had to be recognized, however, that cost-benefit studies had shown that, no doubt in the more developed countries, the presence of A. aegypti was not unduly dangerous and small outbreaks of disease could be easily contained and eliminated, as had recently been the case in Trinidad and Tobago. But that was not true of less developed countries, or in remote areas, or in regions climatically more conducive to the establishment of the vector, and disease outbreaks continued to hamper the development of nascent and much-needed industries, particularly tourism, in the Region. The experts in the Secretariat had no further suggestions to offer, except to recall that a group of experts that had met in 1980 had made specific recommendations regarding alternative measures, while continuing to stress the importance of eradication. Those measures included the holding of training courses to orient national personnel in eradication and control. Thus activities seemed to have reached an impasse. Efforts had been made to establish stocks of yellow fever vaccine for use when jungle yellow fever showed signs of invading urban areas.

In view of that situation, and the current lack of political will, modest provision had been made in the regional budget for efforts to promote government interest and train personnel in the hope of reviving political commitment to the eradication of A. aegypti from the Americas.

Dr LEPES (Director, Malaria Action Programme) said that the points raised during the discussion had been noted.

The structural organization of malaria control within health services was a subject of continuing debate. The Director-General's report on malaria control strategy mentioned in paragraph 4 of the narrative emphasized, inter alia, flexibility and the epidemiological approach. What the structure would be within primary health care - whether vertical or horizontal - would therefore obviously depend on the intensity of the programme planned and so was necessarily a matter for each country to decide.

Where the implementation of malaria control strategy was concerned, there were in fact four types of activities that should be carried out practically simultaneously: control of epidemics, preparation of long-term control programmes, training, and research. Clearly research required well-trained personnel. At the same time it was very necessary for the preparation of the long-term programme. It was thus at the very basis of the future success of the programme. But each country would have to decide for itself which, among the few effective measures for malaria control, were suitable for its own special situation, where vector control measures were concerned. As regards drug resistance, the Regional Directors for the Americas, South-East Asia and the Western Pacific had taken the initiative in determining how the problem might be dealt with and they advocated the training of nationals in drug monitoring and testing, and epidemiological evaluation. There was shortly to be a meeting involving the Regional Offices for South-East Asia and the Western Pacific, and malaria experts from headquarters to examine the progress made by research so far and decide what the next steps should be. It likewise seemed difficult to predict the most effective drug combinations in the present stage of technology for the identification of strains of P. falciparum. Again countries would have to decide for themselves between the relatively few possibilities open to them.
He acknowledged with thanks the offers made in the course of the discussion regarding training facilities for the development of national expertise which was very important for future activities in the control of communicable diseases, including malaria.

He assured delegates who had inquired about progress in the development of a malaria vaccine that the subject was being pursued with great intensity; it would no doubt come up for discussion again when the Committee considered programme 4.1.6 (Special Programme for Research and Training in Tropical Diseases). Every avenue open at the stage reached in science and technology in the knowledge of the development of plasmodia was being explored, but at present no immunizing agent was ready for large-scale field trials. In the light of experience of what could be expected from science and technology at the moment, such an immunizing agent was unlikely to prove a panacea and other measures would remain necessary.

Dr GRATZ (Director, Division of Vector Biology and Control), replying to the delegates of India and Iran on alternative insecticides for use against the prime malaria vector when resistance developed, said that there were currently 51 anopheles and 42 culicine vectors resistant to one or more insecticides.

The WHO programme for the evaluation and testing of new insecticides had examined more than 2000 different compounds for control potential. Pirimiphos-methyl and bendiocar were two that had already been tested in Iran, and both would be suitable alternatives to propoxur should resistance develop. However, particularly as the malaria vector in parts of Iran and parts of India - especially the urban areas - was Anopheles stephensi, it should be emphasized that, as with many other vectors, methods other than residual spraying were also effective; integrated control might include the use of biological agents, which it was hoped would be available in commerce in the near future - perhaps only a matter of months - and new methods of using larvivorous fish, and should also emphasize community participation and sanitation.

Adding to what the Regional Director for the Americas had said, he confirmed that A. aegypti bred in the Americas only in man-made habitats, and the greatest hope for its control was community participation.

In the period 1981-1983 WHO would be convening one expert committee on biological control, another on new approaches to vector control, an informal consultation on the use of fish, and a seminar on integrated control methods; progress along other lines besides alternative insecticide development was therefore being followed up.

There was heavy emphasis on training, and master of science courses were being organized in collaboration with the Special Programme for Research and Training in Tropical Diseases, as well as medical entomology training for vector control in order to make good the serious shortage of that essential category of health worker in endemic countries.

He assured the delegate of Israel that the development of Rift Valley fever was being followed with great attention, as it represented a considerable threat in the Eastern Mediterranean. WHO would be organizing a meeting in June and July 1981 to consider zoonotic, vector biology and immunological aspects of the problem.

Dr DAVIS (Director, Parasitic Diseases Programme) said that global estimates of the prevalence of parasitic diseases were so staggering that it was sometimes difficult to comprehend the statistics; reports quoted 200 million cases of schistosomiasis, with 500 million exposed to infection; 200 million filarial infections; one third of the world's population with ascariasis, a quarter with hookworm; 400 000 new cases of leishmaniasis a year; 10 million with Chagas' disease in Latin America; and 200 endemic foci of trypanosomiasis in Africa. In epidemiological terms those infections were advancing, not receding - in spite of technical progress - owing to the population explosion and unchanging socioeconomic and environmental circumstances.

The outlook was not one of unrelieved gloom, however, as technical advances in the last 15 years had made possible a conceptual framework for measures aimed at parasitic diseases, splitting them into two groups: those against which advances in chemotherapy had made a primary health care approach promising, including gastrointestinal, protozoal and helminthic infections and schistosomiasis; and diseases such as filariasis, trypanosomiasis and leishmaniasis, where the problems were largely a matter for continuing research. Also amenable to the primary health care approach was the detection of African trypanosomiasis using the test kits for diagnosis and treatment originated by WHO.

The delegate of Saudi Arabia had mentioned the new drugs for the treatment of schistosomiasis. A primary health care approach and adequate delivery systems would do much to alleviate the morbidity from infection in that country. Snail control was the subject of continuing research, and two chemical agents offered considerable promise,
but conclusive results could not be expected for three or four years; biological control was still in the experimental stages, and although some lines of research were already hopeful field testing would take two or three years.

Leishmaniasis was a neglected disease, and it was encouraging to find countries beginning to recognize its importance as an increasing public health problem. WHO was organizing the first expert committee on the subject in 1982 to reactivate interest and, he hoped, research and control work.

France's encouragement of the trypanosomiasis test kit programme was appreciated. It was planned to distribute the diagnostic and therapeutic kits in endemic foci of African trypanosomiasis and to run parallel training courses for a primary health care approach to surveillance, which was an essential aspect of control of the disease.

In connexion with the delegate of Niger's reference earlier in the meeting to a centre for studies of schistosomiasis and cerebrospinal meningitis, he said that WHO would be very willing to discuss questions of common interest and areas of expertise with Niger. He assured the delegate that his concern about the need for a horizontal approach in the Onchocerciasis Control Programme was being discussed both at the technical level and by the Independent Commission.

Finally, he fully agreed with the delegate of the United States of America who had emphasized the importance of schistosomiasis control in view of advances in chemotherapy.

Bacterial, viral and mycotic diseases (programme 4.1.3)

Prevention of blindness (programme 4.1.7)

Dr BAJAJ (India) expressed his country's support for the diarrhoeal diseases programme, and said that the oral rehydration salts were so effective that their administration had been entrusted to community health workers at the peripheral level, with good results.

India was currently testing combined drug use in chemotherapy of tuberculosis in order to shorten the duration of treatment, also with good results. The India leprosy control programme was fully centralized.

The production of vaccine to combat the epidemics of Japanese B encephalitis, which usually occurred after heavy rains and the accelerated breeding of the mosquito, was proceeding satisfactorily.

Professor SPIES (German Democratic Republic) said that diarrhoeal diseases control was a priority not only for developing countries but throughout the world, and that environmental measures could be coordinated with those successfully applied against other diseases. It should be borne in mind that a considerable proportion of cases in children were of viral origin; attention was currently focused on rotavirus, and much interesting research remained to be done on the relation of such viral causes to bacteriological and ecological aspects of the diseases, as also on immunological aspects such as those related to the transfer of maternal antibodies through breast-feeding.

But in order to understand WHO's approach to those and other diseases it was necessary to consider the overall problems associated with resistance and with biological control in the environment, especially in relation to resistance to antibiotics in certain bacteria. Research in plasmids and modern techniques in surveillance of resistance should be included in the WHO programme for the coming years.

Countries were also looking to WHO for evidence on new techniques for vaccine production following developments in genetic engineering, such as the use of nonpathogenic germs to produce proteins, nucleic acids and other compounds for therapeutic or prophylactic purposes. Safety and ethical considerations, and the high standards that had to be observed in those respects, had so far received considerable attention, but the answer to the problem of the general principle governing application of findings could only be given by WHO.

He was not very optimistic about hepatitis prophylaxis, as the development of one kind of vaccine, which was so far not applicable in the mainstream of human medical practice, could not be considered a solution to the problem, especially when hepatitis A and hepatitis non A/non B had still to be tackled; although much progress had been made, many questions of epidemiology and pathogenicity of hepatitis of viral origin remained open.

Dr KPOSSA-MAMADOU (Central African Republic) said that, particularly after the admirably clear introduction by the representative of the Executive Board, and with due respect to those who had tried to keep to the main lines of the debate, the discussions had become somewhat fragmentary and repetitive. He felt that a global debate by major programme would have
produced a single, if longer, intervention from each delegation, which would have resulted in a shorter and more comprehensive discussion overall. For example, the special problems of Africa had been drowned among considerations which did not take sufficient account of the primary need for effective measures of prevention of parasitic diseases, including vaccine development and biological control of anophele mosquitos.

He was concerned lest in the current debate measles should be forgotten, since it was a serious threat in African and other developing countries. In particular he noted that the recommended age for vaccination of infants was 9 months, while many serious cases developed in the fifth or sixth month.

Dr HYZLER (United Kingdom of Great Britain and Northern Ireland), referring to the mention, in paragraph 16 (page 157 of the programme budget), of the high mortality rates resulting from acute infections of the lower respiratory tract (more than two million deaths a year) and affecting particularly children, among whom they accounted for 20% of all deaths, said that those diseases were also associated with subsequent respiratory disease morbidity in adults. The regular budget allocation under project BVM 061 seemed rather small, and he invited the Director-General to consider supplementing those activities from his Development Programme.

Dr FEDOROV (Union of Soviet Socialist Republics) drew attention to the urgent need to develop the blindness prevention programme if the lot of the world's 40 million blind, most of whom lived in the developing countries, was to be significantly improved. Otherwise the figure might, without effective measures, double by the year 2000.

Dr GURMUKH SINGH (Malaysia), noting that the proposed programme covered a very wide range of activities - from broad aims such as leprosy and plague control to specific measures such as a review of minimum standards in the control of sexually transmitted diseases among seafarers (which dated back to 1924) - expressed concern lest sight should be lost of the twin threats presented by diarrhoeal diseases and acute infections of the lower respiratory tract, which together accounted for 40% of global child mortality.

The failure to control bronchopneumonia was particularly alarming. He urged that priority be given to measures to combat those major groups of diseases in 1982-1983, with more funds for research and control, especially for developing countries, where the rates were 30 to 70 times higher than in developed countries.

Dr PARADE (France) said that during a recent technical conference on leprosy in Africa he had felt there to be uncertainty about the attitude to be taken in face of the appearance of resistance to dapsone. In cases of multibacillary infection it would seem indispensable to combine at least two drugs in treatment, of which one - rifampicin, if possible - should be used at the beginning of treatment or intermittently. Some experts had contested that view on the grounds that rifampicin should be used only against tuberculosis. He requested that the matter should be elucidated and that treatment schedules be presented which suited the correct situation.

Referring to programme 4.1.7 (Prevention of blindness), he said that onchocerciasis control was a most important target but one difficult to attain; he favoured the application of the strategy that had stood the test of the Onchocerciasis Control Programme in the Volta River Basin, where the analysis of results after five years showed a fall in prevalence, reduced infection and complications, and a particularly significant drop in the number of cases of blindness.

Dr HOPKINS (United States of America) said that his delegation advocated greater emphasis on applied, or operational, research in diarrhoeal diseases directed at demonstration and development of strategies for implementation, as well as basic research. Since Neisseria meningitidis was the most important agent of bacterial meningitis in the developing world, control efforts should be concentrated on that agent.

He added his delegation's support for the programme to combat acute respiratory infections, and urged the Secretariat to publish periodically current information on endemic treponematoses in the Weekly epidemiological record in order to promote their surveillance, in accordance with resolution WHA31.58.

Dr TAMMAM (Egypt), regarding programme 4.1.7 on the prevention of blindness, said that there was a close connexion between that objective and primary health care. Common eye diseases, for example, could be detected at an early stage; simple conditions could be treated; serious cases could be referred to specialists. The two conditions necessary were the training of primary health workers and the preparation of an appropriate manual for them.
His delegation had noted with satisfaction the recognition given in the programme budget to the definition of blindness on which estimates of the number of blind people was based, and considered it an improvement on the programme budget presented in 1979.

He hoped it would be possible to review the position regarding trachoma, as complications were becoming less common and less severe. Increasingly common causes of blindness nowadays were work and traffic accidents, as well as complications arising from diseases such as diabetes. As a result the pattern of the causation of blindness was evolving. For example, it was now becoming difficult to find cases in Egypt of corneal ulceration caused by trachoma or bacterial infection or of dendritic keratitis, but there was no difficulty in finding cases of diabetic retinopathy or of detachment of the retina. The list of common causes of blindness needed to be reviewed.

Dr CHANG (Republic of Korea) said that viral haemorrhagic fever, which had first been recorded in his country in the early 1950s among military personnel having just completed field training in limited mountain areas, had since gradually increased, and occurred sporadically throughout the Republic, annual numbers of cases reaching 100. Farmers were most affected, especially in the early summer and autumn when they were busiest. It had thus become one of the most serious infectious diseases. The virus had been isolated by Professor Lee of Seoul National University in 1979 and named Han Tan virus. Research including immunology was continuing, but so far, in spite of great hopes of a breakthrough, no effective vaccine had been developed and modes of transmission were still unclear. Given the similar pattern of spread in several countries, and considering the high mortality, his delegation requested that WHO should become strongly involved in research and that all possible resources should be mobilized to develop effective prevention and control.

The meeting rose at 19h30.
ELEVENTH MEETING

Tuesday, 19 May 1981, at 8h30

Chairman: Dr J. ROGOWSKI (Poland)

PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA29.47, WHA33.17, para. 4(1) and WHA33.24, para. 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2 (continued)


Communicable disease prevention and control (major programme 4.1) (continued)

Bacterial, viral and mycotic diseases (programme 4.1.3) (continued)

Prevention of blindness (programme 4.1.7) (continued)

Professor AYRES (Portugal) said that Portugal attached great importance to zoonoses control; the incidence of zoonoses had increased in many parts of the world, and they had serious consequences for public health and the economy. Portugal had been one of the first countries to participate in the UNDP/WHO Mediterranean Zoonoses Control Programme and her Government gave financial and technical support to the Programme and its Centre in Athens with regard to zoonoses surveillance and control in general, but particularly concerning food hygiene problems.

Animal rabies had been eradicated from Portugal in the early 1960s, thus demonstrating that any country in southern Europe and the Mediterranean area, even one with modest resources, could achieve similar results, provided there were political will, expertise and community participation. Portugal made its technical expertise and knowledge available to other countries participating in the programme, in connexion not only with the elimination of canine rabies but also the control and surveillance of other zoonoses. She expressed satisfaction with the efforts in the field of veterinary public health both at headquarters and in the European and Eastern Mediterranean Regions, as well as in the Mediterranean Zoonoses Control Programme and at the Athens centre, and hoped that it might be possible not only to continue but to increase support for that work.

Turning to the problem of viral diseases, she said that Portugal gave high priority to their study and control. In recent years it had succeeded in controlling some diseases; surveillance systems had been implemented and rapid laboratory techniques developed. Portugal wished to express its appreciation for the assistance provided by WHO, particularly through technical advice and the supply of reagents.

Dr BEAUSOLEIL (Ghana) said that in areas in West Africa where meningitis occurred sporadically or in epidemic form treatment was often complicated by the fact that there were no facilities for determining the causative organism. Its identification was essential because, as was well-known, the treatment of meningitis varied according to the causative organism. It was therefore interesting to learn of the development of a rapid technique to be carried out by laboratory technicians, and he urged headquarters and the African Regional Office to organize courses in the use of the new technique for countries in areas where meningitis was a problem.

Dr BULLA (Romania) expressed his delegation's satisfaction at the intensification of WHO's activities in the field of rapid diagnostic techniques for viral and bacterial infections. The results of recent studies had been very valuable, particularly in the fields
of immunofluorescence, counter-immunoelectrophoresis, radio-immunoassay and enzyme-linked immunosorbent antibody assays. While recognizing that rapidity was a prerequisite for any technique to be used for primary health care, he emphasized the importance of also taking into account the ability of health personnel to apply the technique, and the cost-effectiveness aspect. The only solution was appropriate operational research. A comparison could be made of the use of the new rapid diagnostic techniques under everyday conditions and the so-called "decision trees" based on signs and symptoms. Rapid diagnostic techniques should continue to be tested under different socioeconomic conditions. He was aware that WHO had already commenced such studies, and in that connexion he endorsed the proposals made by the delegates of the USSR, the United States of America, and Malaysia.

Referring to the pragmatic approach to drug resistance by the immediate use of a combination of two or three drugs to treat various communicable diseases subject to increasing drug resistance, he said that careful cost-effectiveness studies should be carried out. In the case of tuberculosis, and recently leprosy as well, such studies seemed to support the use of drug combinations.

Regarding the prevention of blindness (programme 4.1.7), he said that, although it had been rational to elaborate at first a programme directed towards preventing blindness caused by trachoma, onchocerciasis and xerophthalmia, it was now possible to include the promotion of eye health and eye care - a development which his delegation strongly supported.

Dr QUAMINA (Trinidad and Tobago) expressed satisfaction with the budgetary allocations under the bacterial, viral and mycotic diseases programme, particularly for the Region of the Americas. The highest infant mortality rate in Trinidad and Tobago was for diarrhoeal diseases, and a research project was being carried out to determine the educational techniques needed to teach health personnel and mothers the use of oral rehydration therapy. The use of oral rehydration fluids had transferred the treatment of diarrhoeal diseases from the secondary to the primary health care level.

She had listened with interest to the delegate of Brazil's statement on Aedes aegypti, as well as the comprehensive statement by the Regional Director for the Americas. Trinidad and Tobago was especially interested in the natural history of the yellow fever virus, with particular reference to possible reservoirs during inter-epidemic periods. Studies had been facilitated by the successful utilization at the Caribbean Epidemiology Centre of techniques of virus culture using the mosquito's cell line - a technique that could also be used in diagnosing dengue fever. Assistance in funding had been provided by the International Development Research Centre in Canada.

Referring to programmes on leprosy and sexually transmitted diseases, she said that, while giving wholehearted support to primary health care, at the present time Trinidad and Tobago found it convenient and efficient to retain them as vertical programmes not integrated into the primary health care system, although perhaps at a later stage they might be integrated.

Dr WILLIAMS (Sierra Leone) said that there was a fairly high incidence of sexually transmitted diseases among the school population in Sierra Leone. One solution to the problem was sex education in schools and she asked whether WHO could assist by undertaking a study to determine the best method of introducing the subject in the curriculum of teacher training colleges and schools. There were not enough health workers to visit all the schools and colleges, and Sierra Leone was finding the problem difficult to solve.

Sierra Leone, which had a quite successful leprosy control programme, felt that an integrated leprosy and tuberculosis control programme would be beneficial. It would be interesting to have WHO's views on the matter, as well as assistance in effecting integration.

Dr BAJAJ (India) said that there was an active programme on blindness in India. Regarding prevention, activities were concentrated mainly on schoolchildren with nutritional deficiencies, and good results had been obtained. The "camp approach" was used successfully for the treatment of blindness. Mobile vans with surgeons and ophthalmic assistants visited rural areas to treat the population at the periphery. India's experience in the field could perhaps be of interest to other developing countries.

Dr BORGÓÑO (Chile) noted with satisfaction the structural changes made in the diarrhoeal diseases control programme to include UNICEF, UNDP and other donors of extrabudgetary funds. That would no doubt allow the important control and research activities of the programme to be expanded.
Chile attached particular importance to the problem of acute respiratory infections, especially those of viral origin. He asked what stage had been reached in the development of rapid diagnostic laboratory techniques that could be used at the primary health care level. From the epidemiological point of view, in particular, it was necessary to determine the etiology accurately.

Dr LADNYI (Assistant Director-General) thanked delegates for their valuable comments, which would be taken into consideration. As the discussion had shown, the programmes concerned called for constant attention at all levels; changes were always taking place in the socio-demographic, socioeconomic and epidemiological situations. For instance, the bases for tuberculosis prophylaxis were well known, but it remained necessary to formulate new approaches and make new recommendations for health workers in the field.

He urged delegates who wished to have further information on specific aspects of communicable diseases to contact the directors of the divisions concerned.

Dr ZAHRA (Director, Division of Communicable Diseases) thanked delegates for their constructive suggestions on the important and extensive programme on bacterial, viral and mycotic diseases, which were responsible for the high case fatality and morbidity rates, particularly among children and the elderly, in developing and developed countries. As already mentioned, WHO was aware of the unavoidable conciseness of the various programme statements in the proposed programme budget; more detailed medium-term programmes covering the period 1978-1983 had been prepared at the global and regional levels outlining the situation analysis, objectives, approaches and activities to be undertaken in the bacterial and viral programmes and sub-programmes covered. A medium-term programme on the prevention of blindness was also available.

With a view to achieving wider dissemination of information, WHO regularly reviewed the epidemiological situation and scientific developments in the various groups of diseases or specific diseases listed. The review was carried out through consultation and scientific or working groups. Informative documents and working papers on the subject were available on request. For example, a review of the emerging problem of Rift Valley fever would be made at the end of June 1981, and later there would be a review of the major prevailing threats of epidemics of bacterial or viral origin and the present mechanism of response and aid in the face of such emergencies. There would shortly be a review of developments in treatment regimens necessitated by the advent of new and therapeutically effective short-course chemotherapy regimens in tuberculosis and leprosy, as mentioned by several delegates. The reports of the scientific groups would be widely disseminated in WHO publications. He drew attention to the fact that, however effective it might be, short-course chemotherapy would not by itself solve all the operational problems of tuberculosis and leprosy control, and hence emphasis remained on ensuring an efficient organization of case-finding and supervision of ambulatory treatment at the country level. Rifampicin had now been included in the list of essential drugs, and an agreement had been reached with UNICEF to make it available at the best prevailing market price. In the proposed programme budget for 1982-1983 provision had been made for expert committees and scientific groups to review and evaluate the relevance of recent advances in viral vaccines and antiviral drugs, as mentioned by the delegate of the German Democratic Republic. Provision had also been made for a scientific group to review arthropod- and rodent-borne viral diseases, the importance of which had been underlined by several delegates. With regard to Korean haemorrhagic fever, the South-East Asia, Western Pacific and Eastern Mediterranean Regions had recently reviewed the interesting findings of Professor Lee in Korea.

In connexion with meningitis, he drew attention to the provision made for a review of meningitis vaccine and control development. Several delegations had emphasized that the matter should be kept under review, and the developments mentioned by the delegate of Ghana concerning rapid diagnostic techniques had certainly given rise to new hope and would be of help when governments took decisions on the prophylactic and therapeutic measures that should be followed in each local epidemiological situation.

The delegate of the German Democratic Republic had highlighted some of the significant and exciting advances that were being made in immunology and vaccine and drug development, as well as the revolutionary progress made by scientists through genetic engineering in both experimental and applied biology. Those developments opened up new prospects that would enrich the armamentarium with widely available and cheaper products - for example, interferon, insulin and other hormones and antibiotics. The whole issue of genetic engineering, its potentialities and risks had been discussed in a policy statement published in the *WHO Chronicle*, 1 He concurred

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with the delegate of the German Democratic Republic in the view that the rules and techniques of good microbiological practice had to be applied rigorously, and that researchers carrying out DNA recombinant work should be thoroughly educated in the modern technique of good laboratory practice. Such efforts were being made through the WHO programme on safety measures in microbiology.

Many delegates had referred to diarrhoeal diseases and acute respiratory infections, the killer diseases principally in children under five years of age. During the discussions on family health, particularly maternal and child health, the critical importance of nutritional deficiency and/or low birth weight in such infections had been highlighted. He therefore stressed that the programme on diarrhoeal diseases had set as its immediate objective the substantial reduction of diarrhoea-related mortality and malnutrition, especially in children, by making available oral rehydration therapy; that should be closely and constantly linked with intensive educational and training programmes, as described by the delegate of Trinidad and Tobago, on the use of oral therapy for rehydration as well as for its concurrent nutritional value. He assured the delegate of the United States of America that applied or operational research was an important component, and high priority was given to an action-oriented research component supporting epidemiology, and to operational or applied research that would help to determine the best means of applying available knowledge and technology and improving the management and logistics of activities at the peripheral, intermediate and central levels. In reply to the delegate of Chile, he confirmed that the diarrhoeal diseases programme was being carried out in full collaboration with UNICEF, UNDP and other agencies. It had developed well, and the demand for projects in that field was increasing. Since the commencement of the programme in 1978, extrabudgetary resources amounting to US$ 8 million had been received.

Referring to the programme on acute respiratory infections, he was grateful to delegates for their support and encouragement. During the last two years, combined epidemiological and health services research on the nature and extent of acute respiratory infections and on clinical management at the primary health care level had commenced in a number of countries in various regions. Policy guidelines on appropriate technology for diagnosis and clinical management were being prepared. The development of rapid, simplified techniques related to bacterial and viral agents in acute respiratory infections had been reviewed by two scientific expert meetings and was reflected in their reports, which were available.1

In reply to the question raised by the delegate of the United States of America on endemic treponematoses and the concern to which it gave rise in Western and Central Africa, he said that the situation needed to be kept under review. In Ghana there had been an intensification of surveillance and control over the past year. With regard to wider dissemination of information on the state of endemic treponematoses, in particular yaws and endemic syphilis, he could confirm that up-to-date information would shortly be published in the Weekly Epidemiological record.2

Several delegates had expressed concern at the increase in the overall incidence and prevalence of sexually transmitted diseases and the shift towards the teenage population. He agreed with the delegate of Sierra Leone; it was important that social and other related aspects should be taken into account. The preliminary results of simplified diagnosis and treatment carried out at the peripheral level in Kenya and other countries gave rise to considerable hope. The need for more health education material would be borne in mind when developing the programme.

Turning to veterinary public health, he noted that the delegation of Portugal in particular had highlighted the importance of zoonoses in both animal and human health. He confirmed that the WHO/UNDP Mediterranean Zoonoses Control Centre, Athens, was developing satisfactorily, and that its programme was directed towards currently relevant priorities - namely, rabies control, hydatidosis, brucellosis and foodborne infections.

In conclusion, he thanked those delegates who had endorsed the programme on the prevention of blindness. As had been stressed by the delegates of Egypt, Romania and others, the


programme focused on avoidable causes of an infectious or nutritional origin, or related to trauma and accidents. The programme emphasized simple and effective measures that would help in dealing with the principal causes of preventable blindness and hence eye care through primary health care, as directed by the WHO Programme Advisory Group on Prevention of Blindness, a group of experts which guided and reviewed the programme annually; stress was laid on the importance of elaborating training aids in eye care for various levels of health personnel. In that connexion, manuals with good illustrations were being produced for the use of primary eye care workers, ophthalmic assistants and specialized medical personnel. A data bank on blindness had been established and was regularly updated.

Special Programme for Research and Training in Tropical Diseases (programme 4.1.6)

Dr PARADE (France) underlined the vast scope of the programme. He hoped that the large number of projects involved would not lead to dispersal of effort that would be prejudicial to achievement of the goals set. Significant progress had been made in formulating and using techniques to combat the six target diseases, as could be seen from the narrative in the budget document. His delegation noted with satisfaction the steady increase over the past few years in the proportion of funds devoted to activities carried out within tropical developing countries, and hoped that that trend would continue during 1982 and 1983. The study of tropical diseases could not be confined to the pathogen, vector and host; social and economic factors also played an important role. He therefore welcomed the study on the economic and social impact of tropical diseases, mentioned in paragraph 40 under the Special Programme; he wondered, however, how that research could be fully implemented, since the increase in funds for that purpose was only 17.02% - considerably less than the overall increase of 22.19% for programme 4.1.6 as a whole. His delegation nevertheless supported the proposed programme, since it considered that its impact on the control of the main communicable diseases would be considerable.

Dr BAJAJ (India), regarding malaria, said that in many cases in which other drugs were not effective quinine still gave good results; it should not be abandoned, and further research should be undertaken. At the Central Drug Research Institute in Lucknow, India, research on indigenous plants was being carried out, and it had been found that plants such as tulsi were very effective in treating malaria.

With regard to leprosy, short courses of treatment with rifampicin and dapsone had been given, and the results were being studied. A breakthrough had been made in the search for a leprosy vaccine, and it was hoped that good results would be achieved in the near future.

Dr KASONDE (Zambia) said that his delegation wished to associate itself with the tremendous support for the programme - which had great potential for the transfer of technology, the development of research in disease control programmes, and for finding solutions to specific problems in the developing countries. The earlier discussion on the Expanded Programme on Immunization had clearly indicated many problems in the control of communicable diseases. Some of them were not medical, but were related to the logistics of programme implementation in individual settings. Others were, however, medical and in particular epidemiological. Consequently, his delegation had noted with satisfaction that much attention had been paid to research in the discussions on communicable disease prevention and control so far. Nevertheless, within the maze of research being done there might well be a need for better communication. His delegation would therefore like the results of research in the field under consideration to be communicated speedily to interested persons, including administrators. The need for the communication of information on activities and results was so important that it would have been expedient to include it as a specific financial item. However, his delegation trusted that the item described as "general activities" covered that important aspect.

Dr ALBORSNOZ (Venezuela) expressed gratitude for the cooperation received in the development of a leprosy vaccine at his country's national institute of dermatology, which also housed an international centre for training in leprosy, onchocerciasis and other tropical diseases. Development of the vaccine was now in the experimental application stage and the results were highly encouraging. A leprosy vaccine would also help to extend the scope of immunological research, the results obtained in leprosy patients suggested that the vaccine was effective, and some striking effects had been noted. WHO's cooperation was thus greatly appreciated, as
was that of private organizations in the European Region. His Government was confident that, once its applicability and efficacy had been demonstrated, the leprosy vaccine would help to solve one of the grave problems afflicting mankind.

Dr ESCALÁ (Panama) inquired about research on toxoplasmosis and its role in hydrocephalus in newborn infants, as well as other adverse effects on the health of the mother and child.

Dr LUCAS (Director, Special Programme for Research and Training in Tropical Diseases) assured the delegate of France that social and economic research was regarded as an important area within the Special Programme. The group managing that component had emphasized the importance of the work in the context of national institutions in developing countries.

With regard to the reservations concerning the number of projects supported, it should be borne in mind that that was the way the Special Programme reported its activities. For example, the monitoring of surveillance of plasmodium resistance to chloroquine was carried out in a number of countries in collaboration with the malaria action programme and the regional offices. Each collaborating country used the same approach - standard protocols and a kit, which was produced centrally in the Philippines. The investigators met to review progress. Such monitoring was in essence a single activity but it was recorded as including many projects.

The delegate of India might be pleased to learn that the use of quinine in the treatment of drug-resistant malaria was being investigated. There would be a meeting later in 1981 jointly organized by the regional offices, the malaria action programme and the Special Programme, on the strategy for dealing with drug resistance. There had been reports that in some areas of South-East Asia the response to quinine had not been as good as previously, and in some cases it had been combined with tetracycline. The Director of the Central Drug Research Institute, Lucknow, was Chairman of the Special Programme Steering Committee of the Scientific Working Group on the Chemotherapy of Malaria. The programme took full account of scientific developments at the Institute, which was making a multifaceted contribution.

Progress was being made in the research on a leprosy vaccine, but because the disease had a slow onset and a long incubation period, trials of a new vaccine would require years of research. Nevertheless, the scientific progress had been very encouraging.

The delegate of Zambia had drawn attention to the importance of the communication of results, in that connexion it should be borne in mind that 1% of the budget of the programme was involved in communication: for example, the Newsletter was sent to 10,000 scientists, research institutes and ministries of health. Communication also took place through WHO publications, such as the WHO Chronicle, individual articles in the WHO Bulletin, and sometimes special issues of the Bulletin. A recent issue of the Bulletin contained an article on filariasis. Scientists were being encouraged to publish their results in recognized scientific journals so as to bring their work to the attention of other scientists. The list of publications was being reviewed and over 500 such publications had been documented.

The Special Programme was working in close collaboration with scientists in Venezuela, and it was hoped that the work would continue to produce favourable results.

There was a typographical error in document PB/82-83, page 170, paragraph 15, in which "research development" should read "vaccine development".

He endorsed Dr Lepes' earlier remarks on the work on developing a malaria vaccine, and said that many years of hard work were needed before it would be known whether a useful vaccine would emerge; however, there was reason for cautious optimism.

Noncommunicable disease prevention and control (major programme 4.2)

Cancer (programme 4.2.1)
Cardiovascular diseases (programme 4.2.2)
Oral health (programme 4.2.3)
Other noncommunicable diseases (programme 4.2.4)
Immunology (programme 4.2.5)

The CHAIRMAN suggested that the draft resolution entitled "Use of SI units in medicine: use of the kilopascal for blood pressure measurement" be considered as a technical question.


2 See p. 130.
identified for additional examination during the review of the programme budget and dealt with later under item 24 of the Committee's agenda.

It was so agreed.1

Dr ÁLVAREZ Gutiérrez (representative of the Executive Board), introducing major programme 4.2, said that the Executive Board had been presented with a summary of recent developments in the cancer programme. It had noted with interest the aim of preventing those cancers that could to a large extent be prevented, in particular cancers of the lung and of the mouth. To make such developments possible countries required policies and programmes for cancer control, and the Board had noted that WHO's programme for 1982-1983 included support to countries for the development of such policies and programmes on the basis of the most valid available information concerning technology, and of education of the public to induce people to behave in such a way as to reduce their chances of developing certain cancers.

The Board had interested itself not only in the education of the public but also in the education of health workers. Further research was being conducted and the programme included linking collaborating research centres closely together so that they constituted a worldwide network for the exchange of information and pursuit of research related to the aims of the programme. Finally, the Board had welcomed the efforts being made, through the Director-General's Coordinating Committee on Cancer, to ensure sound coordination of the work carried out under the regular budget, through the International Agency for Research on Cancer (IARC) and by nongovernmental organizations and the International Union against Cancer.

Board members realized that the incidence of cardiovascular diseases was increasing in developing countries and had agreed with the reorientation of the cardiovascular diseases programme, as proposed. The formulation of the medium-term programme in the field of cardiovascular diseases, which ensured the coordination of activities in the regions as well as at headquarters, had been approved. Its major subprogrammes, common for the whole Organization - namely epidemiology, prevention and control, research, exchange of information and coordination, and training - had been found appropriate. The need for research, with the main emphasis on problems connected with the primary prevention of different cardiovascular diseases, had been connected with the primary prevention of different cardiovascular diseases, had been acknowledged and the concept of "primordial prevention" had been considered a worthwhile challenge to governments. "Primordial prevention" meant primary prevention in its purest sense - namely prevention of the development of risk factors in populations still free from some of the cardiovascular diseases. The success of the programmes of prevention and control could only be assured if they were an integral part of noncommunicable disease control programmes, developed and implemented through the existing health services, preferably in the context of primary health care.

It had been acknowledged with satisfaction that the past work of WHO in the cardiovascular diseases field was being internationally recognized. One example mentioned had been the methodology of the myocardial infarction registers in the community, now to be utilized in an international project aimed at providing explanations for the decreasing or, in some countries, increasing trends in mortality from cardiovascular diseases, and specifically from coronary heart disease. The present reoriented cardiovascular disease programme of WHO thus had importance for both industrialized and developing countries.

The Board had reviewed the oral health programme, noting that it was formulated around the specific global goal, relevant to both developing and developed countries, of three or less decayed, missing or filled (DMF) teeth at 12 years of age. The growing number of requests for further programmes in the oral health sector was evidenced by a substantial increase in regular budget funds provided for the next biennium. In addition, extrabudgetary funds of a similar sum had also been identified to support preventive projects and the establishment of demonstration, training and research centres for oral health. An even larger sum for a specific research project dealing with fluoride intake and metabolism might also be identified.

It had been noted that prevention of dental caries in various programmes using fluorides had already been so successful in a number of industrialized countries that potential manpower surpluses were causing concern. In contrast, the increasing oral disease problem in developing countries called for a massive preventive effort.

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1 See p. 223.
Principal programme activities at the country level involved stimulating and supporting the application of a standard approach to the coordinated planning and monitoring of oral health care services, with top priority for prevention. Interregional activities involved the establishment of demonstration, training and research centres for oral health in the African, South-East Asia and Eastern Mediterranean Regions, and the development and updating of methodology to ensure that countries had the essential tools with which to work. In the research area the international collaborative study of dental manpower systems would be completed and a collaborative study of fluoride intake and metabolism would be commenced.

Reviewing the proposals for programme 4.2.4 (Other noncommunicable diseases), the Board had stressed the immense problems facing the developing countries, which now had to contend with noncommunicable diseases without having conquered communicable diseases. The discussion on the report of the WHO Expert Committee on Diabetes Mellitus and on the other noncommunicable diseases programme in general had demonstrated the special relevance of the above approach to diabetes. The Board had welcomed the reorientation of the emphasis to be found in the programme under consideration, diabetes now being one of the three major areas listed under other noncommunicable diseases. The Board had repeatedly stressed that diabetes might in fact serve as a model for community-oriented action on a group of chronic diseases through the development of a comprehensive approach integrated into primary health care, and satisfaction had been expressed that initial plans had been made for field tests in that connexion.

Immunology was a discipline which cut across many areas of interest to the Organization. Immunological methods were now used for the diagnosis of several diseases of public health importance and in inpatient care. Work on the development of new vaccines had been intensified over the past few years. In the light of that trend the Organization was placing great emphasis on the training of scientists from developing countries so as to enable them to carry out research on problems of importance in their own countries. Emphasis was also to be placed on the local production of essential immunological reagents.

Dr LENFANT (United States of America) congratulated WHO on its dynamic programme for noncommunicable disease prevention and control. Many of those diseases were increasing in incidence and prevalence in both developed and developing countries. However, his delegation wished to express its concern regarding the proposed budget allocations for some of the noncommunicable disease categories, particularly those included under programme 4.2.4 (Other noncommunicable diseases), in respect of which the provision, both under the regular budget and in toto, showed a substantial decrease. Nevertheless, that programme included important diseases such as diabetes, nonspecific respiratory diseases, arthritis and liver and renal diseases. Genetic disorders and some blood diseases were also briefly mentioned in the programme description.

The worldwide importance of the diseases included under the programme 4.2.4 had been emphasized by a number of studies. It was acknowledged, for instance, that diabetes afflicted millions of individuals and that no country and no race was exempt from it. In some regions of South-East Asia 20 to 25% of the people suffered from nonspecific respiratory diseases. Blood disorders, often of a genetic nature, afflicted a large number of people, especially in the Americas, in Africa and around the Mediterranean. While noting with satisfaction the increased attention given to noncommunicable diseases in general, his delegation considered that the programme should be balanced and therefore questioned the desirability of the proposed reduction in the provision for a programme that included so many diseases of worldwide significance.

Dr FAREED (Mauritius) thanked WHO for its collaboration with his country in the field of communicable and noncommunicable diseases.

In 1979 cardiovascular diseases had been responsible for 39% of all deaths in Mauritius. Among them, hypertension and stroke were the leading causes. His Government realized that WHO's concept of community programmes of prevention and control of cardiovascular diseases could be applied in a developing country. In Mauritius the problem was that the incidence of cardiovascular diseases was increasing steeply at a time when the problems of communicable diseases, especially malaria, had not yet been completely solved. The Government had now launched a national programme of prevention and control along the lines of the WHO proposals. As soon as the basic experience had been collected, the prevention and control measures would be integrated with the existing system of health services, particularly the primary health

His Government would be grateful if WHO could continue, and even enlarge, its activities in the important field of cardiovascular disease control.

In association with the cardiovascular disease control programmes his Government was also carrying out activities for the control of other noncommunicable diseases such as diabetes, liver diseases and cancer.

Dr LEPPÓ (Finland) commended the objectives and approaches presented in the programme statement on cardiovascular disease control in the light of experience in his country. A programme for community prevention of cardiovascular diseases carried out in North Karelia with WHO's support, as well as a nationwide hypertension control programme implemented as an integral part of the general health services, had convincingly shown that intervention against major cardiovascular diseases at the community level was feasible and that it had produced encouraging results. The logical extension of the community control principle was the "primordial prevention" approach presented in paragraph 3 of the programme statement. That concept entailed anticipation of unfavourable trends in cardiovascular diseases due to adverse behavioural changes affecting health, as well as tackling the problem before it reached the epidemic proportions now faced by the industrialized countries. His delegation endorsed that policy because it believed that it was likely to be the only way to save the least developed countries from the cardiovascular disease epidemic already prevailing in the developed countries.

One of the major risk factors, both for some important forms of cancer and for coronary heart disease, was cigarette smoking. His delegation was therefore glad to note that for the first time due emphasis had been given to the WHO programme on smoking and health pursuant to resolution WHA33.35. The Director-General was to be congratulated on his success in attracting extrabudgetary funds to strengthen that important programme.

As far as the content of the programme on smoking and health was concerned, at the present stage priority must be given to strategies to control smoking, since there clearly was an implementation gap between knowledge and action. The list of global and interregional activities indicated that emphasis would be placed on smoking control policies and strategies, and it was hoped that the emphasis on control measures would be reflected in the building up of the international clearing house for information on smoking and health. The information most needed at the national level related to the experience gained in different countries from various strategies and tactics to combat smoking and the related consequences for health.

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His delegation was pleased to note the increased, though still small, allocation for oral health, and it wholeheartedly supported WHO's programme on noncommunicable disease prevention and control as a whole.

Professor JAKOVLJEVIĆ (Yugoslavia) said that his delegation considered the cardiovascular disease programme to be very promising in so far as it was oriented towards reducing mortality and disability through the use of simple methods of prevention, early detection, treatment and rehabilitation.

The comprehensive community approach to prevention of cardiovascular diseases that had started in Finland in 1972 was now being applied in more than 30 developed and developing countries, including Yugoslavia. The Yugoslav approach followed WHO principles as expressed in its general programme and also the more concrete guidelines given in the project proposal itself; it was innovative in so far as it did not apply sophisticated technology but was based on the participation of the community as a whole. It was, in the true sense, a societal approach to disease prevention: allied health workers participated in the programme alongside physicians and the whole of society was being mobilized to achieve prevention of cardiovascular diseases. That involved a great deal of education and public information; it also required certain changes in the system of values with regard to food and tobacco consumption and similar behavioural characteristics. The front-line physician played an important role in the programme, which was integrated with all other aspects of health care in the community.

The role of the Health Assembly did not consist only of adopting resolutions. Discussion should also include the experience gained, in the individual countries, in implementing the health policies outlined by WHO. The programme which he had chosen as an illustration was of special importance because it also implied that industrialized societies had, in the course of their development, committed certain health errors leading to cardiovascular diseases - errors that should be avoidable if developing societies adopted the principle of "primordial prevention".
Dr STOKE (New Zealand) said that problems of dose response and species specificity were arising in connexion with carcinogenesis attributed to chemicals in the environment. There was a constant flow of reports from research workers that they had found tumours in animals exposed to chemicals, often in large doses. It was difficult to decide, on the basis of such reports, what action, if any, should be taken, and so the views of an independent authority on their practical implications would be welcome. Would such guidance be provided under programme 4.2.1?

Professor SENAULT (France) said that his delegation was pleased to see the ever increasing priority being given to the major programme on noncommunicable diseases; as those diseases were now becoming prevalent also in the developing countries preventive action was especially opportune. His delegation's views coincided with those of the delegation of Finland. He would merely add that there was clear need for WHO and Member States to set up action in health education, a type which was less expensive than other forms. Some noncommunicable diseases were clearly and incontestably linked with certain forms of behaviour, such as smoking, improper nutrition, unhealthy life-styles etc. Because people were particularly sensitive about certain of them, such as cancer and cardiovascular diseases, they would be open to motivation, so that well-designed educational activities promoting awareness could really reach them and influence their behaviour. Such action would also reduce the cost of care.

He was pleased to note, from paragraph 166 of the Executive Board's report (document EB67/1981/REC/3), that further efforts would be made to improve the coordinating mechanisms between WHO headquarters and IARC and would like to know what improvements were proposed.

Professor LU Rushan (China) said that China supported major programme 4.1 (Communicable disease prevention and control) and major programme 4.2 (Noncommunicable disease prevention and control) both of which should be strengthened. During the past 30 years there had been a marked improvement in the health service in China, and in the health status of the people. Through the development of the health services and through economic development, the disease structure had changed since liberation. Some communicable diseases had been eradicated or brought under control: there had been a sharp drop for instance, in the incidence of schistosomiasis, malaria and other diseases. But the prevention of noncommunicable diseases in China was a task that needed further consolidation, particularly with respect to cancer, rheumatic diseases and some occupational diseases. His delegation therefore considered that financial support for the programme on noncommunicable disease prevention and control should be increased.

Dr HYZLER (United Kingdom of Great Britain and Northern Ireland) said he had listened with interest to the comments of the United States delegate on diabetes with which he concurred. He would recommend further attention to the use of diabetes as a model disease for the development of a community-oriented comprehensive chronic disease control programme.

With respect to the proposed expenditure under global and interregional activities on public health aspects of community control of diabetes (project OND 012), the proposed amount of US$ 40 000 for the biennium seemed a modest amount in view of the importance of the activity, and he hoped that there were extrabudgetary funds that could be drawn upon to buttress it.

With reference to the problem of diabetes control, he suggested that the possibility should be considered of moving towards standardization of insulin concentration on the basis of 100 international units per ml. He believed that in a number of countries that had already been done and would welcome more information, possibly under agenda item 24.

Professor LISICYN (Union of Soviet Socialist Republics) said that his delegation fully welcomed and supported major programme 4.2, which was particularly important because the problem of chronic diseases affected all countries, and changes were being seen in the pathology typical of such diseases. He welcomed the increased attention being paid to endocrine diseases, and especially to diabetes.

With respect to programme 4.2.1 (Cancer), he thought that the description of the programme should be improved to make its aims clearer. The programme budget document concentrated on the preparation of general guidelines covering various aspects of cancer control, but it was not specific enough as regards practical applications. Possibly WHO, in cooperation with IARC, could make clear the aims of research, which should be oriented less
towards compiling information and formulating standards, and more towards finding means of reducing the prevalence and mortality of the disease, for example, by 15-20%. Also there should be more studies concerning what might be termed the decancerization of the environment by reducing the presence of toxic substances, and through studies on the chemical and biological causes of cancer. Some results had been obtained in that field, but more intensive work was needed. He agreed with those who had drawn attention to the insufficient allocations under all aspects of the cancer programme, especially for headquarters and the Regional Offices for Africa, the Western Pacific and Europe.

Referring to programme 4.2.2 (Cardiovascular diseases), he said that his delegation welcomed the decision to convene an expert committee on cardiomyopathies, a subject that had been insufficiently studied. He expressed interest in contributing actively to that committee’s efforts to help solve the problem. He also supported those who had drawn attention to the need to strengthen studies on the life-styles and behaviour to which cardiovascular disease control would have to be directed. Those were important targets for primary prophylaxis. It was a logical development for general epidemiological surveys to lead to the theory of risk factors, including social conditions and habits of living.

With respect to programme 4.2.4 (Other noncommunicable diseases), he agreed that insufficient resources had been allocated to such diseases as diabetes. He hoped that WHO would give more attention to that subject and to other endocrinological problems. He would like to see a broader study of allergic diseases, such as asthma. There were common factors present there, and possibly the point could also be considered in other programmes such as research promotion and development (major programme 2.4), in the light of the background of allergy and endocrine disease against which the chronic pathology developed. More epidemiological studies were required in that field.

Dr BAJAJ (India), referring to programme 4.2.1 (Cancer), said that many costly drugs were being used, but it was not known how effective they were. Consequently it was quite likely that a lot of money was being wasted on expensive but ineffectual treatment. He would like WHO to provide guidelines on effective treatments, including chemotherapy, for cancer.

Referring to paragraph 18 of the programme statement, he asked whether the 25-volume series of the International histological classification of tumours dealt only with malignant tumours.

Regarding programme 4.2.2 (Cardiovascular diseases), he said that yoga had been found very useful in the treatment of hypertension, and asked whether there was a WHO project on such treatment.

Turning to programme 4.2.3 (Oral health), he said that in some parts of India there was a problem of fluorosis which could affect the bones of children, and asked if there was any water treatment that could prevent such effects.

Concerning programme 4.2.4 (Other noncommunicable diseases), he said that in some countries no oral treatment was available for diabetes and there was total reliance on insulin. He therefore asked WHO to provide guidelines on the various types of insulin available and their dosages.

With reference to programme 4.2.5 (Immunology), he said that the Chest Institute in Delhi had done extensive work on respiratory diseases and had produced some vaccines which were highly effective in certain cases. He hoped that WHO would be willing to cooperate with the Institute in the production of those vaccines.

Dr KLIVAROVÁ (Czechoslovakia) said that her delegation fully supported the programme on chronic diseases and agreed with those delegates who considered that the funds allotted to it were too modest.

In 1980 the WHO Regional Office for Europe had organized a meeting, attended by representatives from headquarters and from other regions, which had discussed the use of community health services to detect and treat cardiovascular diseases. The meeting had considered which primary health care services or specialized medical units could be used for screening, in conjunction with X-ray and laboratory tests, to detect the early stages of heart disease, hypertension, diabetes, rheumatic diseases, tumours and chronic renal and hepatic disorders. Services of this kind in Czechoslovakia could provide a model for detecting and treating a number of chronic disorders included under programmes 4.2.1, 4.2.2 and 4.2.4. The meeting in question had been highly successful and she felt the results should be reflected in WHO’s chronic diseases programme.
Dr HUYOFF (German Democratic Republic) said that the objectives set forth in paragraph 1 of the programme statement on noncommunicable disease prevention and control (programme 4.2) were acceptable in the light of its national experience. The multiple causation of those diseases in terms of the environment, nutrition, behaviour and individual predisposition meant that prevention could be effective only within a specific national health and social strategy. His delegation supported WHO's promotion of research in immunology and human genetics, and of methodological training in immunology, genetics and biochemical techniques. WHO's strategy was in harmony with his Government's aims and it wished to offer its participation in some of the fields concerned.

With reference to programme 4.2.1 (Cancer), his delegation looked forward to intensified worldwide promotion of cancer research through the provision of more personnel and of more material resources from those liberated by strengthening the peace policy of all countries, and to the formulation of clearer strategic advice for national cancer control programmes on the basis of expertise.

Regarding programme 4.2.2 (Cardiovascular diseases), he said that special priority was being given to risk groups through a system of dispensary care covering more and more of such groups. In his country emphasis was placed on coordinating control measures against cardiovascular diseases with those directed to other chronic diseases such as cancer, lung diseases and diabetes. In recent years elements of a comprehensive programme for the control of chronic diseases had been tested. At the level of the population and in the territorial health services a model district had been introduced, and a multi-centre study was being prepared for use in testing, with respect to cost and effectiveness, different variants of the methodological approach to comprehensive control of chronic diseases in the community, with the aid of the existing primary health care system. The central role was given to the specialist physician of general medicine, as the main provider of the generally cure-orientated basic care, and to physicians in the occupational health system. His country looked forward to the results of the study and hoped to draw further benefits from it.

With respect to oral health (programme 4.2.3), he believed that the development of a national prevention programme was essential for the implementing of short-term and long-term goals. His Government expected to be able to solve the oral health problems of young people, adults and high-risk groups in that way. In that connexion, his country had participated in a pilot five-year study on the spread of periodontal diseases and was working on the development of a uniform epidemiological examination and assessment of periodontal diseases. It had also participated in the organization of a WHO/International Dental Federation scientific workshop on etiology and prevention of dental caries and periodontal diseases. His delegation recommended the continued development of that approach.

On the basis of his country's experience in the assignment of specialist nurses to dental and oral hygiene, his delegation supported developments envisaged in the medium-term programme on oral health.

It was clear that the main burden in terms of staff and finance must be met at the national level, and that WHO's resources should be concentrated even more on research promotion, and coordination and information activities.

Dr KASONDE (Zambia), referring to programme 4.2.4 (Other noncommunicable diseases), supported the United Kingdom request for standardization of insulin concentrations as a matter of urgency.

With respect to programme 4.2.1 (Cancer), he expressed appreciation of the increasing cooperation between WHO and IARC. The administrative relationship between the two organizations had been the subject of some discussion and it might not be fully realized what an achievement the present degree of coordination represented. However, he would be interested to know how the proposed Appropriation Resolution could be related to the IARC budget shown in programme 4.2.1. In particular, he wondered whether the Health Assembly was the competent body to approve the IARC budget.

Dr ESCALA (Panama), referring to programme 4.2.1 (Cancer), said that in Panama, perhaps because the average life expectancy had reached 70 years, cancer was the third cause of death, the main site being the uterine cervix. Cancer of that site was even found among women of reproductive age, so that early screening for this disease had been included in the country's maternal and child health programme. That situation had come as a surprise to some of the funding agencies and he wished to draw attention to the fact that there was no evidence in the cancer research programme, of any increase of effort regarding cancer of that site.

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Dr CASTELLON (Nicaragua) said he was pleased that WHO was taking programme 4.2.3 (Oral health) into account as part of the strategy of health for all by the year 2000, particularly as that problem had not previously been given priority. A recent survey in Nicaragua had shown that dental caries and periodontal disease was found in 98% of the population, and it was all too likely that many other countries were similarly affected. Such diseases had to be prevented if the aim of health for all by the year 2000 was to be achieved, so he requested the Organization to make a recommendation, with financial support, that all countries prepare DMF and periodontal disease indices and indices for oral health status so that those data could be put in the WHO global data bank, to be established with a view to the control of those diseases. It was also necessary to test drinking-water for fluoride in order to ensure that it did not contain too much or too little, and to consider fluoridation where that was indicated. In such underdeveloped countries as Nicaragua, remote areas had no drinking-water supplies and fluoride would have to be provided otherwise, e.g. in salt.

In order to combat those diseases and carry out the strategy for health for all by the year 2000 it was important to train and retrain professional and non-professional and auxiliary staff and teach them improved techniques. Community participation in prevention programmes was the only way to educate people in oral health measures and techniques for preventing plaque formation and thus preventing dental caries and periodontal diseases.

Dr POUDAYL (Nepal) appealed for attention to be given to the predicament of small countries, like his own, where cancer could be diagnosed but there were few, if any, treatment facilities. The situation was giving rise to even greater concern now that more and more of the women were going on the pill. He hoped that WHO would be able to help with the provision of treatment facilities for Nepal, among other countries.

While he agreed with the emphasis on myocardial infarction in programme 4.2.2 (Cardiovascular diseases), it should not be forgotten that chronic bronchitis could lead to cor pulmonale and should therefore also be given due prominence in the programme. Chronic bronchitis was a very common condition in certain areas of Nepal, and other cold-climate countries might well have a similar problem. Only 6 km from Kathmandu 14% of the workers had been found to have chronic bronchitis because they lived in closed rooms where cooking was done over open wood fires and were thus continually exposed to smoke.

Dr ABUDAJA (Libyan Arab Jamahiriya) drew attention to a classification problem relating to communicable and noncommunicable diseases. Was accident prevention to be included? It was an important problem, and especially relevant in the International Year of Disabled Persons.

The CHAIRMAN said that the Committee had now concluded its discussion of Appropriation Section 4 (Disease prevention and control).

The DEPUTY DIRECTOR-GENERAL said it was clear from the discussions that the entire programme of noncommunicable diseases was of the highest importance, and was of growing significance for the developing countries, who would have to take account of those diseases within the forthcoming strategy for health for all. Likewise important was the role of health education as an essential part of primary health care, particularly for coping with chronic diseases, the incidence and prevalence of which, in the developing countries, was rising as new behavioural patterns and life-styles evolved.

Reference had been made to the relationship between WHO and IARC with regard to cancer programmes. He stressed that the two organizations were entirely separate with regard to budgets.

The IARC Governing Council had been informed, at its April 1981 session, that the Director of the Agency was resigning at the end of the year. Nominations for the post should be submitted as early as possible to the Director-General, pursuant to the Governing Council's decision.

Dr POUSTOVOI (Director, Division of Noncommunicable Diseases) said he was gratified to note the attention and encouragement given to the major programme on noncommunicable disease prevention and control by the Executive Board and in the present Committee.

The activities of WHO in noncommunicable disease prevention were based on the removal of risk factors in populations. Obviously, chronic diseases could not be combated solely on the basis of prevention; etiology and pathogenesis, and epidemiological aspects, required further research. Therefore, all programmes should contain a considerable research component.
Despite the shortage of funds for noncommunicable disease prevention and control programmes, to which a number of speakers had alluded, a great deal of help had been received during the past two years, stemming from the Secretariat's cooperation with nongovernmental organizations, institutions and individuals; such extrabudgetary resources would help the Secretariat to establish an appropriate balance between different parts of the programme without change in the regular budget provisions.

With reference to a question raised by the delegate of France, it was necessary to mention that there were two mechanisms for the coordination of the cancer programme: the Director-General's Coordinating Committee on Cancer and the ACMR Subcommittee on Cancer Research. Perhaps it would be desirable to circulate to all countries information and resolutions and recommendations adopted by those Committees.

The delegate of the Soviet Union had asked about allergic diseases. A programme was being prepared, and a number of countries were also conducting epidemiological studies aiming to find out the social and economic significance of those diseases, and to develop appropriate programmes.

The delegate of the United States of America had referred to the need for an expanded human genetics programme. Such a programme was being prepared, and the points raised by that delegate would be borne in mind when the final version was drawn up.

Dr PISA (Cardiovascular Diseases) expressed his appreciation of the support given to the programme, whose aim was to develop and test methods of prevention and control of cardiovascular diseases suitable for application by individual countries' health authorities under their own conditions. Control programmes, such as those for hypertension, rheumatic fever and rheumatic heart disease were then being integrated into primary health care programmes.

The proposed programme budget showed an increase in research activities at headquarters level. They concentrated particularly on the areas related to the development of effective prevention and control methods - for example, studies on precursors of atherosclerosis in children, primary prevention of hypertension and on cardiomyopathies. There was, however, a great deal of collaboration with research institutes around the world on other specific subjects which would be best dealt with at national level. The unit also collaborated closely with the International Society and Federation of Cardiology, particularly in the standardization of nomenclature and diagnostic criteria. Collaboration was systematically being strengthened with institutes in the developing countries, and means were being sought to establish research and training opportunities relevant to the conditions found in the trainees' own countries.

WHO had received a heartening response to the programme on control of smoking; an attempt was being made to identify key elements with a view to concentrating effort on the activities most appropriate from the point of view of WHO's overall programme.

The unit would be glad to collaborate with national programmes - for example, with the programme in Mauritius on prevention and control of cardiovascular diseases, and with the Government of India on the use of yoga to combat hypertension. With regard to the problem of bronchitis and cor pulmonale, mentioned by the delegate of Nepal, a consultant sent by the Regional Office for South-East Asia had already submitted some basic recommendations, and it was hoped that a programme could be drawn up in the future.

Dr BARMES (Oral Health) said he was grateful for the interest expressed in the use of the DMF indicator to evaluate global, regional and national achievements in oral health and the emphasis on coordinated planning with a view to prevention of oral diseases.

Although the main focus of the programmes was on fluoridation, attention was also paid to the need to reduce fluoride ingestion in certain areas. Fluorosis was a problem in some areas of many countries, especially in the Eastern Mediterranean, South-East Asia and African Regions and programmes were being promoted to overcome it. Unfortunately, the most effective methods were very costly and involved high technology; therefore, the development of simple methods was encouraged, and it was always advocated that alternative sources of water should be sought first. It was also important to assess, in many communities, whether problems were being accentuated due to other sources of fluoride ingestion, e.g. tea and certain other high fluoride bearing dietary items.

Dr STJERNSWÄRD (Cancer) thanked the delegates for their interest in the cancer programmes.

With regard to the questions of the delegates from France, the United Kingdom, the Soviet Union and Zambia, and earlier from Dr Kruisinga (Netherlands), concerning the coordination of

1 See p. 71.
the work of IARC and WHO, the Executive Board had established, some years ago, an ad hoc committee which had made recommendations leading to the creation of the Director-General's Coordinating Committee on Cancer. There would also be a meeting during 1981 of the ACMR Subcommittee on Cancer Research, with the mandate "to work with IARC and the WHO Secretariat in order to develop research for the prevention of cancers whose etiologies are known, for early diagnosis and optimization of treatment methods, with due regard to their efficacy and economic feasibility". A strong coordination between IARC's research on the causation of cancer and WHO's health service function was a vital link in the global programme to achieve prevention and control of cancer. IARC had collected important data over the past 15 years and enough was known today about cause-relationship in cancer for the adoption of practical health service measures in cancer prevention which, if implemented, would have considerable impact.

With regard to the mandate of IARC, the latter covered epidemiology, causation and related research. WHO covered cancer control, prevention, including detection, therapy and after-care, with related health service research.

With regard to an optimally integrated approach, in reply to the delegates of Nepal and Czechoslovakia, he said that the newly-oriented cancer control programme of WHO would have three main targets: first, to prevent as high a percentage as possible of the estimated one-third of cancers known to be preventable; secondly, in the four-fifths of the world's population, at present not benefiting from existing therapies with demonstrated cure rates of 35%, to decrease morbidity and mortality by as great a percentage as possible; and thirdly to promote quality of life, and death in dignity for incurable cancer patients.

As the delegate of Panama had pointed out, cancer was not a problem only of developed countries but occurred often with higher incidence, as for cancer of the cervix, in developing countries. Unfortunately, in cancer there was a disproportion of the global resources allocated to developing countries. Tumours of the skin, mouth, oesophagus, liver and cervix, for instance, were more frequent in developing countries and had nothing to do with industrialization.

The delegates of New Zealand and India had asked for consensus reports in the field of cancer and guidelines relating to drugs and the need to examine the efficacy of various forms of therapy. Regarding the question of control and surveillance of carcinogenic factors, IARC had produced and was still producing monographs on the evaluation of carcinogenic risks of chemicals to humans. Those monographs summarized the evidence for the carcinogenicity of individual chemicals in a condensed uniform manner after evaluation by a working group of experts, and the twenty-third volume was currently available.

Regarding the international histological classification of tumours, 25 tumour sites had been covered, including more than 100 tumour types, benign as well as malignant. The delegate of the German Democratic Republic had mentioned pragmatic research on specific sites and national programmes. In that connexion, work was being carried out in Sri Lanka and Sudan, serving as indicator countries, with a view to determining priorities on the basis of effectiveness and economic feasibility.

To the question from the Indian delegate regarding use of costly chemotherapeutic drugs and their effectiveness, Dr Stjernswärd replied that regular consensus reports on major topics in cancer control were being planned, starting with status reports on prevention strategies and on lung cancer in the autumn of the current year. The question raised by the Indian delegate had bearing on the problem that in the developed countries, present cancer treatment was geared to high technology treatment. If gains were spectacular that was acceptable, but if the benefit was marginal that might not be the way to proceed. Especially if analyses of present therapies led to negative conclusions, it would be important to have WHO-based assessments of cancer management. Current definitive clinical trials usually involved leading medical institutions; there was no assurance that any favourable results from those trials could be duplicated in the developing countries, or even in community hospitals within highly developed countries. The headquarters unit would be concerned with initiating studies which could be-classified as "search for base-line therapies in the out-reach treatment of cancer".

In reply to the delegates of the Soviet Union and of the German Democratic Republic, he added that whether a relevant programme could now be implemented depended on whether adequate funding would become available.

Dr GRABAUŠKAS (Division of Noncommunicable Diseases) thanked the Committee for the interest expressed in and the support given to the programme on other noncommunicable diseases (programme 4.2.4). Questions had been asked about the reduction in the budget allocation, although the burden of that group of diseases was becoming increasingly heavy. However, in
fact the actual figures did not reflect the real scope of programme activities. For example, there had been an increase of some 30% in respect of global and interregional activities; and the decrease relating to the regions might be partially explained, in his opinion, as due to the reallocation of funds, since a large part of the activities relating to programme 4.2.4 was covered under other programme headings.

With regard to the budget for the diabetes programme, efforts were being made to obtain extrabudgetary resources. For instance, there was close cooperation with the International Diabetes Federation, which provided some of those resources. In that connexion, the WHO budget was used as a catalyst for a number of activities at national, regional and interregional levels. Similarly, there was also close cooperation with nongovernmental organizations in other subprogramme areas. During 1980, joint meetings had been held with the International League against Rheumatism and the Scientific Committee on respiratory diseases of the International Union against Tuberculosis to discuss mutual strategies with a view to programme implementation at community level.

Due note had been taken of the suggestion by the United Kingdom delegate concerning the use of diabetes as a model disease for development of the comprehensive chronic disease prevention and control programmes. Such work, in fact, had already been initiated in some interested countries - in Malta, for example.

The question of standardizing insulin concentration at 100 international units per ml was included on the agenda of a newly-formed WHO/International Diabetes Federation steering committee, that was to meet in Geneva in September 1981.

Note had also been taken of the request by the delegate of India concerning a guide for the use of different types of insulin. The matter would be considered in cooperation with the International Diabetes Federation, bearing in mind particularly the needs of the developing countries.

PROMOTION OF ENVIRONMENTAL HEALTH (Appropriation Section 5; Resolution WHA29.47; Documents PB/82-83, pages 196-211, EB67/1981/REC/3, paras 172-174, and A34/4)

Promotion of environmental health (major programme 5.1)

The CHAIRMAN suggested that programmes 5.1.1, 5.1.2, 5.1.3 and 5.1.4 should all be considered together, and that documents A34/4 and A34/A/Conf.Paper No.4, both dealing with the International Drinking Water Supply and Sanitation Decade, should be considered later, under agenda item 24.1

It was so agreed.

Environmental health planning and management (programme 5.1.1)
Basic sanitary measures (programme 5.1.2)
Recognition and control of environmental hazards (programme 5.1.3)
Food safety (programme 5.1.4)

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board) said that the Board had realized that the major programme on the promotion of environmental health was directed mainly towards activities relating to the International Drinking Water Supply and Sanitation Decade and to the problem of chemical safety. A third priority was the prevention of environmental hazards and the promotion of food safety in national programmes. The work entailed close coordination with the United Nations and the specialized agencies, including the World Bank, as well as with other programmes of WHO. In his Introduction to the programme budget the Director-General had not only emphasized WHO's assumption of a central technical responsibility in the United Nations system for the Decade, but had also underlined its fundamental role in ensuring that water and sanitation related to people, and to their use by people, as part of primary health care, rather than merely to pipes and pumps.

Much of the basic work in planning and management (programme 5.1.1) had been completed and would be published during 1981, thus allowing a temporary reduction of headquarters activities in that area and releasing more resources for activities relating to the Decade in programme 5.1.2 (Basic sanitary measures).

1 See p. 216.
The Board had noted that the main points of the international programme on chemical safety were the evaluation of the effects of chemicals on health and the dissemination of information thereon; training; and methodology for the testing of chemicals and for risk evaluation. Close cooperation with other organizations, particularly UNEP and ILO, were essential.

It might be noted, in studying the provisions in programmes 5.1.3 (Recognition and control of environmental hazards) and 5.1.4 (Food safety), that, although there was a specific project for the promotion of the international programme on chemical safety under programme 5.1.3 a number of other activities in that area, and also under programme 5.1.4, would contribute directly or indirectly to that international programme. He drew attention in particular to the joint FAO/WHO meetings on pesticide residues and on food additives, and to direct contributions from the UNEP-assisted programme for the development of environmental health criteria.

Environmental pollution control - for both air and water - and food safety were matters of growing concern to Member States. During the biennium expert committees on those subjects would be convened, and increased attention would be given to the principles and methods for developing national food protection programmes. The Organization continued its support for the Codex Alimentarius.

The Board had noted that the Thirty-Fourth World Health Assembly would be presented with a full report on the Decade, describing the progress of preparations in Member States.

Dr Rosdahl (Denmark) said that, as could be seen on pages 175-178 of document EB67/1981/REG/2, the Executive Board had devoted little discussion to the programme on environmental health. That might have been due to lack of time, or to the feeling that there was no need to question the obvious importance of that programme.

With regard to programme 5.1.3 (Recognition and control of environmental hazards), he stressed the importance of radiation hazards, not only in the industrial environment but also in the home. In that connexion he noted that reference was made to building materials for houses. The hazards in everyday life from chemical and mechanical sources should also be borne in mind. He was pleased to note in paragraph 11 that the evaluation of the effects of chemicals would take account of hazards in the home. Of the agencies cooperating in the international programme on chemical safety, it was WHO that had special responsibility with regard to safeguards in the home, particularly for children and the elderly.

Dr Klivarová (Czechoslovakia), also referring to the programme on chemical safety, drew attention to the danger of congenital defects stemming from chemicals. In her delegation's view, the programme should deal with the influence of environmental factors, including chemicals, on the fetus. Paragraph 11 contained a reference to certain "international tasks" being delegated to national institutions. She wondered what the tasks were, and whether they were assigned by WHO or another organization.

Dr Bajaj (India), referring to the control of water-borne diseases such as cholera and typhoid, recalled that the September 1980 issue of World Health had contained an article by India's Prime Minister; the article had stated that every nation should collaborate with WHO for the purpose of attaining the goal of clean water supplies for all by 1990.

In connexion with environmental health planning and management (programme 5.1.1), he said that the Indian Council of Medical Research had established an institute of environmental health.

With regard to basic sanitary measures (programme 5.1.2), the Indian Government had established a committee to consider water problems; his delegation thanked UNICEF for the help it had given in that connexion.

He noted that paragraph 9 under programme 5.1.3 referred to a series of monitoring projects undertaken since 1975 within the context of the Global Environmental Monitoring System (GEMS); he asked whether any relevant documentation had been issued.

With regard to programme 5.1.4, the importance of pesticide residues and food additives had been emphasized; he wondered whether WHO might consider setting up food testing laboratories.

Professor Lisicyn (Union of Soviet Socialist Republics) wished to join the previous speakers in stressing the importance his delegation attached to the programme for the promotion of environmental health. He believed that the programme should gradually cover all factors
in the environment that might possibly have an adverse effect on health. He suggested, particularly, strengthening the study of physical aspects of the effects of environmental hazards on human health and on groups of populations. This aspect could have been included in the programme statement in more detail.

He emphasized the need for a stronger connexion between the various components of the programme and activities concerned with environmental protection as regards not only the natural environment but also man’s environment and habitat. He drew attention to recent decisions of the United Nations General Assembly concerning the responsibility of States to protect nature for present and future generations. In view of the scope of the activities of the environmental health programme, his delegation also wished to express its concern at the reduction in the total financial resources allocated.

He again drew attention to the advisability of emphasizing the medical aspects of all these programmes as well as the social and public health aspects, and suggested that careful research should be carried out on various hazards and their effects on health.

Greater attention should be paid to the methodology for controlling chemical factors in the environment – in the air, water and soil. His delegation believed that the international programme on chemical safety should be strengthened through increased cooperation with the many existing national institutions. The study of the effect of chemical substances on the environment should be carried out on a priority basis; their classification on the basis of the extent of their effects on people living in various conditions was most important.

Finally, his delegation considered that the information component for the programme in general needed strengthening.

Dr Tammam (Egypt), referring to the table for the major programme (page 197 of the budget document), noted with regret that for the Eastern Mediterranean Region the estimated obligations from other sources for 1982-1983 has decreased as compared with 1980-1981. Yet the implementation of the global targets of the International Drinking Water Supply and Sanitation Decade would require more resources than ever before. He would therefore call upon Member States, through the Committee, to reaffirm their commitment to the goals of the Decade as a means of attaining the goal of health for all by the year 2000; the donor communities should also be urged to increase their contributions for activities relating to the Decade. His delegation accordingly wished to be numbered among the co-sponsors of the draft resolution on the subject, which would be discussed under agenda item 24.1

Mr Hallowell (United Kingdom of Great Britain and Northern Ireland), referring to programme 5.1.4, noted that training programmes for the promotion of food safety were to be further developed and standardized. Effective training had to be relevant to national needs and specific to local circumstances. He therefore hoped that the Organization would not go too far in the standardization of such training programmes but, rather, that suitable training packages would be prepared which each country could adapt to meet its individual requirements.

Professor Ayres (Portugal), commenting on programme 5.1.3 (Recognition and control of environmental hazards), stressed the impact that environmental agents - biological, toxic or others - could have on the unborn. Her delegation wished to propose that the activities within this programme also include the development of surveillance systems for congenital malformations and further research on the evaluation of the effects of environmental agents on the birth of defective children.

Miss Giddings (Liberia), referring to programme 5.1, expressed concern about certain findings, published recently, which indicated possible adverse effects of the chlorination of drinking-water. She requested clarification on this subject in view of the importance of chlorination as a means of providing a safe water supply.

Her delegation wished to draw attention to certain ecological problems faced by her country. Mining had depleted large areas of land and left it unfit for agriculture, and as a result food production was decreasing. At the same time, wastes from ocean vessels were polluting the sea, destroying aquatic life and adversely affecting the fishing industry; there was a noticeable decrease in people’s protein intake. She wondered what activities were being carried out at the international level in that field to exert pressure for better control, and whether guidelines existed for the prevention and control of such problems.

1 See p. 216.
Mr KIBIKONDA (Zaire) recalled a recent experience in Zaire related to environmental health. Epidemics of diarrhoeal diseases had occurred in the eastern part of the country; the pathogenic agent had been diagnosed and huge quantities of medicaments had been delivered, but the epidemics continued. The conclusion had been reached that the disease was being caused essentially by environmental conditions. Various specific measures had therefore been introduced through intersectoral collaboration involving not only the health authorities but also those responsible for the environment, energy, and rural development. The health department, apart from treatment of cases, also undertook health education activities to inform the population of simple methods of purifying water - by boiling it, or using simple sand filters. The department dealing with rural development had the task of digging wells and constructing latrines. The department of energy had been charged with the improvement of methods of treating water supply, and the department of the environment with the improvement of waste disposal. The financial and manpower resources of the different sectors had been pooled. The result was that the incidence of diarrhoeal diseases was constantly decreasing. That was an illustration of the vital importance of the environmental aspects, and of health education.

Dr POUDAYL (Nepal), commenting on programme 5.1.2 (Basic sanitary measures) said that faecal contamination of the environment was a long-standing problem in his country. His delegation consequently accorded high priority to energetic action in that field. Nepal supplied a lot of water to the surrounding region, but its population did not in fact have ready access to safe drinking-water. It was to be hoped that the problem of water supply would receive the serious attention of the world community.

Professor HAVLOVIC (Austria) expressed his delegation's general support for the programme for the promotion of environmental health. Regarding programme 5.1.3 (Recognition and control of environmental hazards), he stressed the importance of limiting human exposure to hazards of physical origin. The work WHO had carried out on the development of criteria concerning physical agents was appreciated, and it was to be hoped that it would intensify its work in that field, especially with regard to non-ionizing radiation; otherwise, other bodies - for example, those concerned with industrial technology - might establish their own criteria or guidelines relating to various hazards of physical origin without sufficiently taking into account the environmental or occupational health aspects.

Dr BEAUSOLEIL (Ghana) shared the concern expressed by the delegate of Liberia about the possible adverse effects of chlorination of drinking-water. The programme on basic sanitary measures was very important, but all efforts could well be in vain unless there were also changes in behaviour. He therefore hoped that considerable emphasis would be placed on health education in this programme.

Dr HUYOFF (German Democratic Republic) expressed his delegation's support for the environmental health programme. His country would support activities through the promotion of national research potential and international cooperation. Referring to the recognition and control of environmental hazards (programme 5.1.3), he asked whether WHO envisaged the possibility of environmental monitoring of air, water or land through modern space technology, possibly in cooperation with UNEP.

Dr ISLAM (Saudi Arabia), referring to programme 5.1.2, said that his delegation believed that basic sanitary measures were of top priority if the goal of health for all by the year 2000 was to be reached. Improvement in water supply and sanitation would dramatically reduce many of the major communicable diseases, such as diarrhoeas, schistosomiasis, helminthic and other parasitic infections, including ascariasis and guinea worm infections; he believed that the eradication or reduction of those diseases could be taken as indicators of the success of the programme. The timely role of health education for the proper implementation of the programme had to be stressed.

Referring to programmes 5.1.1 and 5.1.3, he said that his country was now pooling all efforts in the field of environmental health and safety, and that it was being promoted through one coordinating body at the highest level.

Many food products had to be imported into his country, so that careful monitoring was required before they could be marketed. His delegation therefore attached great importance to programme 5.1.4, on food safety, and it hoped that WHO would intensify its efforts in the field of standardization and training.
Dr CONTY (Spain), referring to programme 5.1.4, said that, since modern methods of food production included the use of substances designed to accelerate the growth of plants and animals, improved monitoring of residues was required. Increased emphasis should also be laid on coordination between the agricultural and health sectors. The legitimate interests of agricultural development should not allow the safety aspect to be neglected.

Dr TAJELDIN (Qatar) said that more than 15 brands of mineral water were available in Qatar and neighbouring countries. Analysis had indicated that some did not differ from normal drinking-water, and that some did not even comply with the international drinking-water standards. WHO had not made any specifications regarding mineral water, and it would be helpful if it could produce guidelines that would facilitate countries' efforts in that field, and help control commercial fraud.

Dr DIETERICH (Director, Division of Environmental Health) noted that the debate showed an increasing interest on the part of delegates in problems of environmental pollution and food safety, which seemed to indicate a widening awareness of the impact of environmental health conditions on human health.

Replying to the delegate of Czechoslovakia, who had sought clarification with regard to the "international tasks" which were being assigned to national institutions within the framework of the international programme on chemical safety, he stated that the Director-General had been requested in resolution WHA31.28 "to strengthen the implementation of the programme through a central WHO unit at headquarters for planning and coordinating and a network of national institutions that would be assigned specific tasks". The intention was to delegate identified tasks to national institutions, while retaining the ultimate authority of the central unit with regard to the needed international status of the work. He explained that expert committees would as in the past play a major part in this process. Nine countries had officially joined the programme, five more were expected to do so shortly, and negotiations were under way with a further 12 countries. About 20 national institutions had been identified to assume the above-mentioned specific tasks. It should also be noted that extrabudgetary resources were becoming available in the amount of about US$ 1 million per year, in addition to extrabudgetary resources contributed by UNEP.

The delegate of India had requested information with regard to the Organization's publications in the field of air, water and food monitoring within the context of the Global Environmental Monitoring System (GEMS). Guidelines and publications that had been issued included the following: selected methods for measuring air pollution; the design of air monitoring networks; analysing and interpreting air quality data; an operational guide for monitoring pollution in water; and guidelines for establishing and strengthening national food contamination monitoring programmes. There were three publications on air and one on food, that also contained the data that were being received from the monitoring programme, while a report on water quality monitoring was in preparation. The next edition of the International standards for drinking-water would be published in 1982.

The decrease in extrabudgetary resources as shown for the biennium 1982-1983 and noted by the delegates of the Soviet Union and of Egypt was related in part to the usual uncertainty with regard to the amount of resources that would be made available from UNDP two years hence.


3 Summary report of data received from collaborating centres for food contamination monitoring, Stage I, 1977, under the Joint FAO/WHO Food and Animal Feed Contamination Monitoring Programme. Phase II (Document FAO/ESN/MON/78.2 - WHO/HCS/FCM/78.2, Geneva, World Health Organization, 1979.)
However, the decrease might also well reflect the low priority which Member States themselves were attributing to activities when programming for the UNDP indicative Planning Figure. Health ministries were often not sufficiently forceful in asserting the health priorities, and this, in turn, could be reflected in the overall decrease in the allocations.

The subject of priority-setting in the international programme on chemical safety had recently been discussed, and the relevant information would be made available to the delegate of the Soviet Union. Work had started on ways of formulating guidelines for the application in national practice of environmental health criteria produced by the international programme on chemical safety and on the setting of national standards by governments. Furthermore, "executive summaries" of the criteria documents were being prepared to help governments when they made use of this information in national regulatory action.

The comments made by the delegates of the United Kingdom and Portugal had been noted. Regarding the question of congenital malformation, WHO sponsored a joint activity with ICSU/SCOPE (Special Committee on Problems of the Environment), and a publication on the subject was expected shortly. Collaborating centres in the European Region and the Region of the Americas were particularly interested in this question.

In reply to the query of the delegates of Liberia and Ghana on the possible adverse effects of chlorination of drinking-water, he drew their attention to the summary record of the Board's discussion (document EB67/1981/REC/2, page 177), which dealt with that issue. Details would be made available to those delegates.

Repeating to a question raised by the delegate of the German Democratic Republic, he explained that environmental monitoring from space was normally related to the monitoring of ecological factors, rather than those in which WHO was interested - that is, human exposure and contaminants in human tissues and body fluids.

Finally, he informed the delegate of Qatar that the question of mineral water had been on the agenda of the Codex Alimentarius Commission for many years. There had been a proposal that a possible standard for mineral water might include a reference to what were called health benefits accruing from mineral water. WHO had taken a firm stand on this matter and convened consultations of experts who had not confirmed any such beneficiary effects. The matter had not been pursued by the Codex Commission.

The CHAIRMAN, adjourning the meeting, announced that the delegates of China, Egypt, Poland and Sierra Leone had expressed the wish to co-sponsor the draft resolution on the International Drinking Water Supply and Sanitation Decade, which would be discussed under agenda item 24.

The meeting rose at 12:55.
TWELFTH MEETING
Tuesday, 19 May 1981, at 14h30

Chairman: Dr A. A. K. AL-GHASSANY (Oman)

1. PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA33.17, para. 4(1) and WHA33.24, para. 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2) (continued)

HEALTH MANPOWER DEVELOPMENT (Appropriation Section 6; Documents PB/82-83, pages 212-224, and EB67/1981/REC/3, para. 175)

Health manpower development (major programme 6.1)

Dr BARAKAMFITIYE (representative of the Executive Board) said that the Board was satisfied with the major programme's objectives, approaches and planned activities. Health manpower continued to be, and would increasingly become, of major concern to all Member States since, without sufficient and competent manpower to meet the health needs of the entire population, it would be impossible to achieve national development for health. The training and utilization of manpower accounted for a very large proportion of the health budget of Member States. It was crucial, therefore, to achieve optimal cost-effectiveness, and WHO would continue to collaborate with Member States in their efforts to improve the planning, production, and management of manpower for health development.

The programme covered the last two-year phase of the medium-term programme endorsed by resolution WHA31.36; it reflected the principles, objectives and priorities laid down by the Twenty-ninth World Health Assembly in resolution WHA29.72, which required the Organization to collaborate with Member States in satisfying the health needs of their entire population through health services provided by balanced teams of health personnel, trained to give optimal health care. The programme focused on and supported national, regional and global strategies to achieve health for all by the year 2000 through primary health care. Its basic philosophy was relevance to the needs of health services and of populations. Its basic approach was technical cooperation among Member States and the development of networks of institutions and programmes. The programme was geared to the two principal objectives identified in the Sixth General Programme of Work. Their achievement was essential to the realization of health for all by the year 2000 and was a vital element in the primary health care approach, as formulated in the Declaration of Alma-Ata.

The programme consisted of a coordinated set of approaches to increase national capability and self-reliance. Activities were based on the principle that service and training were interdependent and that training must be relevant to health requirements. Planning and management would be one of the main thrusts of the programme and WHO would collaborate in determining national policies consistent with policies in other sectors, and would continue to cooperate in realistic, task-oriented manpower planning within national health plans that were themselves an integral part of national socioeconomic development plans. WHO would also collaborate with Member States in their efforts to develop a proper working environment, increase productivity, ensure social relevance and maintain quality of services and job satisfaction of health workers. That would entail the creation or strengthening of incentives, career structures, job security, satisfactory living and working conditions, and the development of continuing education for all health personnel, including training in management skills and attitudes. The development of educational institutions and training programmes for all categories of health manpower, including practitioners of traditional medicine, would be promoted, strengthening the capacity of Member States to train health personnel as members of a community health care team.
Educational institutions and programmes would be strengthened, e.g., by developing curriculum plans, teachers, and learning materials. Promotion of networks of innovative educational institutions, and particularly those using community-oriented, problem-solving teaching/learning processes, would be continued.

Finally, WHO planned to promote research, in all areas of the programme, the main thrust of which was to promote the integration of health services and health manpower development within the context of national health development in order to further the attainment of health for all by the year 2000 through primary health care.

Dr HAPSARA (Indonesia), noting the budgetary allocations to the various regions and programme components, asked whether regional variations in the approach to health manpower development accounted for them and requested clarification regarding the extent of the similarities and differences. His delegation supported WHO’s activities for the integration of health manpower planning within the context of national health and economic plans and in collaboration with the general education system, and urged greater attention to that question.

Dr BAJAJ (India) said that the delivery of health services was essentially a matter of teamwork, involving a large number of different categories of workers, each of which had its own role, responsibilities and functions. Greater emphasis should be given to cultural and social aspects in health manpower development, and training should be fully oriented to the people’s needs. Selection and training should be based on the requirements of the specific tasks concerned. At the lower levels, those selected should come from the community itself. Training should be adequate and effective, and provision should be made for in-service training.

Dr POUDAYL (Nepal) said that his country was faced with the problem of inducing the small number of doctors available to work in the interior - a common problem in developing countries. It had been suggested that the curriculum should be changed so as to produce doctors who would be dedicated to such work. The approach adopted over the last 25 years in Nepal had been to train paramedical personnel, instead of doctors, but it had been found that even such personnel were also purely urban-oriented. All communities possessed traditional health workers; they should be given in-service training, since they would be far more useful than paramedical personnel who had received formal training in an institution. What progress had been made in motivating doctors and other health workers to work in the interior of countries? WHO should provide leadership.

Professor HALTER (Belgium) pointed out that the promotion of traditional medicine, which he thought justified, was being questioned, both by practitioners of western medicine and by people in countries where traditional medicine was still practised. He suggested that an evaluation would be relevant even in the developed countries with their fringe medicine, e.g., homeopathy and acupuncture. Indicators of the efficacy of such procedures were required.

In schools of medicine and schools for paramedical and nursing personnel, the standard of teaching was often low; teachers were unable to pass on information, either because they did not use suitable teaching methods or because the information was not related to day-to-day practice. Many otherwise competent teachers in medical schools did not know what public health was, or were unaware of what the public wanted from medical practice. WHO should therefore develop teaching methods and analyse the material to be taught, with a view to increasing the output of the personnel after training.

Finally, his delegation was fully in agreement with the the major programme as presented in the programme budget (document PB/82-83).

Dr ISLAM (Saudi Arabia) said that, in Saudi Arabia, the quantity and quality of manpower was the main constraint on the provision of health services. National health manpower had to be developed but large numbers of expatriate health workers accounting for 80%-90% of total health manpower, also required orientation.

In many countries, ministries of health planned health manpower development without reference to those responsible for the education of the personnel; in Saudi Arabia an attempt was being made to ensure joint action with the education authorities in planning and development and in establishing curricula, and a high-level body for coordination and planning manpower development, which would cover health manpower, had been set up. If the concept of the primary health team was really to be accepted, it would have to be instilled into the minds of doctors and other health workers right from the start.
Dr PONCE DE LEÓN (Peru), referring to manpower training for primary health care, drew attention to the need to adapt medical training, which currently was directed towards curative medicine in the modern hospital and advanced medical technology, to the totally different requirements, with a backward glance at the old concept of the family doctor, who treated patients in their homes with the help of family members.

Dr POPOVIC (Yugoslavia) considered that the entire major programme on health manpower development reflected the many specific features of countries and regions; it had his delegation's full support.

With regard to the reform of medical education, there was a need for the integration of the educational and scientific work of health professionals, although complete integration was impossible. It was also necessary to adopt a more critical approach to day-to-day problems and to ensure or re-emphasize self-evaluation of practical work. Similarly, continuing education was very important as a form of re-evaluation and criticism of practical work. In that way, medicine could defend itself against those who criticized it as doing more harm than good.

Innovations in health care delivery systems and medical education should be encouraged, relevant information passed on to other countries, and exchange of information promoted, in the interests of a better understanding of health needs and of planning and making necessary changes.

Consideration might be given to the possibility of instituting prizes, awarded jointly by WHO and governments, for innovations in primary health care in recognition of the efforts of those who were really trying to achieve WHO's objectives.

Professor ARAUJO (Cuba) expressed his concern at the failure to give adequate emphasis to the integration of teaching and provision of health care. Medical and dental training, especially at the highest level, were currently academic; though held in high prestige - since medical schools accepted only the most talented - such academic training was remote from the reality of health care, especially primary health care. While national health services needed manpower trained to give such care, medical schools turned out scientists, or doctors trained for private practice. That had serious consequences. Graduates trained in curative medicine lacked understanding of the tasks that they were called upon to perform, which they regarded as inferior.

Reference had been made in earlier discussions to the possibility of training doctors who were also psychologists; some delegations had considered that to be essential. In his view, that would not be a good idea; the next step would be to train doctor-sociologists, doctor-anthropologists, and so on, since medicine was a social, and not a purely biological science. In Cuba, the aim was to produce an all-round doctor, and not one who was trained solely in the hospital ward, surrounded by sophisticated equipment. Training on the ward was necessary, of course, so as to give the doctor experience in dealing with serious cases, but the medical student should be brought into contact, right from the start, with the day-to-day problems of front-line medicine.

The two factors that he had mentioned were fundamental to health manpower training at all levels. The programme should perhaps have paid greater attention to them, with a view to enabling the health authorities to establish a fruitful dialogue with medical schools, which were usually totally isolated from ministries of health. That was not a criticism of the programme, only a suggestion for the future.

Miss GIDDINGS (Liberia) noted with concern the decrease in the budgetary appropriation for programme 6.1.3 (Educational development and support). For instance, in the case of the African Region which was a large one, the existing allocation would not go far in support of so many Member States. Her country was attempting to increase appreciably the numbers of its trained health personnel and also to develop its own teaching materials in basic training programmes and in-service education, and was hopeful that it could become self-sufficient. Liberia's midwives were being trained using textbooks written for use not only in Liberia but in Africa as a whole. With so much to be done to develop health manpower for primary health care, including retraining of all categories of health personnel, it was hard to explain the reduction in the budget.

Dr NDLOVU (Zimbabwe) recalled that at an earlier meeting the delegate of Kenya had asked for information at a future date about WHO country activities and projects relating to the preparation of nurses in primary health care. Such information would indeed be of great interest to all delegations.
Her delegation noted with special interest the reference, under programme 6.1.2 (Promotion of training), global and interregional activities, on page 220 of the programme budget to the plan to hold an expert committee on training nursing teachers and managers with special regard to primary health care in 1983, and she wished to commend WHO for its foresight.

Regional needs for such training varied greatly. Leadership preparation was essential to change nursing curricula. She hoped plans would include nurse-teacher and management training centres in every WHO region and networks of national centres. Rapid advances in nursing and increases in numbers of nurses were needed.

She had especially noted from paragraph 3 under the major programme, on page 212 of the programme budget, that the health manpower development programme would place special emphasis on those concerned with first-line health care, which was a most relevant priority. She hoped to hear and read more detailed information about front-line health workers: village health workers, auxiliary health workers, nurses and midwives - those actually implementing primary health care, rather than about doctor/population or doctor/bed ratios. Methods of information exchange, sharing of experiences, technical cooperation between countries and between primary health care workers needed to be fostered, and career structures should be improved through better programmes in continuing education and leadership training.

The strengthening of education institutions preparing such staff should receive priority over those concerned with high technology care, although even WHO was not well endowed with health professionals such as social scientists, health educators and nurses for primary health care.

WHO's study of its structures in the light of its functions should pay attention to the need for multidisciplinary health teams with a balanced mixture of relevant health professionals attuned to community work, primary health care and community health development.

Lastly she suggested that a full report to the Thirty-fifth World Health Assembly on progress in implementing resolution WHA30.48 (The role of nursing/midwifery personnel in primary health care teams) be requested.

Dr DIALLO (Mali) said that Professor Halter's reference to traditional medical practitioners had touched on a fundamental problem. It was vital to know what type of practitioner one was dealing with. He recalled an occasion some six years previously when a Chinese colleague had been cured of a snake bite by the administration of a remedy given him by a local healer. There was no doubt in the minds of the local people that the remedies they obtained for snake-bite from their healer were superior to the serum which he himself had offered to administer.

On another occasion he had been surprised at the evident success of a healer whom he regarded as a rogue and who prescribed yohimbine as an aphrodisiac. There was very much to be learnt from practitioners of traditional medicine and great merit in being able to discriminate between good healers and the others.

Mrs NGUGI (Kenya) said that her delegation placed great stress on the need for additional manpower in the effective delivery of health services especially in rural areas. There was a clear need for an expansion and acceleration of both basic and in-service training programmes for members of health teams. Nursing training curricula had been revised to include maternal and child health and family planning and practical field experience. Training for clinical officers would also include obstetrics and gynaecology and family planning. The availability of trained nurse tutors/specialists remained a major constraint in the training of community health nurses. There was provision for the enrolment of 3-5 students per year.

The Government of Kenya pursued a policy of coordination and technical cooperation with other Member States; training vacancies for nurses and auxiliary staff at both basic and post-basic level had been offered to other countries of the Region at the medical training centre in Nairobi. Post-basic courses in surgery, paediatric medicine, obstetrics and gynaecology were well established at the University of Nairobi. The department of advanced nursing formed part of the medical school and offered a few places for training nurse teachers and administrators from other countries of the Region. There was a student exchange programme on a small scale which was being actively encouraged.

Mrs MAKHWADE (Botswana) stressed the important role of nurses in the planning, implementation and coordination of primary health care programmes and as team leaders in the front-line of health work. WHO's continued collaboration would be much appreciated in the up-grading of nurses' technical and management skills to enable them to discharge their responsibilities effectively.
The delegation of Botswana welcomed the increase in the budget for the promotion of training (programme 6.1.2).

Dr. COELHO (Portugal), fully supported the proposed programme and budget for health manpower development, which was currently one of the top priorities in his country. A health manpower development department had been created in 1980 and a major training scheme for auxiliary health personnel was being developed. That would certainly bring dividends in the near future in the development of the Portuguese health services.

He expressed appreciation of cooperation with WHO and of its help in connexion with education planning and methodology.

Professor LISICYN (Union of Soviet Socialist Republics) said that his delegation had noted with satisfaction the progress made in some of the matters under discussion. His delegation attached importance to all categories of health workers, to the quality of their work, and to the job satisfaction they derived from it. It further followed with keen interest the efforts being made to adapt staff to the needs of primary health care and the fulfilment of other recommendations of the Alma-Ata Conference. An expert committee on the subject had been scheduled for 1983; his delegation would have preferred it to meet sooner, say in 1982. Also of interest were the efforts being made to prepare profiles or models for health workers.

To improve the programme further, more attention might be given first to research in the training of family doctors, whose numbers were diminishing despite the fact that it was they who best met the needs of the primary health care Global Strategy; there was a disturbing tendency towards over-specialization. Secondly, greater attention should be paid to new types of training for health workers, especially to in-service continuing education. Such courses could be longer or shorter but were to be preferred to isolated courses. Thirdly he commended the self-instruction programmes in use in his country; he hoped that the use of self-instruction programmes could become more generalized. Fourthly, a sharper line should be drawn between the spheres covered by the three levels - headquarters, regional and country levels. Headquarters should be concerned with the further medical training of specialists, of an intensive and theoretical nature, while the regional offices should be concerned with the preparation of models for generalists and specialists, paramedical and other health personnel. In countries like his own, symposia attended by deans of medical schools and institutes to discuss trends in medical training and textbooks were most fruitful. WHO should take further initiatives to plan and organize such meetings.

Dr. PATTERSON (Jamaica) spoke of the vital role of the front-line hospitals in the development of primary health care support systems, and welcomed WHO's initiative in the development of a programme of essential surgery. She stressed the importance of anaesthetic services in such a programme and hoped that the essential surgery programme could be linked from the start to an anaesthetics programme. Over the past 10 years a small cadre of nurse anaesthetists had been working in Jamaica, and experience had shown that graduate nurses could be trained for that service and would perform at consistently high levels, particularly in rural settings where medical anaesthetists were extremely difficult to recruit.

Her delegation particularly commended that category of health personnel, considering them to be an integral component of a health team. She wished to know whether there were any plans for their development.

The DEPUTY DIRECTOR-GENERAL said that it was a source of pride that it had been possible to maintain the quality of the health manpower development programme over the years. In discussing the research promotion and development programme earlier, mention had been made of the participation of outstanding and dynamic men and women of science; the same was true of the health manpower development programme, which attracted scientists of the highest calibre from medical schools and the academic community, as well as from health ministries. As a result, information flooded in from all corners of the world. It was a pleasure to note, also, that the foundations of the programme had been laid by the Chairman of the present Committee, Dr. Braga.

Without the right quantity, quality and variety of manpower, the concepts of primary health care and health for all by the year 2000 were unworkable. The new element in the programme was the broad and highly sensitive methodological approach employed in monitoring the diverse needs of Member States and responding to them. The one worrying feature was the way in which dynamic ideas and the programme's progressive vision had gone on ahead of the capacity of Member States to make effective use of them. That presented a challenge to Member States.
Listening to the discussion, he had felt a sense of growing pride at the variety of needs the Organization was able to meet, for example, integrated teaching and care, as proposed by the delegates of Cuba and Belgium. He had reflected that what was apparent in the document was no more than a fragment of total activity.

The reasons for the budgetary decrease deplored by the delegate of Liberia were given in paragraph 28 under programme 6.1.3, on page 223 of the programme budget.

The delegate of Mali had alluded to the need for classification of different kinds of healer especially in the Third World. It might be a long time before that stage was reached, but it certainly was very important. One interesting aspect of the traditional healer's use of plant-based drugs was that, whatever the pharmaceutical properties of the medicinal plants might be, even if they were mere placebos, most healers of that type were masters of the power of words. That was particularly noteworthy at a time when so many doctors trained in orthodox medicine in the modern world lacked the ability to enter into dialogue with a patient. That too had been taken into account in the programme under consideration.

Dr FULOP (Director, Division of Health Manpower Development) thanked all 16 speakers for their encouraging remarks and constructive suggestions, which had been duly noted and would be taken fully into account in programme formulation. He also thanked those who had expressed their readiness to collaborate in the programme.

Nineteen questions had been asked in all. The first, put by the delegate of Indonesia and raised again by the delegate of Liberia, related to the wide regional variations in budgetary allocation to the programme. Those variations were due to the fact that Member States themselves decided on priorities. The allocation to different programme elements of the WHO programme was at the discretion of each country, and was therefore bound to vary. As to shifts within the programme, an explanation of the phenomenon was to be found in the heading to programme 6.1.0 on page 214, in the words: "In the budget estimates for the regions shown under this programme, the increases or decreases as compared with the previous biennium relate mainly to changes in programme classification." Taking the programme as a whole, the regular budget showed an increase of 15.2% (US$ 7 952 400) over the previous biennium. Within global and interregional activities, there was an increase of US$ 113 800, which represented a larger percentage increase (28.6%).

The delegate of India had asked, as had the delegate of Cuba, what could be done to eliminate the divergence between service and training objectives. WHO was fully aware of the importance of that aspect, and had indeed coined a new term for it, the "HSMO concept", standing for integrated health services and manpower development. The first of the objectives for health manpower planning and management (programme 6.1.1) under paragraph 1 on page 215, in referring to coordination between "educational and service institutions" was only one expression of WHO's determination to give it due weight. Everything would be done to ensure that it was given even more attention in future.

The second question raised by the delegate of India referred to the problem of selecting students, and was dealt with in paragraph 11 under programme 6.1.3 (Educational development and support) on page 221. A draft publication had in fact been prepared, entitled Selecting students for training in the health professions: a practical guide. It was now being reviewed and should be available early in 1982.

The delegate of Nepal has asked the very important question of how to attract health workers into the interior of the country or to rural districts, a question which had been under discussion for the past 33 years. There was no easy answer, but there were useful approaches, some of which had already been mentioned in the course of the debate. The first was not to rely exclusively on medical doctors in rural areas but to plan appropriate health services manned by balanced health teams; the second was to base the training of all types of health workers, including medical doctors, on the community; and the third was to provide appropriate working conditions and career prospects for those prepared to work under conditions of hardship. In connexion with the point raised by the delegate of Belgium he drew attention to the details given on teacher training activities, in particular on nursing teacher training in the European Region, in paragraph 14 under programme 6.1.2 (Promotion of training). That very important training aspect would be receiving close attention from the expert committee which would in 1983 be considering, among other subjects, the training of nursing teachers.

The delegates of Peru, Cuba and Yugoslavia had raised the question of the need for a new orientation in the training of medical doctors. The relevant WHO activities in promoting innovation in the training of all categories of health personnel and in particular medical doctors were covered in programme 6.1.2, including the establishment of a network of community-oriented educational institutions for health sciences (paragraph 10). There had been a
Yugoslav participant at the recent network meeting in Bellagio in March-April 1981. WHO had also issued two publications in the Public health papers series, Nos. 70 and 71 both entitled Personnel for health care: case studies of educational programmes, which described a total of 27 innovative schemes. Replying on a point raised by the delegates of Zimbabwe and Botswana about the relation between primary health care and nursing programmes, he drew attention to paragraph 16 in programme 6.1.2, which should in fact have referred not to the four regions specified, but to all regions. The draft guidelines mentioned in that paragraph had been prepared with the participation of several nursing facilities and had been reviewed in 11 different countries by 79 schools, in order to assist those responsible for basic nursing training programmes to bring their curricula into line with evolving principles of primary health care. The guidelines should be ready for field tests in July 1981.

No statistical information was yet available on manpower in primary health care. It was hoped to collect sufficient information on the number of primary health care workers and the teacher training facilities available in order to report to the Health Assembly on that subject and to prepare an appropriate guideline for teacher training in primary health care.

Relying to the delegate of USSR, he said that the proposed programme budget contained 27 research projects, which were representative of many further projects liable to materialize in the near future. There had been a distinct shift of emphasis towards research in the allocation of funds for global and interregional activities: US$ 350 000 out of US$ 511 600 had been allocated to research activities.

Paragraphs 17 and 18 in programme 6.1.1 gave examples of activities relating to continuing education. The production of self-instructional "packages" for use both by teachers and students at professional and intermediate levels would be continued (paragraph 24 under programme 6.1.3). He drew attention also to the statement that the development of regional networks of institutions engaged inter alia in the definition of job profiles ("models") would continue (paragraph 12 under the same programme).

Dr KO KO (Regional Director for South-East Asia) said that the fundamental aim in his and in all other regions was to reach the goal of health for all by the year 2000. The variations between individual countries related to differences in individual work plans or tactics, which had their origin in the local administrative machinery, political structures, state of preparedness and their manpower and financial resources. A common feature, however, was that the entire manpower development package rested on the foundation of the primary health worker, though the intermediate and high levels could not be neglected; the entire manpower pyramid had to be taken together.

Manpower training involved two basic components, a proper orientation and the imparting of skills and knowledge. Orientation was particularly important in the training of primary health care manpower. In many parts of the Region leaders of primary health care programmes and related training programmes were cardiologists or surgeons in various specialist fields, who were motivated, having sound convictions, and were properly oriented towards the primary health care tasks they had to perform. Probation and orientation, supported by a proper monitoring and feedback machinery, were essential. Without adequate planning and appropriate orientation the results would never be satisfactory, and even voluntary health workers might become quacks instead of front-line primary health care workers.

HEALTH INFORMATION (Appropriation Section 7; Documents PB/82-83, pages 225-243, and EB67/1981/REC/3, paras 176-182)

Health information (major programme 7.1)
The aim in the programme on WHO publications and documents (programme 7.1.2) was to ensure an even more direct contribution to the goal of health for all by the year 2000. An important step forward, which the Board had warmly supported, was the publication in all six working languages of a new quarterly journal on health development, World health forum. In addition, an allocation of US$ 200 000 had been made to encourage the translation of WHO publications into vernacular languages. A comprehensive review of WHO documentation would in any case be carried out in the context of the study of WHO's structures in the light of its functions.

The reinforcement of health legislation (programme 7.1.3) had been very fully discussed by the Board at its sixty-fifth session; the views expressed had covered both technical cooperation and information transfer components. The Board had welcomed in particular the new orientation given to the International digest of health legislation so as to provide more analytical material of direct benefit to Member States.

In programme 7.1.4 (health literature services) the main emphasis had been placed on helping Member States to formulate plans for the development of national health literature services, the setting up of health sciences library networks to facilitate more general use of the information, the provision of more staff and equipment, thus fostering cooperation between information networks at the national, regional and global levels, and providing improved access to medical information originating from the developing countries.

The general trend had been towards a rationalization of activities in the field of health information, involving a greater emphasis on catalytic rather than directly operational work and providing essential support, in spite of a budgetary reduction in accordance with Health Assembly resolution WHA29.48, for attainment of the goal of health for all by the year 2000.

Dr HAPSARA (Indonesia) accepted the validity of the division into five component programmes. He suggested that the experience of other specialized agencies would have been relevant and useful for comparison with WHO in that particular field. Further development of the five component programmes would be desirable in order to ensure a precise identification of the information required, to be accompanied by the development of systems within the countries themselves.

Dr HYZLER (United Kingdom of Great Britain and Northern Ireland) said that the reduction in the budgetary provision for traditional activities for ICD (paragraph 14 under programme 7.1.1 (Health statistics)), coupled with the abolition of three headquarters posts in the 1980-1981 biennium and a further four in 1982, had given rise to some disquiet in regard to the future of ICD. The Classification was a basic WHO activity, invaluable for purposes of comparison at the national and international levels, and it was the view of his delegation that that activity should continue to be provided with adequate resources to maintain its work at an effective level.

Professor MODAN (Israel) fully supported the view of the delegate of the United Kingdom on ICD, which he believed should be expanded to cover further areas, such as psychiatry and geriatrics. One important requirement which had not been mentioned was that of better indicators of utilization of health services. Another subject of importance was the secrecy of information, which hampered epidemiological research and the obtaining of health data. The increasing number of case-control epidemiological studies incriminating commonly used substances necessitated the establishment of a central data control system and basic rules for policy decisions, for example in regard to saccharin, pesticides, household drugs and possibly even coffee.

A start had been made in Israel with a health legislation effort and the definition of the risks in smoking and radiation, but there was a public demand and a need for action on other environmental agents. The promotion of health legislation in such fields was an obvious opportunity for WHO.

Dr IKENOUCHI (Japan) emphasized the importance her country attached to WHO's work on ICD, which was an indispensable basic standard tool for use by all countries and which played a fundamental part in clinical studies, epidemiological research, health records, and various other statistical activities. Her delegation believed that periodic revision of ICD, incorporating the progress made in medical science, was one of the most important functions of WHO. She therefore recommended that that task and supplementary classifications, should be given continuous priority in WHO's work.
Dr BORGONO (Chile) said it would be difficult to overestimate the importance of activities in health statistics. A great deal of effort had been devoted in the Americas to setting up the necessary infrastructures for an efficient information service, which was important for the analysis of health programmes, for the evaluation of disease control programmes and also for epidemiological purposes. The widely heterogeneous group of countries that made up WHO were anxious to use the most modern and sophisticated technology to accumulate the necessary statistical data.

He believed that WHO publications and documents (programme 7.1.2) were a most efficient means of disseminating technical and administrative information, covering the research that was being done and the achievement of individual programmes. Although the publications themselves were excellent, there appeared to be room for improvement in the system of distribution, especially to more distant countries, and he urged that the problem should be looked into.

Professor LISICYN (Union of Soviet Socialist Republics) also stressed the importance of statistical information and statistical services and regretted the reduction in budgetary allocations in that field, especially where research was concerned. He suggested the setting-up of expert committees or study groups to consider producing positive-health status indicators of populations; for example, numbers of people who had not suffered any illness for a certain period of time.

Since a new WHO publication, World health forum, was being launched he asked whether it would not be desirable to reduce the number of issues of the WHO Chronicle.

He stressed the importance of health legislation and suggested the holding of a seminar or symposium on the legal aspects of the development of primary health care. Unfortunately, the subject was not sufficiently developed in the reports and plans of WHO.

He wondered whether information on medical research, as reflected in published and unpublished papers, was adequately passed on to the public. There was no reason for such a task to be restricted to medical libraries.

He asked about related activities of the WHO library and what progress had been made with automatic data systems, such as the MEDLINE system. In his country health statistics and information on health were considered separately and were provided by two different organizations, dealing with the research and practical aspects. In view of the importance attached to health information in countries, it might be desirable for a special study to be carried out, for example by the Executive Board, of research information and its role in health development.

Dr BELCHIOR (Brazil) said that his delegation agreed with the postponement of the Tenth Revision of the ICD, and would be very interested in any classification that could be used in services providing primary care and in lay reporting. He hoped that funds would be provided for the ICD unit at headquarters to continue collaboration with the six international classification centres. There was little doubt that PAHO would be following a similar procedure, with centres in Brazil, Venezuela and the United States of America.

He wished to underline the importance for health information in general and for health statistics in particular, of the joint WHO/CIOMS project for International Nomenclature of Diseases (IND) (project No. HST 023). The mission and objective of IND was to eliminate ambiguity and confusion in medical nomenclature by the establishment of lists of recommended terms, together with their synonyms, accompanied by definitions. That project, as other projects aiming to standardize nomenclature, measures, etc., was of extreme value for improving international understanding in medical communities, not only for improvement with immediate effect - communication in the case in point - but also to create a basis in that complicated field for future generations. It had to be realized that international standardization of that type could only be accomplished by such global organizations as WHO and CIOMS.

He welcomed World health forum, an excellent publication, and suggested an edition in Portuguese, to be published jointly by the Regional Offices for Europe, Africa and the Americas.

Dr BAJAJ (India) said that his country had established a Central Bureau of Health Intelligence to collect medical information from all over India on various subjects such as population trends, information on births and deaths, health sector outlay, numbers of medical institutions, numbers of medical personnel and the Expanded Programme on Immunization.

That work was being done in the context of ICD and if any changes were planned in the status of ICD, due notice should be given to Member States.
Dr BULLA (Romania) said that his delegation fully supported programme 7.1.1 (Health statistics). It recognized that the programme had good prospects of further developing towards a comprehensive statistical information system capable of providing the necessary support for assessing the health situation, the projection of health trends and the background for programme development, decision-making and monitoring. But there was room for improvement; among the elements which might be improved, he singled out uneven performance in reporting from national statistical boards; a lack of continuity in reporting to WHO caused difficulties for those wishing to use the data. In addition, there was inadequate coverage of the population of particular areas or subjects. For example, as regards mortality data, only 30% of the world population was covered by reporting. The situation was slightly better as regards morbidity, for which coverage was about 60%. The most important adverse factor was the confusing criteria for coding diagnosis and reporting.

Although much improvement was needed from national systems, at the same time, at the global level, a regular, annual, critical analysis of the available data would prove extremely useful. In that area, one of the main difficulties was the lack of precise nomenclature and scientifically proved criteria for diagnosis.

The importance of statistical information for the increase and further development of primary health care and its monitoring could not be overemphasized.

Professor HALTER (Belgium) said that the programme under discussion represented WHO's communication with the world and should not, if possible, be subjected to cuts. A year or two previously his country had been worried about the problems of health legislation and, owing to WHO's structural changes, had feared that related information might be affected. In the Regional Office for Europe work on health legislation was continuing successfully to the great satisfaction of his country.

As regards health indicators, he informed the Committee of a meeting which had been held in Belgium on the initiative of the Regional Office to analyse and specify methods of using statistics so as to make them real health indicators. It was important that that work should be followed up, for statistics were valueless unless put to practical use.

Dr GÖRRES (German Democratic Republic) said that for health information to fulfil the role set out in paragraph 4 under major programme 7.1 (page 223) health education was essential. His delegation therefore considered that the health information should be associated in future with health education.

It recommended that WHO should always explain to the public in all countries and in a convincing way the connexion between peace, disarmament and health; and should apply in health information the principles worked out by a WHO working group in 1977, namely, community responsibility for health education; organized and efficient planning; a scientific approach; motivation of the population in health protection; recognition of the special role to be played by medicine in education and information; and differentiated orientation according to different target groups.

In view of the new emphasis on self-care and mutual-aid health groups mentioned in programme 3.2.4 (Health education), his delegation endorsed the European Region's support for active, conscious participation of individual citizens and of groups and social communities in the maintenance, promotion and rehabilitation of health as a necessary addition to the social and State-supported activities to protect health as a whole. Self-care and self-aid should not, however, be considered as an alternative or substitute for generally available and scientifically based medical and social care and living and working conditions conducive to health. Individual citizens should not be burdened with full responsibility for their own health while social and State benefits were reduced.

Professor SENAULT (France) said that although it was understandable that some reorientation was needed to meet the new policies and strategies, his country was concerned about the reduction in the budget allocation for ICD.

His delegation considered that, as regards WHO publications and documents (programme 7.1.2), the Organization had done considerable work useful to all Member States and he was pleased to see the quality of the publications continue to improve.

He endorsed the comments of the Belgian delegate on the usefulness of the work being carried out on health legislation. Concerning health information of the public (programme 7.1.5), his views on health education were well enough known to allow him simply to express satisfaction with the line being taken.
Professor GIANNICO (Italy) expressed his delegation’s satisfaction with the programmes under Appropriation Section 7. Health information had an essential part to play in helping to meet worldwide needs and cooperation between WHO and countries was necessary in that field. The documentation and information provided by WHO was very useful and greatly valued.

His delegation however noted that the Weekly epidemiological record did not appear in the list of publications given under WHO publications and documents (programme 7.1.2) on pages 234-237 of the programme budget. He wondered whether that was due to an oversight or whether its publication was being stopped. That would be unfortunate as it contained recent information and dealt with current problems.

Dr SADRIZADEH (Iran) said that health statistics were one of the fundamental components of health planning and health programme evaluation. Data were mainly obtained through hospital, dispensary and laboratory records. Laboratory and hospital data were usually more reliable than those of dispensaries. In order that inaccurate data should not lead to misinterpretation of the health situation, he urged that efforts be made to standardize diagnostic criteria and related training.

Since in most developing countries private practitioners and nongovernmental institutions were reluctant to report cases of communicable diseases, strict rules and regulations were needed to oblige them to do so.

Finally, simple methods should be selected for data collection, especially at the peripheral level.

Dr MAGNUSSON (Iceland) said that to the objectives of the major programme should be added that of increasing the comparability of health statistics from different countries.

He was disturbed to note cuts in the budget for the ICD unit at headquarters and wished to know whether the Tenth Revision of the Classification was being prepared and, if so, when it would be published.

The DEPUTY DIRECTOR-GENERAL said that the reduced allocation for ICD had been discussed at the Executive Board session in January, when the Director-General had reassured members of the Board that the work on the Classification would continue (document EB67/1981/REC/2, page 184). Since January, efforts had been made to redress the apparent reduction.

Dr HAMON (Assistant Director-General) acknowledged with thanks the comments made by delegates. He wished to add to the assurance given by the Deputy Director-General that ICD was not being abandoned. Although there was a reduction of funds allocated to the Division of Health Statistics at headquarters, there was a more than compensatory increase of almost 50% in the resources allocated to health statistics activities in the regions and at country level. That indicated the importance attached to those activities and to the hope that the decentralization recommended in resolution WHA29.48 would lead to an improvement in the quality of health statistics and greater comparability of the data from different countries and regions. Preparation of the Tenth Revision of ICD was, however, influenced by the transfer of resources and that was why its postponement was proposed.

As regards the point raised by the Indonesian delegate, a comparison of the publications of other agencies in the United Nations system could certainly be made, but it would involve considerable work and could probably not be done by WHO alone. It would be easier to provide information on one particular subject, and if a specific proposal was made its feasibility could be studied. Coordination of information activities between the regional offices, countries and headquarters was close and it was intended to intensify that coordination.

As several delegates had stated, much remained to be done concerning health statistics. In view of the variations in infrastructural level between countries, and until data collection methods had been improved, it would be impossible to avoid certain distortions in information.

A private discussion with Dr Borgoño, the delegate of Chile, had shown that his concern about the dissemination of WHO publications was probably due to a local problem, and the matter would be reviewed separately with a view to a suitable solution.

With regard to the question raised by the Soviet delegate, he had already indicated that there was no decrease in allocations to health statistics but that the effort was to be concentrated at the regional and country level. It would certainly be very useful to establish new health indicators, and the subject would be studied during the coming years. If there were precise suggestions for types of indicators not yet considered by WHO and which might be helpful in evaluating primary health care, the Secretariat would be happy to receive them.
Publication of World health forum in all the Organization's working languages was costly, and as no supplementary credit had been requested economies had been made by reorganizing the Office of Publications and in particular by reducing the frequency of the publication of the WHO Chronicle. In view of the fact that certain subjects formerly dealt with in the WHO Chronicle were being included in the Bulletin of the World Health Organization in the form of very brief notes, the general quality of the information disseminated by WHO would be improved and the Forum could be produced without additional costs. The production of the Forum in a Portuguese language version, as requested by the Brazilian delegate, would be possible but would cost about US$ 60 000 and there was no provision for it in the budget. Should such a decision be made, a supplementary allocation would be needed.

The effort made during the last few months to present the analysis of health legislation in a different way should go some way to meeting the Soviet delegate's suggestion for a new approach, but further suggested improvements would be taken into consideration. The aim at present was to include review articles on health legislation topics of current relevance to Member States in the International digest of health legislation.

As regards the dissemination of scientific information, whether published or not, the problem was being approached at two levels. In the framework of the programme of public information a few months ago a seminar had been arranged for scientific journalists on the activities of the Special Programme for Research and Training in Tropical Diseases; furthermore, a network of scientific journalists had been developed and was kept informed of important health scientific developments about which it would be desirable to inform the public. On the other hand, the Health and Biomedical Information Programme was reviewing its information system with the aim of developing systems which would take into account unpublished as well as published information.

As regards the points raised by the delegates of the German Democratic Republic and of France concerning the relation of health education to public information, it was hoped that they would be pleased by the closer association between health education and public information which was planned, under the Seventh General Programme of Work as it was clear that the two were different aspects of the same activity. The content of each was similar, but the way the information was disseminated was different.

He assured the delegate of Italy that there was no intention to stop publication of the Weekly epidemiological record; the reason why it did not appear in the list was that it was not produced by the Health and Biomedical Information Programme but by the Division of Communicable Diseases.

The comments made by the Iranian delegate on the need for suitable laboratory support and technology for the collection of accurate health data were of great importance but were more relevant to the general problems of diagnostic quality, which had been discussed earlier, during the review of communicable disease prevention and control (major programme 4.1), than to the health information programme, since the latter was mainly concerned with disseminating information received and not with the diagnostic methods used for collecting it.

GENERAL SERVICES AND SUPPORT PROGRAMMES (Appropriation Section 8; Documents PB/82-83, pages 244-254, and EB67/1981/REC/3, paras 183-185)

General services and support programmes (major programme 8.1)

The CHAIRMAN invited the Committee to discuss the programme with its subitems as a whole.

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board) said that in reviewing the general services and support programmes (major programme 8.1), the Board had noted with satisfaction the overall reduction in the estimates despite increased costs and wages.

In considering the provisions for programme 8.1.1 (Staff development and training), the main objective of which was to strengthen the professional and technical competence of staff at all levels, the Board had been informed that the programme, which had been introduced in 1975 at headquarters, had since then been extended to the regions, three of which had initiated their own staff development and training programmes with the establishment of training officer posts. The Board had been further informed that the programme cooperated with other WHO programmes and national authorities in developing techniques for training in management of health personnel. Since 1975, nearly 300 nationals had participated in various training workshops organized under the programme in that field. It was deemed likely that the programme of management training of nationals would be expanded under the general direction of the
programme for health manpower development in the light of recommendations made by the Board during the discussions of the organizational study on the role of WHO in training in public health and health programme management, including the use of country health programming.

With reference to supply services (see programme 8.1.3) the Board had inquired as to the use being made of the reimbursable procurement services and the measures taken to stimulate their use. The Board had been informed that reimbursable purchases in 1980 amounted to approximately US$ 1.5 million, representing 4.50% of all supplies procured during that year for WHO programmes. WHO provided that facility against a modest charge of 3%. Member States had again been informed of the availability of those services in 1980. It was for the Member States to decide whether they wished to use them. The Board had suggested that the service should be more widely publicized since it appeared to be potentially valuable to many Member States.

Dr ESCALA (Panama) called attention to the importance of administrative problems in a poor country such as his; maintaining equipment such as motor vehicles was an example. In the past it had been the custom to replace what was of no use, but it would more economical to engage in "preventive maintenance". Advice was badly needed on the whole broad field of administration so that countries could make the best use of what little they had.

Dr GURMUKH SINGH (Malaysia) said he was glad that headquarters had been able to make a reduction of over US$ 1 million in its allocation for the major programme and that this amount was being transferred to the regions. However, he asked why it was that the European Region showed an increase from $ 5.9 million to $ 9.5 million, or over 70%. The sums quoted under programme 8.1.6 (Finance and accounts) also showed remarkable regional differences. In the African Region and the Region of the Americas, that item cost over $ 700 000, whereas in the Western Pacific Region it amounted to only $ 187 800, which was a decrease from the 1980-1981 figure - a praiseworthy achievement if it involved no loss of effectiveness. He wished to record his appreciation for WHO's management training course for senior staff of the Ministry of Health in Malaysia.

Dr KAPRIIO (Regional Director for Europe) explained that the considerable increase in budget allocation for major programme 8.1 (General services and support programmes) in the European Region was due mainly to inflation in Denmark, which had caused an increase in costs and salaries at the Regional Office.

Mr GROENENDIJK (Director, Division of Budget and Finance) explained that the increases in costs of the African Region and the Region of the Americas recorded under finance and accounts were in general due to increases in salaries. The decrease recorded in the Western Pacific Region was due to the substitution of a general service post for a professional post. The differences in cost in the different regions reflected the structural pattern of each regional office and the different local salary levels.

Dr NAKAJIMA (Regional Director for the Western Pacific) said that a fortunate situation existed in Manila, where it was possible to employ a larger number of qualified general service staff such as certified public accountants, in Finance and Budget than was usual elsewhere.

The DEPUTY DIRECTOR-GENERAL, referring to the reduction of US$ 1 million mentioned by the delegate of Malaysia, called attention to Executive Board document EB67/1981/REC/3, Chapter II, which showed that the decrease was due to the exchange rates used in calculating the budget. A rate of exchange of 1.63 Swiss francs per United States dollar had been used for the 1982-1983 estimates, whereas the budget for the previous biennium had been based on a rate of exchange of 1.55 Swiss francs per dollar. The resulting overall saving of US$ 6.5 million could be traced through all sections of the proposed programme budget.

The CHAIRMAN said that the review of the proposed programme budget for 1982-1983 had been completed.1

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1 A request for further information concerning the programme budget is recorded in the summary record of the fifteenth meeting, section 4.
2. **BUDGET LEVEL AND APPROPRIATION RESOLUTION FOR THE FINANCIAL PERIOD 1982-1983:** Item 19.2 of the Agenda (Resolution EB67.R6; Documents PB/82-83; EB67/1981/REC/3, Chapter III, paras 208-210, and document A34/34)

The CHAIRMAN welcomed the delegates who had joined the meeting from Committee B. The Executive Board had proposed that the Appropriation Resolution contained in resolution EB67.R6 be adopted by the Health Assembly. However, in the light of the report of Committee B to Committee A on the rate of exchange to be used in the programme budget and the amount of income to be used to help finance that budget (document A34/34), a change in the figures was now proposed, so that the draft resolution before the meeting now read as follows:

The Thirty-fourth World Health Assembly

RESOLVES to appropriate for the financial period 1982-1983 an amount of US$ 524 933 400 as follows:

<table>
<thead>
<tr>
<th>Appropriation section</th>
<th>Purpose of appropriation</th>
<th>Amount US $</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Policy organs</td>
<td>9 719 700</td>
</tr>
<tr>
<td>2.</td>
<td>General programme development, management and coordination</td>
<td>63 601 700</td>
</tr>
<tr>
<td>3.</td>
<td>Development of comprehensive health services</td>
<td>88 654 100</td>
</tr>
<tr>
<td>4.</td>
<td>Disease prevention and control</td>
<td>86 311 500</td>
</tr>
<tr>
<td>5.</td>
<td>Promotion of environmental health</td>
<td>31 004 300</td>
</tr>
<tr>
<td>6.</td>
<td>Health manpower development</td>
<td>86 089 300</td>
</tr>
<tr>
<td>7.</td>
<td>Health information</td>
<td>44 876 600</td>
</tr>
<tr>
<td>8.</td>
<td>General services and support programmes</td>
<td>86 598 100</td>
</tr>
</tbody>
</table>

**Effective working budget** 470 855 300

| 9. | Transfer to Tax Equalization Fund | 44 000 000 |
| 10.| Undistributed reserve            | 10 078 100 |

**Total** 524 933 400

B. Amounts not exceeding the appropriations voted under paragraph A shall be available for the payment of obligations incurred during the financial period 1 January 1982 - 31 December 1983 in accordance with the provisions of the Financial Regulations. Notwithstanding the provisions of the present paragraph, the Director-General shall limit the obligations to be incurred during the financial period 1982-1983 to sections 1-9.

C. Notwithstanding the provisions of Financial Regulation 4.5, the Director-General is authorized to make transfers between those appropriation sections that constitute the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made, this percentage being established in respect of section 2 exclusive of the provision made for the Director-General's and Regional Directors' Development Programmes (US$ 7 780 300). The Director-General is also authorized to apply amounts not exceeding the provision for the Director-General's and Regional Directors' Development Programmes to those sections of the effective working budget under which the programme expenditure will be incurred. All such transfers shall be reported in the financial report for the financial period 1982-1983. Any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.5.

D. The appropriations voted under paragraph A shall be financed by assessments on Members after deduction of the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount US $</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) reimbursement of programme support costs by the United Nations Development Programme in the estimated amount of</td>
<td>4 600 000</td>
</tr>
<tr>
<td>(ii) casual income in the amount of</td>
<td>24 400 000</td>
</tr>
</tbody>
</table>

29 000 000

1 See document WHA34/1981/REC/2.
thus resulting in assessments on Members of US$ 495 933 400. In establishing the amounts of contributions to be paid by individual Members, their assessments shall be reduced further by the amount standing to their credit in the Tax Equalization Fund, except that the credits of those Members that require staff members of WHO to pay taxes on their WHO emoluments shall be reduced by the estimated amounts of such tax reimbursements to be made by the Organization.

Dr DLAMINI (Swaziland), Chairman of Committee B, introducing the report of Committee B to Committee A, said that, as all were aware, since the sixty-seventh session of the Executive Board certain developments of a strictly financial nature had taken place which had prompted the Director-General to submit to the current Health Assembly a report on casual income and the budgetary rate of exchange between the US dollar and the Swiss franc to be used in the programme budget for 1982-1983 (document A34/11). On the basis of that report and after thorough discussion, Committee B had decided to recommend to Committee A that $ 24.4 million of available casual income be used to help finance the budget for that period and that the budgetary rate of exchange between the US dollar and the Swiss franc be adjusted to 1.82 Swiss francs per US dollar. The combined effect of those recommendations would be to reduce the effective working budget level from US$ 484 300 000 to $ 470 855 300, with corresponding reduction in the contributions of Member States.

Mr BOYER (United States of America) recalled that, during the discussions in Committee B, his delegation had urged that the proposed budget for 1982-1983 be computed, not at the level of 1.78 Swiss francs per US dollar, as proposed by the Director-General, but at the official United Nations rate of exchange for May 1981 of 2.02 Swiss francs to the US dollar, in the belief that as a general rule the budget adopted in any United Nations agency should be calculated at the rate established by the United Nations for the month of its adoption. Accordingly, in Committee B, his delegation had worked for a recalculation at the official May 1981 rate of 2.02 Swiss francs to the US dollar. As delegates would recall, there had been little support for his delegation's desire for a recalculation at that level, so that, when the Director-General had proposed a compromise at 1.82 Swiss francs per US dollar, his delegation had decided not to press for a vote on the higher rate, and Committee B had decided to recommend the Director-General's figure which was now before Committee A. His delegation had received no instructions on the specific compromise proposed at that time and therefore had reserved its right to raise the question of the exchange rate again.

His delegation had since received instructions and would be able to vote in favour of the budget if it were recalculated at a rate of 1.85 Swiss francs to the dollar, i.e., a rate just 3 Swiss centimes higher than the one recommended by Committee B, but still significantly lower than the current official United Nations exchange rate. It was felt that that was not unreasonable. The effect would be to further reduce the level of the budget by another US$ 2 million, by comparison with the current financial period, and to reduce to almost exactly 4% the increase in Member States' assessments for 1982-1983. It was felt that the Organization was not likely to suffer from falls in the exchange rate, especially because the Health Assembly, on the recommendation of Committee B, had adopted a new casual income facility of some US$ 20 million to protect it against just such losses. The rate of 1.85 Swiss francs to the dollar, which his delegation now proposed, would thus save Member States more money, afford protection against exchange losses, and still permit full implementation of the programme for 1982-1983 as proposed.

In Committee B the Director-General had eloquently appealed for unanimity on the question of the exchange rate and the budget. The United States delegation agreed that such unanimity would be of great value to WHO, and would like to join in it. It would be able to do so if the budget were recalculated at 1.85 Swiss francs to the dollar, especially in view of the other financial benefits that the Organization had provided to the membership. He would like to know whether other delegations could support that minor adjustment and whether it would also be acceptable to the Secretariat.

Mr VOHRA (India) said that the United States' proposal entirely changed the position reached in Committee B where, following a personal appeal by the Director-General at the end of a fairly prolonged debate on rates ranging from 1.78 to 2.02 Swiss francs to the dollar, it

1 Document WHA34/1981/REC/1, Annex 1.
had been decided to recommend the compromise rate of 1.82. The main argument advanced by his delegation, which could not agree to the rate of 2.02, was that the very foundation of a good budget was to secure against uncertainties and large numbers of supplementary demands, and to permit expansion of programme activities and be realistic in relation to the Organization's ambitious goal of health for all.

However, on account of the rather varied debate and the personal appeal by the Director-General, all delegations had agreed on the rate of 1.82 Swiss francs per US dollar. Now the United States delegate, mentioning instructions received, had proposed the rate of 1.85, putting forward in support *inter alia* the argument that the higher rate would afford further protection against exchange losses - an argument with which the Indian delegation could not agree. That, however, was not the issue before the Committee. Moreover, the reduction of $2 million in the budget would have consequential implications for the programme proposals, as well as for contributions; both would have to be recalculated, although he believed the United States delegate's calculation to be correct.

Now that the issue had been reopened, and if the basic agreement had been lost, there appeared to be little point debating at length the marginal difference between 1.82 and 1.85 Swiss francs to the dollar in a discussion that could produce little more than had already been produced in Committee B. Therefore, although he was personally opposed to principles that involved and implied uncertainties, in view of the total situation and the instructions that the United States delegate had received, the Indian delegation would go along with the new proposal and, in its turn, appeal for unanimity on the new rate of 1.85 Swiss francs to the dollar.

The DIRECTOR-GENERAL said that, after hearing the delegates of the United States and India and bearing in mind all the arguments advanced in Committee B, he could only reiterate his reference to the sacrifice involved in every choice. Every upward revision of the exchange rate, however slight, would involve risk. But the Indian delegate was right: if the rate of 1.82 Swiss francs to the dollar was acceptable, it would be difficult to maintain that a rate of 1.85 was not. Considering what he had heard about likely proposals, he and his advisers had already made a meticulous study of the extent of the risk, in terms of programme delivery, that Member States might be taking in making a change of the kind now before the Committee, with a facility of up to $20 million provided for meeting adverse fluctuations in the exchange rate.

In his personal opinion there were two principles of the utmost importance in the life of the Organization: universality and unanimity. No occasion for obtaining them should be neglected. The importance of unanimity went beyond the actual provision of regular budget funds; it also facilitated the mobilization of extrabudgetary funds. There was - as he had said on the same occasion previously - tremendous merit in obtaining resounding support for the programme budget in particular. With that in mind he had made his compromise proposal in Committee B. With that again in mind, he could now say that he, and the Secretariat, would be ready, if Member States agreed, to take on their behalf and with their support the slightly increased risk - thought to be remote enough thanks to the facility to which he had referred - of recalculating the programme budget for 1982-1983 on the basis of an exchange rate of 1.85 Swiss francs to the US dollar.

Dr MORKAS (Iraq) said that, in view of the fact that the preparation of the proposed programme budget had not followed a normal course and that the programme budget had not been discussed at the regional level in the Eastern Mediterranean owing to the critical situation there regarding the Regional Office, he wished to place on record his delegation's intention to reserve its vote on the item before the Committee.

Dr AL-SAIF (Kuwait) observed that all the regional committees except the Regional Committee for the Eastern Mediterranean had met to discuss the proposed programme budget. As the Board had been informed by the Regional Director (document EB67/1981/REC/2, page 201), the regional programme budget proposals (document EM/RC30/3) had been sent out to the Member States of the Region who had been informed that, should no comments be received from them, it would be assumed that they were in general agreement with the proposals as shown in that document. Some Member States had responded. However, that method of processing the proposals did not meet the requirements of the Region. His delegation therefore wished likewise to place on record its reservations regarding the regional budget proposals. He requested the Committee to authorize the Director-General to administer the budget of the Region in a flexible manner,
making the necessary amendments to meet the requirements of Member States of the Region as manifested when the Regional Committee met in the future. In conclusion, he thanked the Director-General and the Regional Director for the great efforts they were making in the service of the Region.

Professor SPIES (German Democratic Republic) expressed his sorrow that some of the world's most gifted experts on health policy should have to deal with a subject that had nothing to do with health.

He supported the principles underlying the preparation of the programme budget, which were designed to help achieve health for all by the year 2000. His delegation reiterated its willingness to make its assessed financial contribution. It was important that the Health Assembly should adopt a realistic programme budget taking into account the great challenges to WHO in developing fruitful international cooperation, safeguarding international peace and security, fighting colonialism and apartheid and promoting national independence for social progress.

In the preparation of the programme budget, one point was inescapable: that there were limits to the growth of WHO's expenditure. That view had been expressed at the current Health Assembly, as indeed on similar occasions in the past by certain Member States whose contributions formed a considerable proportion of the regular budget. His delegation welcomed the more business-like approach adopted in the preparation of a budget which provided for a real increase of 2.25% for the coming biennium. However, another 11.09% had had to be allowed for inflation, so that nearly four-fifths of the total increase, which Member States would have to provide, went not into WHO activities, but to meet the consequences of the financial crisis in the capitalist system due, essentially, to military expenditures. His delegation could not agree to any automatism in the establishment of the budget proposals that would distribute the burden of those costs between all Member States, not all of which were rich. Such wealth as they had was gained through the hard work of their citizens and they should not be charged for the losses and financial inefficiency of the capitalist system. It was serious to see in the Press that countries deeply involved in the crisis to which he had referred could nevertheless find twice the WHO biennial budget to spend on single items of military equipment. That situation could only be ascribed to the very incomplete coverage of any new international economic order. The increase in the WHO budget should not be higher than the average growth of national income in all Member States.

As on previous occasions, his delegation considered that attention should be given to increasing the effectiveness of programme activities in order to minimize the budget's high rate of growth; the possibility of authorizing payment of contributions in national currencies might also be explored. Other ways and means of obtaining more resources for the regular budget might be sought along the lines indicated in the draft resolution on the role of physicians and other health workers in the preservation and promotion of peace.¹ His delegation was unable to approve the high growth rate in the proposed programme budget and would abstain from the vote.

Mr HALLOWELL (United Kingdom of Great Britain and Northern Ireland) expressed strong support for the United States proposal, welcoming that delegation's willingness to modify its previous position. He hoped that that exceptional gesture would enable the Committee to achieve the consensus that was the aim of all delegations.

Professor LISICYN (Union of Soviet Socialist Republics) laid stress on the steps taken by the Executive Board and the Secretariat to prepare the implementation of the Global Strategy. The discussion of the programme budget had shown the possibility of redistributing appropriations so that they could be used in programmes where the need was most pressing. He agreed with those delegations which, on similar occasions in the past and at the current Assembly, had emphasized the need to reduce some programmes and the constant need to stabilize WHO's budget. That would be not just a technical or financial exercise undertaken for reasons of economy, but an essential contribution to the achievement of WHO's goal of health for all by the year 2000 and the effective discharge of its leadership role in world health.

Nor had he in mind a rigid fixing of the budget at a given level; for even if it were increased two-fold or three-fold, it would still represent only 1% of the total world expenditure on health. A considerable reorientation of the programme had already been carried out; the problem now was to provide sufficient resources. There were still inefficient projects;

¹ Subsequently adopted as resolution WHA34.38 (see document WHA34/1981/REC/1).
overlapping between programmes; maldistribution of resources between the three levels of the Organization, and a sometimes unjustified trend to decentralization that did not always coincide with the reorientation of the work at headquarters; technical cooperation sometimes degenerated into technical assistance; primary health care was promoted in isolation from existing health systems, and, in spite of the basic importance of research to WHO, and its developing Member States in particular, activities under research promotion and development and the research components of other major programmes were being reduced.

In addition, it now appeared that some quite substantial programmes and projects could not count with certainty upon the availability of the extrabudgetary funds that had been anticipated. The increasing reliance on these only increased the instability of the financial basis of the Organization's work. At the same time, Member States were being asked to approve a budget level increased, not by some 2% but by over 13%. The financial crisis in the West was thus the main factor aggravating the instability of WHO's finances, accounting for some 11% of the proposed increase. That was a considerable burden to place on the shoulders of Member States, many of which had no part in the responsibility for that state of affairs, so that it was no accident that on the eve of the current Assembly a record number of 52 Member States were in arrears in the payment of their contributions.

The budget had reached a very high level and the rate of increase was still very high, far outstripping the rate of increase in the amounts countries were able to spend on their own health work. His delegation had no alternative but to reiterate its opposition to such constant increases. It was in favour of finding resources to stabilize the Organization's financial position. That should be done by further study and reorientation of the programme in the light of the Organization's goals. The work of Committee A and the Secretariat's efforts had shown that much could be done along those lines. Meanwhile, in the interests of unanimity, his delegation would not vote against the proposed budget level and draft Appropriation Resolution, but would abstain.

Dr ZIESE (Federal Republic of Germany), recalling his delegation's position as expressed at the second meeting of Committee B, said that with the US$ 20 million casual income facility the adoption of a more realistic exchange rate than the ones so far proposed should give rise to no difficulty. His delegation was therefore in favour of the proposed upward revision of the rate from 1.82 to 1.85 Swiss francs to the dollar.

Professor JAKOVLEVIĆ (Yugoslavia) said that, in view of the increased role of WHO in implementation of programme policy based on the Organization's overall goal, his delegation considered the proposed budget level realistic and supported the proposed draft Appropriation Resolution.

On the question of exchange rates, he feared that the new upward revision to 1.85 Swiss francs to the dollar might lead to unforeseen difficulties and seriously affect the delivery of the programme if the dollar fell. However, having heard the Director-General accept the increased risk, and although his risk was also the risk of Member States, the delegation of Yugoslavia was prepared to support the United States proposal.

Professor SENAULT (France) said that, having heard the statement by the United States delegate and the Director-General's comments, his delegation would also accept the United States proposal.

Dr CABRAL (Mozambique) observed that the problem of the budget level was, as previous speakers had rightly said, a matter of principle and not of the marginal amounts of money involved in the situation under debate. At the time of the launching of the Global Strategy for the attainment of health for all by the year 2000, Member States could not afford to play about with budgets which might not even be able to provide for ongoing programmes, let alone accommodate new priority programmes or the geographical extension of existing programmes. When cost increases had reached a level of 11.09%, were Member States going to aggravate the position by embarking on new adventures with the exchange rate? Recalling that the budget exchange rate used in the calculation of the 1980-1981 programme budget had been lower, although the Organization's losses on exchange had already reached $100 million, he suggested that nothing in the behaviour of the exchange rate in the intervening period justified the
upward revision of the budgetary rate, especially as there was now a $20 million casual income facility to protect the Organization against future losses. In the light of past experience of market fluctuations, his delegation would oppose the adoption, for budget calculations, of the United Nations monthly accounting rate for the month in which the budget was adopted, which rate by its nature could not remain suitable for two years. There was a need for some long-term trend calculations on which to base the budget.

For the moment, he would like to know down to what level the rate of 1.85 Swiss francs to the dollar would protect the Organization and whether the $20 million facility would suffice.

Congratulating the Director-General on his courageous commitment and appreciating his concern to have the largest possible measure of support for the programme budget, he expressed his opposition to the principle involved in the upward revision of the exchange rate in response to the desires of some Member States whose interests it served. As they were unlikely to make any compensating contributions to voluntary or extrabudgetary funds, their move was tantamount to the exertion of pressure on the Organization and on the Health Assembly. That pressure should be resisted.

In view of the commitment demonstrated by the Director-General his delegation would nevertheless be able to support the rate of 1.82 Swiss francs to the dollar, but if the question of the further revision to 1.85 Swiss francs to the dollar were pressed, his delegation would abstain.

Professor HALEEM (Bangladesh) expressed his concern that any upward revision of the exchange rate might produce a budgetary deficit to be met by supplementary budgets and an increased burden on developing countries in the form of supplementary contributions. Unanimity had been reached once already: how many times had it to be reached on the same subject? He pleaded with the delegate of the United States, whose change of mind had called that unanimity into question, like an elder brother to bear in mind the interests of smaller brethren and to reconsider his viewpoint. Frequent changes could sap confidence.

On the point before the Committee, he wondered what would happen if exchange losses went beyond the $20 million casual income facility and what could be done for the developing countries then.

Professor DOĞRAMACI (Turkey) pointed out that to take no risk at all meant making no progress. When the Secretariat proposed, or accepted, an exchange rate they had done the necessary calculations, on a very prudent basis in view of the fact, that the exchange rate for the day was 2.047 Swiss francs to the dollar. In view of the high interest rates to be earned on both the Swiss franc and the dollar, the Organization could expect to be able to acquire casual income by investment, and there was the casual income facility to provide protection. For all those reasons his delegation considered that there was no serious risk in adopting the rate of 1.85 Swiss francs to the dollar and would vote in favour of that rate.

Dr IKENOuchi (Japan) said that in the interests of achieving a consensus in the Committee, her delegation would support the rate of 1.85 Swiss francs to the dollar.

The DIRECTOR-GENERAL wished to make it clear that at no time had there been any danger to actual programme delivery in terms of the purchasing power of the budget. The point at issue was the acceptable margin of risk in a complex and uncertain world.

In Committee B the question had been raised why WHO was by so far the most conservative of the organizations of the United Nations system. That conservatism was intended to serve the interests of all Member States, but most of all of the developing countries among them, which most needed to be secure where the real purchasing power of the budget was concerned. It was in order to increase that security that the Health Assembly, for reasons of good, prudent financial management, had approved the casual income facility.

As there had been a substantial change in the Swiss franc/US dollar market rate since the budget had been prepared, it had seemed not unreasonable to bring up the possibility of a recalculation of the budget, based on an increase of the budgetary rate of exchange, from 1.63 to 1.78 Swiss francs to the dollar. In bargaining for unanimity, or consensus, in Committee B the figure of 1.82 Swiss francs to the dollar had been reached. In reacting as he had done earlier in the meeting to the statements by the delegates of India and the United States, he had been pressing his belief that - with the help of the $20 million casual income facility, which could not be put to any use other than the meeting of losses on exchange and, in particular, could not be made available to Member States - he could protect the "smaller brethren" even with a budgetary rate of exchange of 1.85 Swiss francs to the dollar.
In reply to the interlinked questions of the delegate of Mozambique, he said that the proposed 1.85 rate, with the $20 million casual income facility, would protect the Organization against a fall in the accounting rate to 1.57 Swiss francs to the dollar, as compared with protection down to 1.55 with a budget rate of 1.82 Swiss francs to the dollar in the same circumstances, i.e., a marginal increase in uncertainty of 2 US cents.

In that connexion he would hasten to add that, in indicating his acceptance of that marginal increase in uncertainty, he had been acting under no pressure; he had in fact volunteered. Nor had he been trying to sway Member States in any way. In putting forward his successive proposals, he had merely been providing Member States with as valid a basis as possible for their decision: they would have genuine cause for dissatisfaction with their Director-General if he did not do so. But if Member States felt uncomfortable at the prospect of an increase in uncertainty, they should feel free and not hesitate to adopt whatever lower rate they wished, even going below the rate of 1.78 Swiss francs to the dollar that he had originally suggested at the beginning of the discussion in Committee B.

He hoped that the remarkable degree of democracy that had made possible the adoption of important resolutions, such as resolution WHA29.48, would continue to prevail in WHO and that Member States would always be able to exercise their democratic rights there in complete freedom under the democratic principle of "one country, one vote".

Noting the consensus reached on the adoption of the budgetary rate of exchange of 1.85 Swiss francs to the US dollar, the CHAIRMAN invited the Assistant Director-General to read out the draft Appropriation Resolution incorporating the consequential changes in the figures.

Mr FURTH (Assistant Director-General) read out Section A of the draft Appropriation Resolution, as follows:

The Thirty-fourth World Health Assembly

RESOLVES to appropriate for the financial period 1982-1983 an amount of US$ 522,933,500 as follows:

<table>
<thead>
<tr>
<th>Appropriation section</th>
<th>Purpose of appropriation</th>
<th>Amount US $</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Policy organs . . . . . . .</td>
<td>9,615,200</td>
</tr>
<tr>
<td>2.</td>
<td>General programme development, management and coordination . . .</td>
<td>63,362,100</td>
</tr>
<tr>
<td>3.</td>
<td>Development of comprehensive health services . . . . . . .</td>
<td>88,493,400</td>
</tr>
<tr>
<td>4.</td>
<td>Disease prevention and control . . .</td>
<td>86,054,200</td>
</tr>
<tr>
<td>5.</td>
<td>Promotion of environmental health . . .</td>
<td>30,927,800</td>
</tr>
<tr>
<td>6.</td>
<td>Health manpower development . . .</td>
<td>60,056,100</td>
</tr>
<tr>
<td>7.</td>
<td>Health information . . . . . .</td>
<td>44,525,900</td>
</tr>
<tr>
<td>8.</td>
<td>General services and support programmes . . .</td>
<td>85,865,300</td>
</tr>
<tr>
<td></td>
<td><strong>Effective working budget</strong></td>
<td>468,900,000</td>
</tr>
<tr>
<td>9.</td>
<td>Transfer to Tax Equalization Fund . . .</td>
<td>44,000,000</td>
</tr>
<tr>
<td>10.</td>
<td>Undistributed reserve . . . . . .</td>
<td>10,033,500</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>522,933,500</td>
</tr>
</tbody>
</table>

He informed the Committee that the new exchange rate involved no changes in Sections B and C.

The first three figures in Section D remained unchanged, but the following line would now read: ". . . thus resulting in assessments on Members of US$ 493,933,500".

With the new effective working budget level of $468,900,000, the percentage increase for the biennium would be 9.74%, compared with the 13.34% recommended by the Board on the basis of the Director-General's proposals (resolution EB67.R6), and the increase in contributions would be 4.02%, compared with 10.60%.

Professor SPIES (German Democratic Republic) said that his calculations of the effect of the proposed exchange rate of 1.85 Swiss francs to the dollar on the effective working budget
gave a saving of US$ 17.39 million rather than the US$ 2 to 3 million mentioned earlier in the meeting. No doubt the exchange rate savings could be applied only to the Organization's Swiss franc expenditures, which might account for the difference. In that connexion he wondered whether the 11.09% increase provided for inflation would also be affected by the increase in the budgetary rate of exchange.

Mr FURTH (Assistant Director-General) said that the change related only to Swiss franc based expenditures; they were mainly incurred at headquarters and in Geneva; because the dollar was worth more, fewer would be required to meet the same expenditures.

The further US$ 2 million reduction related to the reduction in provision for cost increases from 11.09% to 7.49% and did not affect the programme increase.

Mr BOYER (United States of America) expressed his delegation's appreciation of the Committee's acceptance of its proposal and promised the delegate of Bangladesh that it would not be changing its mind again.

In the general discussions and in Committee B his delegation had voiced its concern about steady increases in the budgets of organizations of the United Nations system. There had been considerable discussion, as he was aware, about the position that his Government would be taking on the budget: it was believed that the steady growth in the budgets of the organizations of the United Nations system should end. Within that system the need was for sound financial management which could make existing dollars go further, eliminate marginal and outdated programmes and administrative activities, and focus the substance of programmes - in the case of WHO on the health areas of the greatest priority. His delegation had done much probing on budgetary and administrative items during the discussions at the Health Assembly, particularly in Committee B, since it took the issues concerned very seriously. It had raised many questions and called for a number of votes, and he hoped that it had given no offence either to other Member States or to the Secretariat. Its search to identify ways to save money in the United Nations system could be expected to continue. But although his delegation might occasionally have been a thorn in the side of the Director-General or of the Assistant Director-General, Mr Furch, he wished to make it clear that the United States delegation was very pleased with the general approach of WHO's financial management. In fact, it wished to commend the administrative work done at WHO to the representatives of the other organizations of the United Nations system present in the Committee; it hoped that word would also reach the organizations not represented. Member States could be proud of the conservative use made by WHO of the monies they provided.

The programme budget for 1982-1983 now before the meeting was particularly exemplary. Although the Secretariat had been authorized by the Health Assembly in 1979, by resolution WHA32.29, to produce a budget containing programme growth of up to 4% for the biennium, the budget before the meeting provided for only 2.25% real growth for the two-year period. Taking advantage of high interest rates and favourable exchange rates, the Organization had wisely invested available monies and produced a sizeable amount of casual income. US$ 24.4 million of casual income was being applied to the proposed programme to reduce the assessments of all Member States. That was probably a record setting a precedent for any organization of the United Nations system to follow. The Secretariat's offer to recalculate the budget from the original 1.63 Swiss francs to the US dollar to 1.78 indicated great responsiveness to the interests of Member governments. That act alone had had the effect of reducing the original budget by another US$ 10 million, without affecting the proposed programme, and a further recalculation, to 1.85 Swiss francs to the dollar, had achieved still further savings. The total reduction in the budget left a total increase of only 4% in Member States' assessments - and not of 13% as some other delegations had noted. In addition, new costs due to inflation during 1980 and in 1981 to date, above the levels estimated when the current budget was adopted in 1979, were being absorbed by the Organization, and Member States were not being subjected to a supplementary appropriation. Finally, the programme budget before the Committee indicated that more than US$ 13.8 million in marginal and outdated programmes had been removed from the budget to make room for new and more pressing programmes. That was exactly the way in which new programme needs should be handled - within the existing budget level.

In all those respects WHO had been extraordinarily responsive to the interests of its major contributors. Those practices should serve as an outstanding example for other organizations of the United Nations system. It was hoped that they would take note of the activities mentioned.
Beyond the financial concerns, it should be already clear from the discussions in Committee A that his delegation largely supported the programme initiatives proposed in the programme budget document, while at the same time urging consideration of revised priorities and needs in certain fields. Certainly his delegation fully supported WHO's goal of health for all.

For all those reasons, his delegation was able to vote in support of the 1982-1983 programme budget and expressed the hope that it could be unanimously adopted, since the increase in assessments over the two-year period was only 4%. He hoped that the delegates of the Soviet Union and the German Democratic Republic would also be able to join in the support of the budget.

The CHAIRMAN reminded delegates that, according to Rule 72 of the Rules of Procedure, decisions on the amount of the effective working budget had to be made by a two-thirds majority of the Members present and voting. He then put to the vote the draft Appropriation Resolution, incorporating the amended figures read out by the Assistant Director-General.

The resolution, as thus amended, was approved by 84 votes to none, with 15 abstentions.1

3. FIRST REPORT OF COMMITTEE A (Document A34/39)

At the CHAIRMAN'S request, Dr KASONDE (Zambia), Rapporteur, read out the draft first report of the Committee.

The report was adopted (see document WHA34/1981/REC/2).

The meeting rose at 20h00.

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1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA34.16.
THIRTEENTH MEETING
Wednesday, 20 May 1981, at 8h30
Chairman: Dr E. P. F. BRAGA (Brazil)

INFANT AND YOUNG CHILD FEEDING: Item 23 of the Agenda

Progress report: Item 23.1 of the Agenda (Resolution WHA33.32, para. 6 (7); Documents A34/7 and A34/INF.DOC./10)

Dr MORK (representative of the Executive Board) said that the Health Assembly, in resolution WHA33.32, para. 6 (7), had requested the Director-General to submit to the Thirty-fourth World Health Assembly, and thereafter in even years, a report on the steps taken by WHO to promote breast-feeding and to improve infant and young child feeding, together with an evaluation of the effect of all measures taken by WHO and its Member States. The Director-General's report, which was reproduced as an annex to document A34/7, provided information on the steps taken by WHO since the Thirty-third World Health Assembly to implement the main recommendations of the joint WHO/UNICEF Meeting on Infant and Young Child Feeding held in October 1979. As members of Committee A would recall, those recommendations had been endorsed in their entirety by the Thirty-third World Health Assembly in resolution WHA33.32.

The report reflected the comprehensiveness of the programme developed by headquarters, the regional offices and at the country level in response to previous Health Assembly resolutions to meet one of the major health issues of the times - to secure children's health. The report covered the following areas: the encouragement of breast-feeding; the strengthening of education, training and information; and the development of support for the improved health and social status of women. The Director-General had reported separately on the steps taken with regard to the preparation of an International Code of Marketing of Breast-milk Substitutes.¹ That important part of the comprehensive programme on infant and young child feeding would be considered by the Committee as item 23.2 of its agenda.

The report by the Director-General had been well received by the members of the Board. The Board had expressed satisfaction that so many varied activities had been carried out in such a relatively short period as part of the overall programme of family health and as an essential element of primary health care. A summary of the Board's discussion on the item would be found on pages 302-306 of document EB67/1981/REC/2.

Dr HADJ-LAKEHAL (Algeria) said that his delegation was pleased to note that progress was being made and that regional cooperation was really beginning to take shape. For his country everything connected with the health of young children was of particular importance, as a fundamental part of family health care.

He went on to introduce a draft resolution sponsored by the delegations of Algeria, Angola, Benin, India, Mali, Morocco, Mozambique, Sweden, Switzerland, Tunisia and the United States of America. The purpose of the draft resolution was to request the Director-General to initiate studies to assess the changes that occurred over a period of time under prevailing storage and distribution arrangements in the nutritional value of products specifically intended for infant and young child feeding. It was therefore a purely technical proposal. The request fell well within the prerogatives of WHO's Nutrition unit. The sponsors felt that it would be better if the draft resolution² was discussed after consideration of the draft resolution recommended by the Executive Board.

¹ For the text of the Code, see document WHA34/1981/REC/1, Annex 3.
² For text, see p. 201.
The CHAIRMAN agreed that it would be more convenient if consideration of the draft resolution introduced by the delegate of Algeria was postponed, and suggested that it should be discussed after the conclusion of the debate on item 23.2 (Draft International Code of Marketing of Breast-milk Substitutes).

It was so agreed (see p. 201).

Dr ANDERSON (Australia) said that his delegation was pleased to note that the activities described in the Director-General's progress report were not being carried out in isolation but as part of the larger programme for family health. Also gratifying was the degree of cooperation taking place between WHO, UNICEF, UNFPA and other United Nations agencies, especially the Consultative Group on Maternal and Young Child Nutrition of the ACC Sub-Committee on Nutrition. His country had always stressed the importance of proper maternal nutrition as part of antenatal care during pregnancy, when the basis for successful breast-feeding was laid.

The emphasis being placed on nutrition education and educational measures to promote breast-feeding was also reassuring. Australia's own efforts were showing a positive effect on attitudes, and in recent years there had been a remarkable increase both in the number of women choosing to breast-feed and in the duration for which the majority continued with successful results. Artificial feeding had loomed large in the deliberations of the Health Assembly, but it was in fact only part of the whole subject. Many different bodies and organizations were involved, and WHO was to be congratulated on the vital coordinating role which it was playing.

Dr LITVINOV (Union of Soviet Socialist Republics) said that the method of feeding infants and young children had a profound effect on their health and development; the lively discussion in the Executive Board had shown full awareness of the current interest in the subject. WHO was doing extensive work in this field, in which both developed and developing countries were interested. The Director-General's report and the recommendations contained in it were worthy of support.

In the Soviet Union breast-feeding was promoted through special legislation benefiting nursing mothers. In March 1981 the Government had taken regulatory measures to strengthen state assistance to families with children, including the provision of partly paid leave to allow working mothers to look after children up to the age of one year, additional unpaid leave until children reached the age of one-and-a-half-years, and special birth grants.

Breast-feeding was traditional in the USSR, largely as a result of successful medical propaganda. Much attention was given to rational infant feeding in the popular medical press. At present approximately 90% of mothers continued to breast-feed their children on leaving the maternity hospital. The importance of breast-feeding was stressed during pregnancy checkups and whenever district doctors and nurses visited families to administer prophylactic immunizations. Medical surveillance of infant feeding was carried out by polyclinic doctors and district nurses. At the monthly checkups of young children district paediatricians gave advice on the duration of breast-feeding and, if breast-feeding was not possible, recommended a particular breast-milk substitute. Research was being carried out to develop breast-milk substitutes of higher nutritional value. Such substitutes should be used only where necessary, only on prescription, and never to the detriment of breast-feeding. A number of scientific institutes in the USSR were collaborating with WHO in research on breast-feeding.

WHO should concentrate on publicizing the advantages of breast-feeding and on developing concrete measures to promote it, including the protection of women at work, providing a rational diet for pregnant women and lactating mothers, and the treatment and prevention of failure of lactation. Weaning foods should be improved and their production controlled; special attention should be paid to the quality of both the raw materials and the finished products and to marketing and utilization. Following study of the precise nutritional requirements of children in different age-groups, commonly agreed recommendations on the rational feeding of children should be developed.

Dr SADRIZADEH (Iran) said that breast-feeding not only provided the child with considerable numbers of maternal antibodies, thus protecting against communicable diseases; it also created an emotional and psychological interdependence between mother and child which resulted in well-balanced physical and mental growth.
In Islam breast-feeding was a must, and mothers had to breast-feed their children unless they were unable to do so because of serious illness; in Iran it was promoted through maternal and child health units integrated into the basic health services. His delegation highly appreciated the promotion of breast-feeding and the provisions of the International Code of Marketing of Breast-milk Substitutes, accompanied by continuous health education and development of the socioeconomic status of the population as a whole.

Dr BRYANT (United States of America) said that his delegation appreciated the broad and comprehensive approach which the Secretariat was taking to the problems of infant and young child feeding. The subject should be seen as part of the larger area of family health, but on condition that it was not construed in such general terms as to preclude careful attention to the specific problems that needed research attention and, where appropriate, field application.

One noteworthy component of the programme was the survey of methodology for evaluating the prevalence and duration of breast-feeding. Since the methodology was simplified and could be standardized it could be relatively uniform throughout Member States, so that the results from one area could be compared with those from another and follow-up surveys could be compared with earlier surveys of the same area. Furthermore, the surveys could be extended to evaluate such important factors as the relationships between breast-feeding and infant growth and between breast-feeding and infant morbidity and mortality. Such surveys were relatively inexpensive and could serve to guide policy and programme decisions when data would otherwise be inadequate or entirely lacking.

A second important problem area, referred to in paragraph 19 of the annex to document A34/7, related to studies to determine the efficiency and duration of breast-milk-mediated protection against diarrhoea caused by rotavirus, enteropathogenic Escherichia coli and Shigella. That was a very important, highly practical direction of research. It was known that lymphocytes in the intestinal wall of the mother were exposed to and immunologically sensitized by pathogens in the gut. Those sensitized lymphocytes could then migrate to the breast and secrete immunoglobulins or antibodies into the milk, thus providing some specific protection for the infant against infectious agents in the environment. Studies of the kind suggested by the Secretariat could extend such findings. It was possible, for example, that the mother could be vaccinated against particular pathogens, which would stimulate the production of maternal antibodies, which would appear in the milk. Moreover, breast-milk immune factors that appeared naturally could be analysed to determine how effective they were, how long they lasted and how their strength could be boosted - a matter of particular importance in the transition from breast-feeding to weaning foods.

His delegation agreed with WHO's plans for widespread and appropriate targeting of breast-feeding promotion programmes. Health care personnel - particularly those associated with the care of women during pregnancy and childbirth - and mothers, including mothers-to-be, should be the targets of appropriate and culturally-specific educational programmes. The Organization's dual emphasis on both breast-feeding and proper weaning practices was well stated and had his country's support.

Through its health, nutrition and food for peace programmes, USAID had long supported the improvement of maternal nutrition and child feeding practices. Financial and technical support was provided for international, regional or national meetings of health policy-makers, paediatricians, nutritionists, dietitians and paramedical personnel to facilitate the exchange of new knowledge regarding the importance of breast-feeding, weaning and maternal nutrition. Assistance was provided to design, implement and evaluate mass media educational programmes, school curricula and the training of field workers in order to bring new information on the importance of good maternal and child feeding practices to target communities. An international information clearinghouse had been established to respond to the needs of developing country professionals for recent publications and news on programmes, legislation, training opportunities and other activities in the area of breast-feeding, weaning and maternal nutrition. Assistance was given for surveys on infant feeding practices and their determinants. Each survey was designed for the country's priority data needs. Emphasis was placed on an interdisciplinary approach which typically included anthropology, epidemiology, paediatrics, nutrition and statistical methods. The use of local foods for appropriate weaning and maternal diets was receiving increasing attention. Technical and financial assistance was available for household and village level production, processing and storage of nutritious multimixes. Information exchange and workshops on weaning foods were included in that activity. USAID had continued its assistance in the form of blended foods for pregnant and nursing women
and preschool children to improve maternal nutrition and weaning practices. Nutrition education accompanying the food included support and encouragement for breast-feeding. Assistance was provided to private, nongovernmental organizations to strengthen those educational components and to add to primary health care services.

Finally, his delegation fully supported the multisectoral approach to infant and young child feeding practices. The participation of the political, agricultural, educational, health and infant food industry sectors was required if the problem was to be dealt with effectively.

Dr Suvannus (Thailand) said that there had been some decline in breast-feeding in Thailand in both rural and urban areas. Recognizing that the decline would affect the nutritional state of infants, the Ministry of Public Health was seeking to encourage breast-feeding through action by the existing health infrastructure and primary health services. An intensive programme to encourage breast-feeding had been launched in 1980 in 16 provinces in the northeast region of Thailand, and would be extended to other regions. His delegation supported the WHO programme to promote breast-feeding, and urged that it continue its work in that field.

Dr Tammam (Egypt) said that according to the Koran mothers breast-fed their children for a certain period; that sacred text made it clear that breast-feeding could not be replaced by any better method. His delegation agreed with the Director-General on the need to hold more interregional meetings on the subject and encourage cooperation and exchange of information. He hoped that the booklet on breast-feeding referred to in paragraph 27 of the annex to document A34/7 would be available soon in Arabic, for the benefit of the health workers in Egypt. It was also to be hoped that the audiovisual information kits would be available as soon as possible.

Dr Borgone (Chile) said that his country had had a long tradition in carrying out nutrition programmes, going back more than 25 years. The Government had always provided substantial sums for nutrition - the prenatal period being US$60 million. In Chile the nutrition programmes covered the prenatal period and the period from birth to the age of six years. They had had a substantial impact on birth weight and perinatal mortality. It was important to continue breast-feeding a child as long as possible within the desirable technical limits. There had been close cooperation in lactation and nutrition programmes with the Pan American Health Organization and WHO. Considerable educational material had been produced to promote the programmes, and it was hoped to change the trend towards shortening the lactation period by changing the attitudes of the population and of the medical profession. Through research, new infant formulas had been developed and there was a nutritional programme covering pre-school children. The aim was to introduce new ingredients in order to reduce the problem of anaemias and other deficiencies in pregnancy. Monitoring with the aid of census advisers provided useful information on the incidence of malnutrition. Nutrition was a vital component of primary health care and of the activities for achieving health for all.

Dr Kalilani-Alfazema (Malawi) said that as yet there was no real problem relating to breast-feeding in his country, where 90% of the population lived in rural areas and it was natural for mothers to stay at home with their children and nurse them. In the urban areas, however, there was a problem with working mothers, due to lack of time for breast-feeding, not to any lack of desire for it. Some mothers provided a mixed feed, which was encouraged by the maternal and child care health workers, but some had changed to wholly artificial foods. There was some danger that excessive advertising of breast-milk substitutes could disturb the natural habit of breast-feeding. There was also a nutrition problem relating to the weaning period, when unsuitable foods might be given. In 1973 a weaning food with a high protein content had been distributed on a trial basis by the maternal and child health workers, being made freely available in hospitals with the aid of the World Food Programme, to which Malawi expressed its thanks. Although the weaning food appeared promising, there were some problems to solve before it could be generally marketed - such as its shelf-life, its cost, and the availability of its local ingredients.

Dr Huyoff (German Democratic Republic) said that his delegation supported WHO's activities in encouraging breast-feeding throughout the world, although obviously social conditions and living standards varied widely from country to country. In the developing countries efforts

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were made to reduce high rates of infant mortality by encouraging longer breast-feeding, improving the nutrition of mothers and providing proper weaning foods. In the German Democratic Republic, where there was a high level of overall development, the aim was not so much to achieve a striking reduction of infant mortality as to avoid such specific morbidity risks as suboptimal resistance to infections, antigen or allergen incidence, infantile adiposity, and their possible later consequences, which might result from a complete lack of breast-feeding or its use for a shortened period. An efficient system of maternal welfare facilities meant that there were no maternal nutrition problems. Appropriate breast-milk substitutes were available and used as necessary. Breast-feeding was promoted through comprehensive educational activities and the provision of facilities in neonatal wards, at home, and at work. A central standing committee of experts in paediatrics, nutritional physiology and industry and trade had helped to improve the feeding of infants and young children. Standardization of norms and recommendations on nutrition for infants was being undertaken within the framework of the Council for Mutual Economic Assistance.

Dr ESHJA (Albania) said that since 1945 legislation in Albania had provided maternal leave with full pay. On her return to work the mother had the right to leave her work to nurse her child as often as necessary. Once the maternity leave had expired the mother had reduced hours of work on full pay for one year after the birth.

Albania had an extensive network of institutions for the protection of the health of mothers and children. There were gynaecological centres in both urban and rural areas to which all pregnant and nursing mothers went, and which conducted continuous audiovisual campaigns on the benefits of breast-feeding. The same educational activities took place in the maternity hospitals, where 98% of births took place.

In 1971 centres had been established for the care of premature infants, which accepted all children with a birth weight of less than 2500 grams or an inadequate physical development. The children remained at those centres with their mothers until they attained the necessary weight and strength. Mothers were able to stay at the centres free of charge, even for long periods, on full pay. The infants were fed with breast milk, either indirectly, or directly by their own mothers. The breast-milk diet had led to a marked reduction in infant mortality and morbidity, and the length of stay of the babies and mothers at the centres had been reduced by half.

The development of infants and their sound nutrition were inseparable from the mother's state of health, and accordingly special legislation in Albania provided for favourable conditions for pregnant and nursing working women.

During the years of popular government Albania had been able to establish correct family views about breast-feeding, mainly through health education provided at maternal and child health advisory centres established in both the rural and urban areas. The result of those efforts was that approximately 80% of all children up to the age of six months were breast-fed.

Dr QUAMINA (Trinidad and Tobago) said that her Government's policy in support of breast-feeding and the nutrition of mothers, infants and young children, and of the various social factors relating to the rearing of young children, had been set forth in the statement made by the chief delegate of Trinidad and Tobago in the general discussion in plenary.1 Referring to paragraph 8 of the annex to document A34/7, she expressed her country's thanks to the Pan American Health Organization and the Caribbean Food and Nutrition Institute for their assistance. Trinidad and Tobago was organizing a seminar on breast-feeding in June, and would be distributing the excellent booklet on breast-feeding.2 She paid tribute to the health education activities of nongovernmental organizations in Trinidad and Tobago, which were most helpful to mothers needing assistance in connexion with breast-feeding. Plans were being made to monitor the foods served in the day nurseries which were now expanding in her country.

She referred to her personal concern about the decline in family meals in her country, not through poverty or famine, but as the result of increased prosperity, which enabled people to buy prepared foods. That trend was encouraged by the increase in the number of working mothers and of children who travelled outside the home area to schools. She feared a damaging effect both on family life and on the nutrition of young children.

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1 See document WHA34/1981/REC/2, verbatim record of the fifth plenary meeting.

Dr CHAMOV (Bulgaria) endorsed the views expressed in the Director-General's report about the significance and advantages of breast-feeding and the need for steps to encourage it in order to ensure good nutrition for young children from an early age. It was important to establish legal norms for the control by state bodies of the production and marketing of children's food. The draft International Code was excellent. In Bulgaria the work of promoting breast-feeding was carried out by medical workers under the guidance of the Institute of Health Education, and by various sectors of the epidemiological stations in the country. In 1979 and 1980 the Ministry of Health had published new instructions on the nutrition of infants and young children. Centres for the collection of breast milk had been established. In accordance with the draft International Code, the Ministry would re-examine the packaging of infant foods, the instructions provided for their use, and publicity; the constituents of breast-milk substitutes; and the frequency and duration of breast-feeding and health education on the subject. Medical legislation in Bulgaria provided for paid maternity leave for one year to enable mothers to continue breast-feeding. The production of all foods for infants and children was carefully controlled by the health services. More information and experience were needed to improve international standards and formulations for children's food in Member States. Bulgaria welcomed the formulation of the draft International Code, and hoped it would enter into force in 1982.

Dr KPOSSA-MAMADOU (Central African Republic) endorsed the views expressed by the delegates of the Soviet Union and the United States of America. The Central African Republic was very concerned with the question of breast-feeding and fully supported WHO's activities in that field. Most of the measures recommended were already practised in his country, where public health officials considered it their duty to do everything to protect the health of infants, the most helpless group in the population. He emphasized the importance of using radio broadcasts in health education activities.

His country attached considerable importance to the use of locally-produced foods at the time of weaning. The Ministry of Health included a national nutrition department which was studying local foods in order to establish their nutritional value so that good nutritional advice could be given to the whole population, and in particular to mothers, with a view to an improved diet.

Mr PAGÉS PINÉIRO (Cuba) said that in Cuba the promotion of breast-feeding was one of the main aims of the national maternal and child health programme, and since 1959 the Ministry of Health had been engaged in that activity. In addition to the usual maternity leave on full pay, special leave was granted to mothers for a year, with the right to retain their job, in order to look after the infant; after the return to work the mother was allowed special working hours to look after the child, and had the right to one day a month for consultation with the paediatrician.

There was currently a campaign to establish breast-milk banks in all the maternity hospitals. The aim was that all healthy newborn babies weighing over 2000 grams would be nursed by their mothers, and those of low birth weight who could not be nursed would receive breast milk from the breast-milk bank. Efforts were being made to persuade pregnant mothers and health personnel of the benefits of breast-feeding. The national health education programme was collaborating with mass organizations in that respect. Paediatricians and obstetric specialists had the duty to advocate breast-feeding at the earliest stage, during prenatal consultation. The immediate target was to ensure breast-feeding during the first three months of life for at least 80% of babies and up to six months for not less than 50%.

All the activities relating to the nutrition of nursing mothers and infants were strictly controlled by means of records and official data in all health districts and hospitals in Cuba.

Dr CASTELLON (Nicaragua) said that his country shared WHO's view concerning the need to promote breast-feeding and infant and child nutrition, and it welcomed the Director-General's efforts. It also welcomed the machinery for that purpose which had been established at the previous Health Assembly.

Nicaragua was facing a task of reconstruction, in which the role of health was of great importance. Malnutrition affected some 67% of the country's children under six years of age;

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1 For the text of the Code, see document WHA34/1981/REC/1, Annex 3.
infant mortality was very high, and life expectancy was less than 50 years. His delegation therefore viewed infant feeding as an essential part of primary health care and of the efforts to achieve health for all.

Having considered the progress report by the Director-General, his delegation wished to make the following suggestions. (1) The question of breast-feeding should be treated as part of an integrated maternal and child health programme. (2) There was a need for inter-sectoral national and local committees to promote breast-feeding, with due emphasis on co-ordination. (3) There should be full exchange of information on progress and experience in the various countries. (4) There should be increased support for workshops on infant and young child feeding - at both regional and country level. (5) Greater impetus should be given to studies to ascertain the situation in both rural and urban areas, with a view to detecting all relevant factors. (6) It was important to ensure adequate coordination of international and bilateral aid. (7) The efforts being made by many countries to produce infant foods on the basis of local foodstuffs should be encouraged. (8) Measures should be taken to ensure wide distribution of all relevant documentation issued by the specialized agencies. (9) Instruction on breast-feeding and infant nutrition, as well as on the surveillance of infant foods, should be given at all educational levels, and not confined to medical training. (10) Women's organizations in all countries should be urged to strive for legislation protecting mothers and children. (11) All countries should ensure the effective implementation, as soon as possible, of the WHO recommendations regarding the marketing of infant foods and breast-milk substitutes.

Dr PATTERSON (Jamaica) thanked the Director-General for his progress report.

As a result of a campaign in Jamaica to promote breast-feeding, there had been an encouraging decrease in morbidity during the first six months of life; Jamaica was therefore pursuing a comprehensive maternal and child health strategy aimed at children under two years of age. But there was still considerable controversy concerning the ability of mothers who might themselves be undernourished to breast-feed successfully, and she would be grateful, therefore, for up-to-date information on that issue.

Her delegation endorsed the tributes paid by the delegate of Trinidad and Tobago to PAHO, the Caribbean Food and Nutrition Institute and thanked the tropical metabolism research unit of the University of the West Indies, which continued to assist the work in Jamaica.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that his delegation welcomed the progress report by the Director-General, and fully supported the drive to promote breast-feeding. A problem in that respect existed in the United Kingdom; a survey conducted in 1975 had revealed that only some 51% of mothers initially put the baby to the breast; for infants aged six weeks and four months the breast-feeding figures had been 24% and 13% respectively. Nevertheless, it was encouraging to note that a recent survey, the results of which had not yet been finalized, suggested that a higher proportion of infants were being breast-fed. The situation, however, did not allow complacency, and the campaign to promote breast-feeding would be actively pursued.

He endorsed the remarks made by previous speakers concerning the need for the surveillance of the marketing of breast-milk substitutes; in that connexion, he referred to the communication submitted by his delegation in document A34/INF.DOC./10. Arrangements by the Department of Health and Social Security to scrutinize all breast-milk substitutes before they could be marketed were being considered.

Dr CORNAZ (Switzerland) thanked the Director-General for his progress report. Priority should be given by WHO to infant and young child feeding; there were four aspects in particular, in addition to direct promotion of breast-feeding, which called for action: first and foremost, the correct feeding of the mother during pregnancy and lactation, for the sake of the child, but also to safeguard the health of the mother herself; second, practices in maternity hospitals before, during and after childbirth; thirdly, adjustment of working conditions for mothers to permit breast-feeding; and, lastly, weaning practices and foods. WHO should take suitable action with regard to all those aspects, pursuant to resolution WHA33.32, in collaboration with UNICEF and other agencies; and Member States themselves, of course, should take appropriate action.

Dr KLIVAROVÁ (Czechoslovakia) said that during the past ten years Czechoslovakia had achieved considerable success in infant feeding, and the result had been a significant decline
in morbidity. However, the value of breast-feeding had always been recognized; there was really no substitute from the biochemical and immunological viewpoints. In her country, paediatricians encouraged mothers to breast-feed at least during the first few weeks of the child's life. The importance of breast-feeding for the child's psychological and emotional development was also recognized, as well as the fact that artificial feeding could lead to overnutrition, with a tendency to obesity, atherosclerosis, allergy and hypertension in later life. As part of the promotion of breast-feeding, everything was done to create suitable conditions for mothers. For example, six months' maternity leave was granted by law, and mothers had the right to remain away from work for up to three years without pay, but without losing the right to return to their job. There was state control of the production of dried milk, which was obtainable only on prescription; no advertising was allowed.

Dr DJEKOUNDADE (Chad) said that one of the problems in developing countries relating to infant feeding arose at the stage of weaning, when there was a risk of kwashiorrok. The problems were difficult to deal with, and called first and foremost for good health education. The biggest problem stemmed from the use of artificial feeding; in industrialized countries, preserved milk was produced not far from the point of sale, was well stored, and was soon consumed; on the other hand, preserved milk sold in developing countries had already undergone long periods of transport and storage, and in many cases the period for safe use had elapsed even before the supplies had reached the country concerned. A system set up in Chad for checking supplies at the centres as well as at local markets, had resulted in a reduction in the cases of disease. Unfortunately, that work had suffered on account of the recent disturbances in the country, but the activities had now been started again.

New techniques for the development and use of breast-milk substitutes should be studied.

Dr ONDAYE (Congo) said that artificial feeding had not yet become a problem in his country, since it was practised only by a small bourgeois group. However, weaning was a problem. Efforts were being made to develop suitable local foods, but there were growing fears that the population might be influenced by unscrupulous marketing pressures by profit-seeking foreign capitalist concerns, whose exploitation of poor and ignorant peoples should be firmly challenged by the international community.

Dr WILLIAMS (Nigeria) said that his delegation regarded the progress report by the Director-General as a milestone in the work of WHO and a true reflection of WHO's determination to protect maternal and child health.

In Nigeria, most infants were breast-fed, but bottle-feeding was increasing alarmingly, with an attendant increase in diarrhoeal ailments resulting from bad hygiene, as well as in cases of malnutrition as a result of over-diluted feeds.

The inculcation of sound feeding habits formed a major part of Nigeria's health programme, and mothers were encouraged to breast-feed their children for at least the first six months of the child's life. The Government had recently introduced legislative measures which included maternity leave of three months on full pay.

The weaning period was a most important part of a child's life, since a poor diet could do irreparable harm. Great efforts had been made to develop suitable locally-produced food-stuffs; one had in fact already been developed and was awaiting commercial exploitation. With a view to avoiding infection, mothers were encouraged to feed their children by cup and spoon. Nutrition information was widely distributed by the mass media and personal contacts, with emphasis on the value of breast-feeding for mental and emotional as well as physical development. The Government had assigned priority to food production with a view to making food available to the population at low prices.

His delegation hoped that more light could be shed on the effect of breast-feeding as a factor preventing further pregnancy.

Dr AL-SAIF (Kuwait) said that his delegation welcomed the progress report by the Director-General. His country's authorities were convinced of the value of breast-feeding, particularly since studies had revealed the link between artificial feeding and the incidence of diarrhoeal and other disorders.

Professor HALEEM (Bangladesh) said that his delegation fully endorsed the Director-General's progress report. In Bangladesh artificial feeding was hardly a problem, since 90% of the population lived in rural areas. But the problem did arise in urban areas; it had already been noted that artificial feeding could lead to malnutrition because of incorrect dilution; indeed, some 80% of cases in children's hospitals were due to malnutrition.
Training and education were very important and his country was giving attention to that aspect. It had also enacted legislation to protect working mothers entitling them to special leave. He wondered whether the United States of America and some of the larger producers of infant foods could make some arrangements to provide the developing countries with milk substitute formulas.

His delegation fully supported the remarks made by the United States delegate concerning the further efforts needed relating to breast-feeding. As a microbiologist, he was aware that very little disease could be transmitted through breast milk, but that some antibodies, on the other hand, might well be transmitted and thus protect the child.

It had to be realized, of course, that efforts to improve infant and young child feeding would be of no avail in isolation, but should be approached in the context of measures to raise living standards in general by means of improvements in food, housing, sanitation and education, with a view to attaining health for all by the year 2000. It was important, in that connexion, that measures should take account of all population groups, should not be too complicated for the developing countries to implement, and should be appropriate for application by the national health services available.

Dr LUBANI (Jordan) said that breast-feeding was a traditional practice in rural areas of Jordan, while in urban areas it was often considered outmoded. His country made every effort to promote breast-feeding through health education at maternal and child health centres and through the mass media, explaining that mother's milk had high nutritional value for infants and conferred immunity against many diseases responsible for infant mortality. He supported the concepts expressed in the Director-General's progress report, and endorsed WHO's efforts to foster breast-feeding - a major element for the achievement of health for all.

Mr VOHRA (India) expressed satisfaction with the progress report of the Director-General. He had been encouraged to note that delegates had spoken in positive, concrete terms, since that augured well for the programme. In India the fundamental importance of breast-feeding had been recognized thousands of years ago; the first feed had been an important occasion presided over by the chief of the village who recited a charm over the mother.

One aspect of the programme in India that was of particular concern was the vital link between lactation and family planning. High rates of infant mortality led to multiple pregnancies. But the key to survival was better nutrition and immunity through breast-feeding.

In countries in the South-East Asia Region programmes in this field laid emphasis on the training of health workers and the production of educational material. India had revised the university paediatrics curricula, introducing the appropriate elements, and had produced a handbook on child health that might be of interest to other delegations. The curricula for training in maternal and child health had also been revised as part of primary health care courses for undergraduates and interns.

Dr H. SYLLA (Guinea) said that it was only in recent years that a study of statistics on parasitic diseases in Guinea had revealed an association with bottle-feeding; no doubt an adulterated product or lack of hygiene was responsible. The Government had therefore decided to monopolize the importation and distribution of breast-milk substitutes, which were only sold in state pharmacies, on prescription - for infants who had lost their mothers, or whose mothers were seriously ill. Hospitals were instructed not to use breast-milk substitutes for the treatment of malnutrition. The first step in treating infant diarrhoea was to eliminate milk. Mothers and infants were hospitalized together so that breast-feeding could continue uninterrupted. In the medical faculty and in midwifery and nursing schools teaching emphasized the importance of breast-feeding. Fourteen months' maternity leave was granted, and nursing mothers were allowed to commence work one hour later and finish one hour earlier.

Dr CONTY (Spain) congratulated the Director-General on the progress report. He drew attention to the importance of workshops, both at the national and international levels. In his view, the number of workshops should be increased, since they helped to encourage breast-feeding by facilitating the exchange of technical knowledge, and promoted collaboration between health workers. He expressed gratitude to the countries and organizations which collaborated in that respect.

Dr ALBORNÖZ (Venezuela) expressed satisfaction at the work accomplished in the field of infant and young child feeding. Venezuela continued to make efforts to reduce infant mortality through nutrition programmes for pregnant mothers and free paediatric care, including, where necessary, the distribution of breast-milk substitutes. The programme was
coordinated with the programme on special care in childbirth, and for the newborn infant, which at present covered almost the whole country. Ante- and post-natal leave for pregnant women had been granted for more than 25 years. The National Institute of Nutrition had permanent education and nutrition programmes dealing with infants and young children, and it was currently organizing a second seminar on breast-feeding which was hoped would even increase the favourable results of the first such seminar. The programme for pre-school children had recently been extended with excellent results. He expressed the hope that the activities undertaken by WHO at the global level would enable rapid progress to be made in that important field.

Dr GUERRERO (Colombia) said that Colombia fully supported the policy of breast-feeding and was making every effort to expand the programme, which was integrated in the overall maternal and child health care programme. In order to encourage breast-feeding mothers were given paid leave, following which they were allowed to leave work for two hours per day in order to feed their babies. Furthermore, when legislation on milk substitutes had been adopted in 1980, many of WHO's recommendations had been taken into account.

Dr ABDULLATIF (Democratic Yemen) congratulated the Director-General on his excellent report. In Democratic Yemen breast-feeding mothers were given leave on full pay, and no advertising whatsoever for breast-milk substitutes was allowed. However, it was not possible to prevent neighbouring radio and television stations from broadcasting such advertisements. The International Code should help to control such advertising.

Democratic Yemen imported two or three breast-milk substitutes that were subsidized by the State - but for reasons beyond its control those substitutes were sometimes smuggled outside its frontiers.

Local traditions of breast-feeding were encouraged by primary health care workers and midwives in maternal and child health centres. Breast-feeding by women visiting the infant during the first few days was a common practice in some rural areas.

Dr WILLIAMS (Sierra Leone) joined other delegates in thanking the Director-General for his progress report. Prolonged breast-feeding was the rule in Sierra Leone, and breast-fed babies were among the most healthy in the world until the age of six months or so, when breast milk was no longer enough. It was at that stage that problems arose, due to lack of suitable weaning foods. Bottle-feeding was adopted because mothers considered it fashionable, because they had certain beliefs, or because they formed part of the 2% of women who went out to work. The price of breast-milk substitutes was extremely high in Sierra Leone compared to the subsidized price of packets of high protein food made from benniseed, blackeyed beans and the staple parboiled rice.

Health and nutrition education for all sectors of the community, including men, should be strengthened so as to counter prejudice against breast-feeding. It was also important to provide sufficient amounts of weaning foods made from locally available high protein foods and to educate the population in their correct use. For the first six months after childbirth mothers should be granted leave or should only work for half the day; nurseries should be set up near their places of work so that they could go and breast-feed their babies during the day.

In her view it was impossible to prepare sterile milk feeds if the environmental conditions and personal hygiene were poor. An effort in that respect was therefore essential. There were obviously cases in which breast-milk substitutes had to be used, but they should be kept to the minimum. Where they were necessary, they would often have to be subsidized by the State, and facilities would have to be provided so that sterile milk feeds could be given, not diluted, contaminated bottle-feeds that would continue to contribute to the high incidence of diarrhoea, vomiting, dehydration and death among infants and young children.

Dr MORK (representative of the Executive Board) thanked delegates for the kind remarks addressed to the Executive Board and for the support given to the Board's work on the subject. In its future work the Board would take into account the concern expressed by many delegates, particularly those from developing countries, in connexion with many factors detrimental to optimum infant and young child feeding.

The numerous activities carried out at the regional and national levels to promote breast-feeding, to improve weaning foods and practices and to provide education and information were most encouraging. The delegate of the United States of America, among others, had spoken about the need and opportunities for research, and reference had been made to
Dr PETROS-BARVAZIAN (Director, Division of Family Health) thanked delegates for their encouraging comments on the Director-General's progress report.

The discussion had covered many aspects of infant and young child feeding and had shown that the question should be considered in a comprehensive manner, and not in isolation. It formed a part of the overall health and nutrition of mothers and children, an essential element of primary health care and, hence, of efforts made by Member States and organizations to achieve health for all by the year 2000.

She had noted the valuable suggestions made for future research and service needs, as well as those in relation to the development of educational workshops and materials, and the need for the encouragement and promotion of technical cooperation among countries. The progress report showed the different activities undertaken at country, regional and global levels, most of which involved the participation of various interested groups, in particular UNICEF which made a valuable contribution.

The delegate of Jamaica had referred to the question of maternal nutrition, and she assured her that it received high priority in WHO's programme. Scientific information available suggested that mothers were able to breast-feed their babies unless they were severely malnourished or unhealthy. The question was being followed not only from the point of view of the relationship of maternal nutrition and the lactation performance, but also from that of the mother's own health and the effects on the fetus, especially in relation to birth weight.

As part of the ACC Sub-Committee on Nutrition there was a special Consultative Group on Maternal and Young Child Nutrition, which had discussed recent knowledge on maternal nutrition and whose report was available. The second phase of the WHO collaborative studies on breast-feeding focused on the volume and composition of breast milk in order to see whether better light could be shed on the possible differences in volume and composition in different population groups.

With regard to lactation and reproduction, she said that scientific knowledge continued to show that there was a relationship between them. WHO studies showed that there was a close link between the frequency and duration of breast-feeding in various population groups and the timing of the commencement of post-partum menstruation. It was planned to hold a meeting in February 1982 on breast-feeding and fertility and the relationship between lactation, reproduction and family planning. Most societies preferred that lactating mothers should not become pregnant so that they would be able to continue breast-feeding successfully. Fully breast-feeding mothers were, in general, less likely to become pregnant than those who were not breast-feeding, but for additional security it was necessary for some women to take contraceptive measures. It was therefore extremely important to know what contraceptive measures should be used during breast-feeding, since there was a likelihood that some hormonal contraceptives could pass to the baby through the milk.

The implication of all this for the policy level showed the need for an integrated programme approach in the context of infant nutrition, maternal and child health and family planning, and primary health care. She hoped that it would be possible to report on the subject to the Thirty-fifth World Health Assembly.

(For continuation, see summary record of the fourteenth meeting, page 201.)

Draft International Code of Marketing of Breast-milk Substitutes: Item 23.2 of the Agenda (Resolutions WHA33.32, para. 6(5), and EB67.R12 ; Documents A34/8 and A34/INF.DOC./9-12)

Dr MORK (representative of the Executive Board) said that the subject had been discussed at length during the Thirty-third World Health Assembly. In that connexion, delegates would recall resolution WHA33.32, which had been adopted unanimously, and which requested the Director-General, inter alia, "to prepare an international code of marketing of breast-milk substitutes in close consultation with Member States and with all other parties concerned ...". The need for such a code and also the principles on which it should be developed had thus been unanimously agreed at the Thirty-third World Health Assembly.

Two issues were before the Committee, namely, the content of the Code and the question of whether it should be adopted as a regulation in the sense of Articles 21 and 22 of the WHO Constitution, or as a recommendation in the sense of Article 23.
The proposal before the Committee in document A34/81 was the fourth distinct draft of the Code - the result of a long process of consultations carried out with Member States and other parties concerned, in close cooperation with UNICEF. Few, if any, issues before the Board and the Assembly had been the object of such extensive consultations.

During the process, the Director-General and the Secretariat had been subjected to a variety of pressures and counter-pressures, in addition to accusations and allegations, from some quarters, which had sought to compromise their integrity. The Board, at its meeting in January 1981, had expressed great admiration for the work of the Director-General and the Secretariat in the face of the accusations they had had to endure.

Members of the Board had expressed resentment at the accusations, which they had considered to be beneath contempt. That activity had regrettably continued, and he was confident that the Committee shared the sentiment expressed by the Board with regard to the work carried out by the Director-General and the Secretariat.

During the Board's discussion on the item, many members had addressed themselves to the aim and principles of the Code and had stressed that, as presently drafted, it constituted the minimum acceptable requirements concerning the marketing of breast-milk substitutes.

Since even at the present late stage, as reflected in recent newspaper articles, some uncertainty persisted with respect to the content of the Code, in particular its scope, he thought it would be useful to make some remarks on that point. He reminded delegates, however, that the scope of the Code had not been a source of difficulty during the Board's discussions.

The scope of the draft Code was defined in Article 2. During the first four to six months of life, breast milk alone was usually adequate to sustain the normal infant's nutritional requirements. Breast milk might be replaced (substituted) during that period by bona fide breast-milk substitutes including infant formula. Any other food such as cow's milk, fruit juices, cereals, vegetables, or any other fluid, solid or semi-solid food intended for infants, and given after this initial period, could no longer be considered as a replacement for breast milk (or its bona fide substitute). Such foods only complemented breast milk (or breast-milk substitutes) and were thus referred to in the draft Code as complementary foods; they were also commonly called weaning foods or breast-milk supplements.

Products other than bona fide breast-milk substitutes, including infant formula, were covered by the Code only when they were "marketed or otherwise represented to be suitable . . . for use as a partial or total replacement for breast milk". Thus the Code's reference to products used as partial or total replacements for breast milk was not intended to apply to complementary foods unless those foods were actually marketed (as breast-milk substitutes, including infant formula) as suitable for the partial or total replacement of breast milk. So long as the manufacturers and distributors of the products did not promote them as being suitable as partial or total replacements for breast milk, the Code's provisions concerning limitations on advertising and other promotional activities did not apply to those products.

The Board had very carefully examined the draft Code. Several Board members had expressed a desire to have certain amendments introduced in order to strengthen the Code and make it still more precise. The Board had considered, however, that the adoption of the Code by the Thirty-fourth World Health Assembly was a matter of great urgency in view of the serious situation prevailing, particularly in developing countries, and that amendments introduced at that stage might lead to a postponement of the adoption of the Code. The Board had therefore unanimously recommended to the present Health Assembly the adoption of the Code as presently drafted, realizing that it might be desirable or even necessary to revise the Code at an early date in the light of the experience gained in the implementation of its various provisions. That was reflected in operative paragraph 5(4) of the draft resolution contained in resolution EB67.12.

The second main question before the Board had been whether it should recommend the adoption of the Code as a recommendation or as a regulation. Some Board members had expressed a preference for the adoption of the Code as a regulation in the sense of Articles 21 and 22 of the Constitution. It became clear, however, that although there had not been a single dissenting voice in the Board with regard to the need for an international code, its scope, or its content, opinion was divided on the question of a recommendation versus a regulation.

It was stressed that any decision concerning the form the Code should take should be based on an appreciation of which alternative had the better chance of fulfilling the aim of the Code, i.e. to contribute to improved infant and child nutrition and health. The Board had agreed that the moral force of a unanimous recommendation could be such that it would be more persuasive

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1 See document WHA34/1981/REC/1, Annex 3.
than a regulation that had gained less than unanimous support from Member States. It had considered, however, that the implementation of the Code should be closely monitored according to existing WHO constitutional procedures; that future Health Assemblies should assess the situation in the light of reports from Member States; and that the Assembly should take any measures it judged necessary for the Code's effective application.

After carefully weighing the different points raised during its discussions, the Board had unanimously adopted resolution EB67.R12 which contained a draft resolution recommended for adoption by the present Health Assembly. In that connexion, he drew the Committee's particular attention to the responsibilities outlined in the draft resolution; those of Member States, the regional committees, the Director-General, the Executive Board, and the Health Assembly itself, for appropriate follow-up action once the Code had been adopted.

In carrying out their responsibilities, Member States should make full use of their Organization - at global, regional and country levels - by requesting its technical support in the preparation of national legislation, regulations or other appropriate measures, and in the monitoring of the application of the Code.

A summary of the Board's discussion was to be found on pages 306-321 of document EB67/1981/REC/2.

At the Committee's previous meeting, when it had considered the budget level, one delegate had pleaded for consensus on a financial issue of particular importance to his country. The Director-General responding to the plea, had reminded the Committee of the tradition in the Organization whereby all parties did their utmost to try to reach a consensus on important issues. It was in that spirit that the Board had considered the issue. Addressing the Board in January the representative of the United States had stated: "In view of all the agreement existing within WHO and its membership regarding infant nutrition questions, it would be very unfortunate if the Health Assembly's conclusion on the matter was arrived at through divisive action."

The Board had shared that sentiment and had consequently done its utmost to arrive at a unanimous recommendation to the present Health Assembly, in the hope that a consensus would also be reached at the Assembly.

He could best reflect the sentiment of the Board by concluding his introduction with a plea for consensus on the draft resolution which had been unanimously recommended to the Health Assembly by the Board. The Committee was not considering an economic issue of particular importance to only one or a few Member States; it was considering a health issue of essential importance to developing countries and the children of the whole world - and, thus, to all future generations.

The CHAIRMAN announced that he had more than fifty speakers on his list.

Professor HALEEM (Bangladesh), speaking on a point of order, suggested that a fixed maximum time, say three minutes, might be allowed to each speaker since there were 51 speakers on the list; he also pointed out that there was specific provision for such fixation of times in the constitutional texts and the Rules of Procedure of the World Health Assembly.

The CHAIRMAN replied that the time of interventions could be restricted voluntarily by delegates on the basis of a gentlemen's agreement, as was the case in the previous discussions, if the Committee so expressed the wish.

Dr BORGOÑO (Chile), also speaking on a point of order, suggested that a procedure that could be used was to close the debate after a certain period of time. That might be preferable to limiting speakers, for example, to three minutes.

Dr KPOSSA-MAMADOU (Central African Republic), also on a point of order, said that he shared the concern of the delegate of Bangladesh and supported the approach suggested by the delegate of Chile; delegates should be urged to be as brief and concise as possible.

The CHAIRMAN said that the discussions would continue in that spirit. He drew attention to the fact that any delegate could move the closure of debate at the appropriate time.

Dr HADJ-LAKEHAL (Algeria) congratulated the Director-General on the fine work carried out and thanked the representative of the Board for his honest presentation and sincere search for a solution which would enable Member States to move forward.
His country, which considered the present issue crucial, agreed wholeheartedly that it was health, and not trade, that was at stake, and, most importantly, the health of infants and small children. The problems of that age-group carried the highest priority in the countries of the Third World, and their solution constituted the greatest challenge for the achievement of health for all.

Such issues touched upon the sovereignty of Member States. It was thus essential to discuss together, so that countries could move forward in a spirit of solidarity in the search for greater justice. The problem of infant and young child feeding was fraught with danger. It was not a question of accusing industry. Changes had occurred with regard to people's customs and, in view of the poor hygienic conditions, lack of knowledge, and low income, competition to breast-feeding was dangerous. The Third World was particularly affected because it constituted the market of today and, even more so, of tomorrow. Its voice should be predominant on the present issue, and it was legitimate to request the international community, in its search for greater justice, to be a bit more concerned about the problems and interests of Third World countries.

Since October 1979 hopes had been cherished about the possible introduction of such a code; they had not always been held high - in fact, they had diminished progressively as a result of various debates. However, it was a fact of life that often, in order to advance, compromise solutions had to be resorted to. In the present case, it was sad to note that compromise had led to a weakened position, adversely affecting the Third World countries. Surely it should not be necessary to have recourse to threats or boycotts.

His delegation continued to hold the belief that the Code should preferably be a regulation. However, with a view to being constructive, it was prepared to support the Board's proposal, even if its consensus had been achieved by a very small margin. He believed, in fact, that the majority of Member States favoured a regulation.

His delegation had serious reservations concerning the scope of the Code and its applications; such reservations, he knew, were also shared by other Member States, including some of the western industrialized countries. He had been surprised to see no mention in the draft Code of the responsibility that exporting States should have for ensuring that the products leaving their countries adhered to the standards that would be applicable in the home market. It seemed to him that that principle had been agreed upon at the September 1980 meeting and that there had been a consensus on that aspect. He requested clarification on that point.

Due to the pressure of time he would not refer to his other reservations. He would, however, state that his delegation's support of the Board's proposal was on the understanding that two years hence the Director-General would ensure that the remarks made and all the experience gained with the Code would lead to its further refinement and improvement.

Finally, his delegation noted with regret the position taken by certain delegations. Everyone, including those delegations, had urged that every effort should be made to reach agreement and consensus. Yet they had already taken a stand and made their negative position publicly known before the subject had even been discussed.

Dr ALSEN (Sweden) speaking on behalf of the five Nordic countries, expressed appreciation for the work carried out by the Organization on the draft Code during the past year. He noted that it represented a minimum compromise which had been the product of thorough consultations among the various parties concerned. As such, while it might not yet fully meet all requirements, the Nordic countries strongly believed that Member States now had a document before them which was essentially acceptable to all. It was therefore hoped that the Committee would be able to dispense with lengthy discussions concerning the Code and proceed rapidly to its unanimous adoption, as well as of that of the draft resolution recommended by the Board in its resolution EB67.R12.

The heads of the Nordic delegations had stated in plenary session that they regarded the Code as one of the most important issues before the present Assembly. From the summary records of the sixty-seventh session of the Board, it had appeared that the majority of the Board members who had addressed the issue had emphasized the advantages which would accrue from adopting the Code as a regulation. However, in order to attain unanimity, the Board had finally decided to recommend adoption of the Code as a recommendation. That position tallied with that of the Nordic countries, which were therefore prepared to endorse the decision of the Board.

Particular importance was attached to operative paragraph 5 (2) of the draft resolution, which called for the monitoring of the International Code at country, regional and global levels. Member States would have to establish some system for a monitoring
process; the information gathered would enable the Director-General to submit the necessary report, after an initial period, to the Health Assembly where the Code would be reviewed in the light of experience gained. At that time, the Health Assembly should be in a better position to establish in more precise terms the responsibility of exporting countries.

In view of the need for monitoring, follow-up and review referred to in operative paragraph 3 of the draft resolution, it would be appreciated if the Director-General could have basic guidelines prepared to facilitate the setting-up of appropriate national monitoring processes, possibly for the next sessions of the regional committees. Such guidelines should also refer to the important role to be played by consumer organizations and other nongovernmental organizations. That would be a concrete example of community involvement, a term too often used in a general way.

The Code and the draft resolution were viewed as a very important part of maternal and child health care, and, as such, an integrated part of primary health care, the key for achieving health for all. What had now to be done was to make a determined effort to translate the recommended Code into national legislation so that it could be implemented in Member States. In that connexion, WHO's continued efforts in collaboration with other relevant bodies of the United Nations system, Member States and concerned nongovernmental organizations, including both consumer organizations and industry, was considered crucial. The Nordic countries stood ready to do their share in that respect.

In conclusion, the Nordic countries wished again to commend the draft International Code along with the draft resolution contained in resolution EB67.R12, for unanimous adoption by the Health Assembly.

The meeting rose at 12h35.
FOURTEENTH MEETING

Wednesday, 20 May 1981, at 14h30

Chairman: Dr E. P. F. BRAGA (Brazil)

later: Dr J. ROGOWSKI (Poland)

INFANT AND YOUNG CHILD FEEDING: Item 23 of the Agenda (continued)

Draft International Code of Marketing of Breast-milk Substitutes: Item 23.2 of the Agenda (Resolutions WHA33.32, para. 6(5), and EB67.R12; Documents A34/8 and A34/INF.DOC./9-12) (continued)

Dr SIKKEL (Netherlands), speaking on behalf of member States of the European Economic Community (EEC), Belgium, Denmark, Federal Republic of Germany, France, Greece, Ireland, Italy, Luxembourg, Netherlands, and United Kingdom of Great Britain and Northern Ireland, said that the Community was in favour of the draft Code presented in the form of a recommendation of the World Health Organization.1

The member States of the Community had examined the Code very closely and subscribed fully to its aims, namely the "provision of safe and adequate nutrition for infants". They also considered that breast-feeding must be encouraged as an unequalled way of contributing to the achievement of that aim. On the other hand, where breast-feeding could not be ensured, it was essential that breast-milk substitutes should be used under optimum conditions.

The Code should also be seen in a more general and broader context. It should be recognized as being one of a variety of features of the policy carried out by WHO, the aim of which was to improve the health of mothers and young children throughout the world.

As regards the implementation of the Code, several of the aims of the Code had already been put into practice within the Community. As regards other parts of the Code, the Community and its member States would endeavour to give effect to the principles and aims expressed as appropriate to their constitutional and legislative framework as well as their social structures. WHO would naturally be kept informed of further action taken on the Code by the Community and its member States.

In conclusion, he reiterated the commitment of the Community to the guiding principles expressed in the Code and thanked WHO and UNICEF on behalf of the Community and its member States for the initiative they had taken. The phase of practical implementation had now been reached, and more experience was needed. After a few years, it would in any case be necessary to meet again to revise and improve one or other section of the Code in the light of the experience gained; he was happy to confirm that the Community's collaboration would be forthcoming.

Dr FREY (Switzerland) affirmed his Government's absolute belief in the validity of the concluding remarks of the statement on infant and young child feeding made at the joint WHO/UNICEF Meeting on Infant and Young Child Feeding held in Geneva in October 1979.2 His Government attached so much importance to breast-feeding because infant and young child feeding played a key role in the health and in the physical and mental development of the child, and indirectly influenced the socioeconomic development of society as a whole. The Assembly's view had been confirmed in resolution WHA33.32 which formed the basis of the draft Code under discussion. That made clear that the use of milk substitutes and publicity surrounding such products was a matter which directly affected the health of the child. That

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1 For text of Code, see document WHA34/1981/REC/1, Annex 3.

was the crucial issue. Any code governing the advertising of breast-milk substitutes should be
designed to offer better protection and to improve the health of the child. The health of
the child must, in other words, be the main criterion used in assessing any code.

His Government had accordingly favoured the preparation of a code explicitly and
categorically designed to protect and encourage breast-feeding.

That was not to imply that any other kind of infant feeding was, of necessity, bad. The
child who could not be breast-fed or could only incompletely be breast-fed needed breast-milk
substitutes. What was important was to ensure their proper use and to make sure that they
were of impeccable quality. There should be no misunderstanding on the subject: the Code
recognized objectively that breast-milk substitutes fulfilled a need and it did not set out
to prevent such products from being sold or used when necessary. What it did set out to do
was, first, to avoid any practice, particularly one connected with sales promotion, which
would act to the detriment of the principle of actively protecting and promoting breast-feeding;
and, secondly, to ensure that such products were correctly used when there was a need for them.

The satisfactory marketing and distribution of breast-milk substitutes and their proper
use only formed part of the complex of factors affecting infant and young child feeding and
health. A number of other important aspects had been touched on during the debate on item
23.1, such as the diet of the mother during the lactation period and possibly still more
during pregnancy, both in the interests of the child and that of the mother herself; maternity
hospital practice; mothers' working conditions, which should be so arranged as to enable a
mother to breast-feed her child; lastly, weaning. It was essential that WHO should take an
active interest in all those questions together with UNICEF and the other agencies of the
United Nations system as well as Member States themselves, in pursuance of resolution WHA33.32.
A further point to be taken into consideration derived from the first operative paragraph of
WHA33.32, which stated that the Assembly endorsed in their entirety the statement and
recommendations of the joint WHO/UNICEF Meeting of October 1979. His Government had repeated
on a number of occasions that there should be no divergence between the conclusions of the
October 1979 meeting and the provisions of the Code. Unfortunately that had not proved wholly
practicable.

His delegation regretted that the provisions relating to the quality of products did not
take account of proposals which it had submitted during the earlier discussions and which were
designed to ensure that products were used in first-class condition.

His delegation endorsed the Executive Board's recommendation that the Code be adopted as
a recommendation and approved the draft resolution submitted by the Executive Board in
resolution EB67.R12. It hoped that that resolution would be approved unanimously. The
implementation of the recommendation relied above all on its voluntary acceptance by Member
States and all those concerned and on their readiness to take or to encourage the necessary
steps. For several years past an agreement freely reached between the Swiss Paediatric
Society and manufacturers had placed major restrictions in Switzerland on the promotion of
breast-milk substitutes, thereby creating favourable conditions for breast-feeding. The fact
that the implementation of the Code was voluntary should not be taken to mean that it was any
less important as a guide to action on the part of WHO, Member States and other agencies,
chief among them UNICEF, aiming at promoting breast-feeding while not deprecating all the uses
of breast-milk substitutes. His delegation considered that the provision of the recommenda-
tion relating to the need for governments to take action appropriate to their social and
legislative framework and their overall development would provide means for his country and
others to overcome any possible difficulties in implementing the Code. At the same time it
should not be used as an escape clause.

The draft resolution recommended in resolution EB67.R12 provided for a set probationary
period. The provision appeared to his delegation to be an important one. In the light of
experience, the situation in various countries would be seen more clearly. His delegation
hoped that the period could be put to good use in clarifying some of the less satisfactory
points about which there had been some misunderstanding, for instance concerning the scope of
the Code, public information, the quality of the products and the responsibility of the
relevant organizations in Member States. He hoped that the Code would make an effective
contribution to the improvement of child health.

Mrs RUMJANEK CHAVES (Brazil) said that her delegation warmly supported the principles
contained in the draft International Code of Marketing of Breast-milk Substitutes. The
encouragement of breast-feeding and the avoidance of premature or unnecessary use of
substitutes had social and economic as well as medical and health reasons. That had been
recognized by her Government which had launched a nationwide campaign in favour of breast-feeding, with highly gratifying results. The proposed International Code appeared to provide Member States with an adequate guideline for the elaboration of national legislation in the field.

Her delegation would vote for the adoption of the Code as a recommendation, in the belief that Member States would thus be free to elaborate national codes in accordance with their legal systems and to adjust the recommendation to local conditions and specific needs. She believed that the adoption of the Code would constitute an important contribution to sound infant and young child nutrition.

Professor DOGRAMACI (Turkey) said that the resolution of the Executive Board on the International Code of Marketing of Breast-milk Substitutes had been prepared in such an objective and even moderate fashion that it hardly needed defending. Apparently, however, certain points had not been clearly understood and certain doubts had ensued.

No one questioned the superiority of breast-milk. Indeed, the biological and psychological benefits of breast-feeding were so well established that it would be superfluous to elaborate on them, except perhaps to say that every year added more knowledge of breast milk's unrivalled anti-infective and nutritive properties. It was also well known that almost every mother was capable of breast-feeding, and that those who could not do so constituted a very tiny minority.

None the less a certain amount of confusion appeared to surround the issue. One misunderstanding was that the Code was directed against the manufacturers of breast-milk substitutes. In fact, the Code in no way discouraged industry from manufacturing substitutes. High quality substitutes had an unquestionably important and legitimate place in infant feeding. The whole purpose of the Code was to avoid encouraging future mothers and especially new mothers to resort unnecessarily to bottle-feeding, particularly in conditions known to be dangerous.

It was argued that mothers had a right to choose whether or not they wanted to breast-feed; no one would deny that, nor would anyone deny that a mother would always choose what was best for her baby, provided she was properly informed about the facts. However, if the expectant mother was showered with clever publicity and sometimes even free samples of breast-milk substitutes, she could not always be expected to make a wise decision in the best interests of the health of her baby. The aim of the Code was precisely to protect mothers and future mothers from unethical marketing practices.

In countries where infant mortality exceeded 100 per 1000 live births, sometimes going as high as 150 or 200, the cause of death in more than half those cases was severe diarrhoea and infection, working in a vicious circle. Breast-feeding of infants was the most effective and the simplest form of prevention.

Comparative studies in affluent areas, or even in the moderately industrialized countries, did not do justice to the dangers inherent in depriving babies of breast milk in the least privileged societies; the results of such studies could therefore not be generalized.

The draft of the Code was of course not flawless. Nothing was perfect. A long time had already been spent in its preparation and processing. Indeed, the subject had been a major preoccupation for more than three years. A meeting where almost all sectors and interested parties were represented had been organized by WHO and UNICEF in October 1979 to discuss the issue. A year and a half had passed since then. It was high time to put something into practice.

One question was whether the draft Code should be adopted as a recommendation regulation. From a legal point of view, a regulation was more binding than a recommendation. However, purely for the sake of avoiding abstentions, his delegation was in favour of having the Code adopted as a recommendation. His delegation supported the Code as proposed by the Executive Board as it stood in its entirety, and as a recommendation for the reasons just indicated.

Under the draft resolution prepared by the Executive Board, the Director-General was requested to report to the Thirty-sixth World Health Assembly concerning the status of compliance with the Code at country, regional and global levels and to make any proposals necessary for revision of the text. His delegation proposed that the Director-General set up an effective mechanism for monitoring and evaluating the Code's implementation from the very beginning. In that way, the Health Assembly could make the revisions and improvements deemed necessary.

Finally he wished to put on record that the statement contained in a circular, apparently widely distributed, to the effect that the International Paediatric Association had taken a decision against the Code was quite inaccurate. The facts were that the issue had come before
the Standing Committee of the International Paediatric Association at its meeting in Tokyo at the end of March 1981, and it had been decided that no official stand on the Code should be taken.

Dr LAW (Canada) said that the superiority of breast milk - psychologically, nutritionally, immunologically - was beyond dispute. Hence breast-feeding must be encouraged and protected as one of the measures essential to the very survival of many infants and desirable for the healthy development of all the world's children.

In Canada, progress in promoting breast-feeding had been encouraging. Federal and provincial health authorities had for some time been working, in conjunction with professional and other nongovernmental organizations, in the development and implementation of breast-feeding promotion programmes. The results indicated that the percentage of infants being breast-fed had, during the past 10 years, increased nationally from a low of about 40% to nearly 60%.

Such Canadian programmes were consistent with the general thrust of the draft International Code and contained some of the measures outlined in the Code. The distribution of samples had already been discontinued in some hospitals of Canada, and continued progress was anticipated in stopping that unfortunate practice. Health authorities were also taking greater responsibility for the education of mothers and prospective mothers about breast-feeding.

It was on the basis of that national experience - and of her Government's belief that the needs of infants everywhere required a concerted and collective effort that her delegation supported the adoption of the draft Code. However, in order to achieve its earliest intended impact, the Code must find the broadest possible acceptance amongst WHO members. It must allow governments to give effect to its provisions in accordance with their respective socioeconomic and cultural situations. Her Government believed that a recommendation would achieve those objectives and accordingly supported the draft resolution recommended in resolution EB67.R12.

It wished to emphasize that WHO had a crucial role to play in assisting governments on request with the development of their respective approaches to the implementation of the Code.

However, because of the particular characteristics of Canadian society - as also reflected in federal and provincial legislation - Canadian health authorities might encounter fundamental difficulties in their efforts to give full effect to all the provisions embodied in the draft Code. Nevertheless, the Code should have a stimulating effect in the further development of programmes in the area.

Despite the various national approaches which would no doubt develop in response to the Code, her delegation wished to emphasize the urgency and importance of a concerted effort on the part of all concerned - whether from government, industry, nongovernmental organizations or the general public - to achieve the essential aims of the Code in a rational manner. She hoped that when progress was reviewed in two years time - as stipulated in the recommended resolution - the effectiveness of that collaborative effort would be clearly demonstrable.

However, it was essential for the Secretariat and the Executive Board to develop clear definitions of the criteria to be used in evaluation and to develop an effective monitoring system - including assistance to requesting governments in developing and implementing their own monitoring activities.

Finally, she recalled that the Code was only one aspect of the comprehensive effort required by all to ensure that as many infants as possible - in every country of the world - experienced the benefits of breast-feeding.

Mr VOHRA (India) said that for him the possible misunderstandings referred to by previous speakers simply did not exist. Such misunderstandings as might exist would have been created by vested interests such as the delegate of Turkey had had in mind. He himself had, while in Geneva, been approached by a number of dubious self-appointed representatives of those interests.

Resolution WHA33.32 had been the culmination of efforts pursued by large numbers of delegations over a considerable period which, under Dr Mork's able guidance, had finally agreed on it, with the exception of one country only, whose representative, after placing his country's position on record, had personally voted in favour of it. Congratulations were due to the Board members, the Secretariat and those in other agencies who had enabled the draft Code to take shape.

The Code was not flawless, as speakers had rightly said, but no code of international status could be flawless seen from 157 different perspectives, each of them relating to a country's special historical, administrative, sociocultural and legislative framework. It was his contention that the Executive Board had wisely allowed for all points, particularly by the provision for periods after which the working of the resolution would be revised and reported upon. It would be premature to speak of taking up positions. All he would say on
his Government's behalf was that it would not press for the adoption of a regulation, but that was hardly necessary since the resolution already provided for the imposition of stricter measures if need be in the future.

To his mind the crucial elements in the resolution recommended in resolution EB67.R12 were, first, the clause stating that it was a "minimum requirement" in the tenth preambular paragraph; secondly, the fact that it was meant to be translated collectively into reality by means of national legislation. India had formed a multidisciplinary team, well advised by representatives of UNICEF and WHO, which had adapted the Code to national requirements and arrived at a draft legislative framework.

Thirdly, operative paragraphs 3 and 4 called upon regional committees, the Executive Board and the Health Assembly to follow up and review implementation, and upon the FAO/WHO Codex Alimentarius Commission to support the implementation of the Code.

He called attention to the draft resolution on nutritional value of products specifically intended for infant and young child feeding which his delegation co-sponsored together with the delegations of Algeria, Angola, Benin, Mali, Morocco, Mozambique, Sweden, Switzerland, Tunisia and the United States of America, and which had as its aim the attainment of high standards of specification, storage and distribution of foods intended for infant consumption, particularly in tropical areas. While there was no direct connexion between that resolution and operative paragraph 4 of the resolution on the draft Code, the aims of both were very closely linked.1

Professor HAMZA (Tunisia) commended the sustained efforts of WHO to promote the practice of breast-feeding, especially in the Third World. Infant feeding was a matter of overriding importance in view of its repercussions on the physical and mental development of the child. In spite of the progress made by industry in producing humanized cow's milk, no product had yet been found which could compete with or replace the mother's milk in ensuring harmonious development and affording protection against infection and cardiovascular accidents in later life. Quite apart from the scientific evidence, which was still accumulating on the biological, immunological and emotional advantages of the mother's milk, the economic aspect was becoming progressively more important in view of the adverse effect of the increasing costs of breast-milk substitutes on the family budget of poorer families. The natural practice of breast-feeding had fallen out of favour in recent years, initially in the developed countries and subsequently in the developing world, and the decline had in some regions reached catastrophic proportions.

The belief had been fostered that malnutrition could be overcome by using breast-milk substitutes for mother's milk, which were available commercially or generously distributed by public, even national institutions. In addition, professional training establishments had been won over to support that type of feeding regime and were imparting theoretical and practical instruction on feeding with breast-milk substitutes. it was of course true that in the developed countries and among privileged populations the advent of pasteurized milk in powder form had reduced bacterial infection of the intestinal tract due to unsterilized cow's milk, but the campaign in favour of breast-milk substitutes had now reached the stage where questionable commercial practices were adversely affecting the training of health workers and misleading the public. It should be pointed out that health authorities and some industrial undertakings had now appreciated the dangers of the situation and were attempting to reach a joint agreement which would safeguard both the health of children and the future of breast-milk substitutes.

As a result of exposure to such commercial abuses, his country had in recent decades suffered a steady decline in breast-feeding, with a consequent increase in the incidence of gastroenteritis, one of the principal causes of infant mortality. Efforts had been made in the past 10 years to reverse the trend by nutritional education in mother and child care centres and by approaches to breast-milk substitute manufacturers, urging them to cooperate in encouraging recognition of the paramount value of mother's milk in the first few months of life. Although some progress had been made, the aggressive sales policy of manufacturers had made its mark not only among the privileged but also among the poorer classes, largely owing to the absence of any international marketing code.

1 For text of the draft resolution on the nutritional value of products specifically intended for infant and young child feeding, see p. 201.
The Code which was now before the Committee was the outcome of careful study and represented a compromise which he hoped would be accepted by all. Although it contained gaps, shortcomings and weaknesses, the Code would assuredly benefit child health. The Tunisian delegation supported its adoption as a recommendation. At the same time, the Director-General should be instructed to pursue studies on the incidence and value of breast-feeding with a view to making any necessary modifications to the Code after the trial period.

As a member of the Standing Committee of the International Paediatric Association he confirmed the statement by Professor Doğramacı that no official action or decision on the Code had been taken at any time.

Dr KPOSSA-MANADOU (Central African Republic) said that the present issue was not so much a conflict between WHO, industrial undertakings and the consumer as a problem in public health, which affected in particular child health in the developing countries. The primary aim was the protection of mother and child health, and the draft International Code of Marketing of Breast-milk Substitutes was a logical follow-up to the discussion of an important public health problem.

The medical profession in his country was well aware of the harm caused by the feeding bottle among ill-informed members of the population, and many of the better-informed were equally unaware of the essential and irreplaceable qualities of mother's milk. In consequence, his delegation fully endorsed the resolution submitted by the Executive Board, and he hoped to see in the near future an effective implementation of the draft Code. Products subject to the Code might continue to be sold in his country, provided that manufacturers and their representatives complied strictly with the provisions of the Code, but there could be no question of allowing corridor lobbying by commercial interests to weaken the provisions of the Code.

Professor HALTER (Belgium) raised a point of order: the present issue had been under consideration by the Director-General and the Health Assembly for the past three years, and the Committee now had before it a draft Code and a draft resolution submitted by the Executive Board. Those documents had been ably introduced by Dr Mork, representative of the Executive Board, and discussed by a number of speakers who had demonstrated their competence, sensitivity to the issue and heartfelt desire to see the problem solved. There were altogether some 50 speakers on the Chairman's list, each of whom would naturally wish to present his own detailed arguments in favour of the proposal, whereas the Committee had not heard a single voice raised against the need for breast-feeding.

The representative of the Executive Board had accepted that the draft Code did suffer from certain deficiencies, which had been brought out also in discussion, but he himself had no doubt that it would prove of inestimable value in protecting child health. At the same time, he had no hesitation in saying that there was nothing in the Code which might in any way run counter to the legitimate interests of industry and those concerned in the marketing of breast-milk substitutes. Such products were certainly essential in many cases, for example where children could not, for some reason, be breast-fed.

The general conclusion to be drawn was that if the Code were to achieve its aim it should be adopted without delay, especially since there were other important items awaiting discussion by the Committee. He therefore moved closure of the debate and formally requested that a vote be taken on the draft Code.

He also urged the Director-General to implement immediately the provisions of the resolution, especially those relating to the surveillance and monitoring in countries which undertook to implement the recommendation.

The CHAIRMAN asked the Secretary to read out Rule 63 of the Rules of Procedure on the closure of debate.

Mrs BRÜGGEMANN (Secretary) read out Rule 63, as follows:

A delegate or a representative of an Associate Member may at any time move the closure of the debate on the item under discussion whether or not any other delegate or representative of an Associate Member has signified his wish to speak. If request is made for permission to speak against closure, it may be accorded to not more than two speakers, after which the motion shall be immediately put to the vote. If the Health Assembly decides in favour of closure, the President shall declare the debate closed. The Health Assembly shall thereafter vote only on the one or more proposals moved before the closure.
Professor HALEEM (Bangladesh) said that he had at the previous meeting of the Committee requested limitation of the time allowed to speakers on the present item, but he had been informed that no provision existed for any such limitation of time. In that connexion he drew attention to Rule 57 of the Rules of Procedure, which stated clearly that the Health Assembly might limit the time allowed to each speaker, and also to Rule 27, relating to the duties of the President.

Mr BENAVIDES (Peru) said that it was a matter of regret that the Committee was meeting in a room in which delegates had to make all sorts of efforts in order to indicate their wish to address the Committee. His objection to the closure motion was based in the first place on his desire to see the discussion conducted in a democratic manner. He also regretted the amount of time spent on proposals aimed, in the words of the speaker, at not wasting time. He was opposed in principle to interruption of the discussion of what he regarded as a most important subject and he therefore urged rejection of the closure motion.

The CHAIRMAN invited the Committee to vote by a show of hands on the motion for closure of the debate.

The motion was carried by 59 votes to 14, with 21 abstentions.

Dr ONDAYE (Congo) requested that the vote on the resolution recommended by the Executive Board be a roll-call vote.

The CHAIRMAN asked the Secretary to read out Rule 74 of the Rules of Procedure, relating to roll-call votes.

Mrs BRÜGGEMANN (Secretary) read out Rule 74 of the Rules of Procedure, and Rule 85 as being also relevant.1

Professor HALEEM (Bangladesh) said that, at the morning's meeting, he had realized that when 50 delegates had put their names on the list of speakers there would not be time for all to say all they wished and he had inquired if a time limit could be imposed. The Chairman had said that not to be possible. At that time, he was aware of the Rule, but could not recall the number, 57. By allowing the closure of the debate, the Chairman had deprived him of the "right to speak" which was accorded under Rule 27, which he read out.2 Moreover, he drew the attention of the Secretariat to a contradiction between Rule 27, which accorded that right, and Rule 55, which stated: "No delegate may address the Health Assembly without having previously obtained the permission of the President".

Mr VIGNES (Legal Adviser) said that, as the motion to close the debate had been approved, according to Rule 63, the Committee should proceed immediately to vote on the proposal before it. The request for a roll-call vote was in accordance with Rule 74 which gave an automatic right to have such a vote upon request.

1 Rule 74: The Health Assembly shall normally vote by show of hands, except that any delegate may request a roll-call, which shall then be taken in the English or French alphabetical order of the names of the Members, in alternate years. The name of the Member to vote first shall be determined by lot.

Rule 85: Subject to any decision of the Health Assembly the procedure governing the conduct of business and voting by committees shall conform as far as practicable to the Rules relative to the conduct of business and voting in plenary meetings. One-third of the members of a committee shall constitute a quorum. The presence of a majority of a committee shall, however, be required for a question to be put to a vote.

2 Rule 27: In addition to exercising the powers which are conferred upon him elsewhere by these Rules, the President shall declare the opening and closing of each plenary meeting of the session, shall direct the discussions in plenary meetings, ensure observance of these Rules, accord the right to speak, put questions and announce decisions. He shall rule on points of order, and, subject to these Rules, shall control the proceedings at any meeting and shall maintain order thereat. The President may, in the course of the discussion of any item, propose to the Health Assembly the limitation of the time to be allowed to each speaker or the closure of the list of speakers.
Mr VALDIVIESO (Peru), speaking on a point of order, said that while conceding that any delegate had a right to propose closure of the debate, he considered it undemocratic to do so when only seven or eight delegates had spoken on the item, out of 50 on the list of speakers. He wished to protest in the name of his delegation at the undignified way in which the closure had been handled.

The CHAIRMAN called for a vote on the resolution recommended for adoption by the Health Assembly in resolution EB67.R12.

The vote was taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with the Republic of Korea, the letter R having been determined by lot.

The result of the vote was as follows:

**In favour:** Afghanistan, Algeria, Australia, Austria, Bahrain, Belgium, Benin, Bolivia, Botswana, Brazil, Bulgaria, Canada, Cape Verde, Central African Republic, Chile, China, Colombia, Comoros, Congo, Cuba, Cyprus, Democratic People's Republic of Korea, Denmark, Egypt, Ethiopia, Finland, France, Gabon, Gambia, German Democratic Republic, Germany, Federal Republic of, Ghana, Greece, Guatemala, Hungary, Iceland, India, Iran, Ireland, Israel, Italy, Ivory Coast, Jamaica, Jordan, Kenya, Kuwait, Lesotho, Libyan Arab Jamahiriya, Luxembourg, Malaysia, Mali, Mauritania, Mauritius, Mexico, Mongolia, Mozambique, Netherlands, New Zealand, Nicaragua, Niger, Nigeria, Norway, Pakistan, Panama, Peru, Poland, Portugal, Qatar, Sao Tome and Principe, Saudi Arabia, Senegal, Sierra Leone, Singapore, Spain, Sri Lanka, Sudan, Suriname, Swaziland, Sweden, Switzerland, Trinidad and Tobago, Tunisia, Turkey, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, Upper Volta, Uruguay, Venezuela, Viet Nam, Yemen, Zaire, Zambia, Zimbabwe.

**Against:** Bangladesh, Chad, United States of America.

**Abstaining:** Argentina, Guinea, Japan, Malawi, Morocco, Republic of Korea, Romania, Thailand, Yugoslavia.

**Absent:** Albania, Angola, Bahamas, Burma, Burundi, Costa Rica, Czechoslovakia, Democratic Kampuchea, Democratic Yemen, Djibouti, Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Fiji, Guinea-Bissau, Guyana, Haiti, Honduras, Indonesia, Iraq, Lao People's Democratic Republic, Lebanon, Liberia, Madagascar, Maldives, Malta, Monaco, Nepal, Oman, Papua New Guinea, Paraguay, Philippines.

The draft resolution proposed by the Executive Board in resolution EB67.R12 was approved by 93 votes to 3, with 9 abstentions.1

The CHAIRMAN said that the debate was closed, but, according to Rule 77 of the Rules of Procedure, delegates could make brief explanations of vote.

Mr HELMAN (United States of America) said that his Government had carefully considered the International Code of Marketing of Breast-milk Substitutes, and sympathized with many of the views set forth in the course of the discussion on problems of infant nutrition. His Government was deeply concerned about maternal and infant health, and was supporting an extensive programme in that field at home and throughout the world. It was particularly concerned about infant malnutrition and infection associated with inadequate and improper feeding practices. It strongly endorsed the work being done by WHO across the broad front of problems associated with infant and young child nutrition, as reported by the Director-General under agenda item 23.1. The United States was committed to improving infant and child health around the world, as its bilateral assistance programme encompassing education, training and dissemination of information in the promotion of breast-feeding and the improvement of infant and maternal nutrition attested.

1 Transmitted to the Health Assembly in the Committee's second report and adopted, after further discussion, as resolution WHA34.22 (see document WHA34/1981/REC/2, verbatim record of the fifteenth plenary meeting, section 2).
The United States recognized that one of the important aims of the code of conduct just adopted was to encourage breast-feeding, it recognized the right of a government to ban or regulate the marketing of harmful products and substances, and recognized in its laws the responsibility of manufacturers to adhere to honest and ethical standards in the marketing of their products. It was unable, however, to support the Code.

In determining its position, the United States had had to balance what it saw as the positive and negative factors involved. On the one hand, it strongly supported efforts to promote and protect breast-feeding as the ideal form of infant nutrition and, as was well known, strongly supported the work of WHO and the Director-General in fostering improved health for all the people of the world. On the other hand, the apparent flexibility provided to governments by paragraph 11.1 did not, in its view, overcome the overall effect of prescribing a rigid set of rules applicable to companies, health workers, and health care systems in all parts of the world. The Code also contained provisions that caused serious legal and constitutional problems for his country.

Moreover, the United States was seriously concerned about WHO's involvement in commercial codes, and that was a central basis for its inability to support the Code.

In weighing that balance and taking into account all those considerations, the United States delegation had felt obliged to cast a negative vote.

Dr BORGONO (Chile) said that his delegation had voted in favour of the resolution because it considered it essential that there should be an international code of marketing of breast-milk substitutes and agreed with most of the proposed Code. However, it had reservations about some of the paragraphs of Articles 6 and 7.

Mr BENAVIDES (Peru) said that his delegation had voted in favour of adopting the Code because it considered it to be of great importance. His delegation had had solid arguments to put forward but had been unable to do so through the regrettable lack of courtesy shown by many of its friends. The decision to prevent him from speaking was all the more unjust as the item was the most important subject on the agenda. Delegates had been bombarded with information on the subject from the international Press with the result that what appeared important was not the Code itself but the problems it was trying to solve. Although it might seem strange that the debate should have been closed after only seven delegates had spoken, his delegation did not wish to interpret that as an attempt to avoid public exposure of the debate and hoped that it was not so interpreted.

Dr ONDAYE (Congo) said that he had voted in favour of the draft resolution but might well have voted against it because it did not fulfil his delegation's original hopes. On the one hand, it did not comply with the conclusions reached in September and, on the other, it was too moderate a recommendation when his delegation had hoped for a regulation. The vote taken, however, represented the beginning of a victory which would be gained in the next two years. He hoped that WHO would help its weaker Members to establish a set of regulations which would be conducive to social justice and respect for human life.

He inquired whether those delegations which had been unable to state their arguments would be able to hand their statements in writing to the Secretariat.

The CHAIRMAN said that he thought they could.

Professor HALEEM (Bangladesh), raising a point of order, gave an explanation of his voting: he had voted for the closure of the debate, which was permissible under Rule 63 of the Rules of Procedure; he had in no way wished to vote against the draft resolution. He requested that his position, in favour of the draft resolution, be made clear.

He reiterated his contention that the debate had been limited unfairly.

The CHAIRMAN, in accordance with Rule 77 of the Rules of Procedure, ruled the delegate of Bangladesh out of order.

Professor HALTER (Belgium) said that he was shocked by the remarks of one delegate, which might be interpreted as a personal attack on him. He was very pleased by the result of the vote on what was a very important resolution; if anyone chose to believe that he had been motivated by anything other than the desire to serve the children of the world, so much the worse for him.
Mrs CONTRERAS (Guatemala) asked for her delegation's reservations with regard to Articles 6, 7 and 11 of the Code to be noted.

Dr DJEKOUNADÉ (Chad) said that his delegation had only intended to vote against the motion for the closure of the debate because it thought democratic principles required that everyone who had asked to speak should be allowed to do so. That did not mean that it was against the Code; on the contrary, it supported it.

Dr IKENOUCHI (Japan) said that the Japanese Government had no doubt that breast-feeding was the preferred form of infant nutrition, and that it needed encouragement and protection. There was, however, a legitimate need for hygienic and nutritious breast-milk substitutes in both developed and developing countries, since many mothers were unable or did not choose to breast-feed. The need for those substitutes varied from country to country and region to region, depending on cultural and environmental conditions. Her delegation had reservations concerning many parts of the draft Code, which were in conflict with the constitution and fundamental laws of Japan, or were not in accordance with local conditions or requirements.

Professor VON MANGER-KOENIG (Federal Republic of Germany) referred delegates to the statement made by the delegate of the Netherlands on behalf of the member States of the EEC, and especially to the point that several of the aims of the Code had already been put into practice within the Community. With regard to other parts of the Code, every endeavour would be made to give effect to their principles and aims as appropriate to the constitutional and legal framework and social structures of countries of the Community.

(For additional explanations of vote, see summary record of the fifteenth meeting, section 2.)

Dr Rogowski took the Chair.

Progress report: Item 23.1 of the Agenda (Resolution WHA33.32, para. 6(7); Documents A34/7 and A34/INF.DOC./10) (continued from the thirteenth meeting, page 187)

The CHAIRMAN recalled that the draft resolution on the nutritional value of products specifically intended for infant and young child feeding, introduced by the delegate of Algeria, remained to be considered. It read as follows:

The Thirty-fourth World Health Assembly,
Recalling resolutions WHA27.43, WHA28.42, WHA31.55, and in particular WHA33.32 concerning infant and young child feeding;
Stressing the urgent need to make the best use of scientific knowledge and available technologies to manufacture and make available, for those infants and young children who need such products, suitable food products of the highest possible quality;
Aware that storage conditions affect the degree to which the nutritional value of products specifically intended for infant and young child feeding is preserved;
Noting the unavailability at the present time of requisite information concerning the effects of storage and distribution that occur over a period of time and under different climatic conditions upon the nutritional value of such products;
Recognizing the essential need for Member States to possess such information so as to enable them to take suitable measures to protect the nutritional value of such products;
1. REQUESTS the Director-General to initiate studies to assess the changes that occur over a period of time under various climatic conditions, particularly in arid and tropical regions, and under the prevailing storage and distribution arrangements, in the quality and nutritional value of products specifically intended for infant and young child feeding;
2. URGES Member States, UNICEF and FAO, as well as all the other international, governmental and nongovernmental organizations concerned, to cooperate actively with WHO for the successful carrying out of these studies;
3. INVITES Member States to make voluntary contributions to enable the speedy launching of the studies.
Professor HALTER (Belgium) said that the draft resolution had come at precisely the right moment. For that reason his delegation wished to be included among the co-sponsors.

Dr PATTerson (Jamaica) said that her delegation also wished to be included among the co-sponsors of the draft resolution. In addition she proposed that the idea of the bacteriological content of products should be mentioned in it. That would involve introducing the words "and bacteriological content" after the words "nutritional value" in the title, the third and fourth preambular paragraphs, and the first operative paragraph. Furthermore, she also suggested that a fourth operative paragraph should be added, requesting the Director-General "to submit a report on the results of his efforts to the Thirty-sixth World Health Assembly".

Dr ONDAYE (Congo) said that his delegation supported the draft resolution and wished to be included among the co-sponsors.

Dr QUAMINA (Trinidad and Tobago) said that her delegation had already asked to be included among the co-sponsors. She supported the amendment proposed by the delegate of Jamaica.

Dr TOURE (Senegal) asked for his delegation to be included among the co-sponsors.

Dr BRYANT (United States of America) said that a great deal of knowledge probably already existed on the important problem of the effects of adverse climatic and storage conditions on infant foods, but might not be readily available or relevant to the conditions in many developing countries. His delegation was pleased to co-sponsor the draft resolution, and also supported the amendment proposed by the delegate of Jamaica calling for studies of the problem. It would be good to see the Codex Alimentarius Commission included among those participating in the studies, especially in relation to the minimum standards set by the Codex.

Dr BORGONO (Chile) supported the draft resolution with the amendment proposed by Jamaica, and the point made by the United States delegate, which he supposed should also be introduced.

Dr KPOSSA-MAMADOU (Central African Republic) agreed with the suggestion made by the United States delegate. The wording of the fourth preambular paragraph did not appear to be correct. The Central African Republic wished to be included among the co-sponsors.

Dr HADJ-LAKEHAL (Algeria) said that he was pleased that so many countries wanted to be co-sponsors. He was also happy to accept the amendment proposed by the delegate of Jamaica. As far as the French text was concerned, he thought that "la qualité bactériologique" would be equivalent to what had been proposed in English. There seemed, however, to be a mis-understanding with regard to the remarks made by the United States delegate, who had not, in his view, suggested that an amendment introducing a reference to the Codex Alimentarius Commission should be made. The study would be made by the Nutrition unit of WHO, in collaboration with UNICEF, FAO and other competent organizations.

Mr LOGGERS (Netherlands), although sympathizing with the aims of the draft resolution, had some doubts as to the effectiveness of the measures suggested; no provision had been made to ensure that the products received by countries satisfied the quality requirements imposed. To fill that gap, he therefore suggested that a fifth operative paragraph should be added requesting the Director-General to establish mechanisms for the control of the quality of food products specially intended for infants and young children. The Netherlands would be prepared to cooperate in setting up such mechanisms.

Dr H. SYLLA (Guinea) said that he had the same doubts about the draft resolution as those expressed by the delegate of the Netherlands. In addition, operative paragraph 1 should be amended to request the Director-General to initiate studies to determine whether changes occurred in the products in question before delivery, and if so, what those changes were.

He suggested that the words "and disseminate the findings" should be added at the end of operative paragraph 2.
Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that his delegation supported both the draft resolution and the proposed amendments. He was surprised that anyone should want to exclude the Codex Alimentarius Commission from participation in the study, since it was the creation of WHO. He would therefore propose that the first operative paragraph should be amended so as to request the Director-General to initiate studies in collaboration with the FAO/WHO Codex Alimentarius Commission. He did not want to tie the Director-General's hands but merely to ensure that the views of health professionals were brought to bear on the standards adopted in the Codex.

Dr CONTY (Spain) said that his delegation supported the draft resolution and the proposed amendments, and especially that relating to collaboration with the Codex Alimentarius Commission. The link with the Codex committees was important, particularly in connexion with the labelling and expiry dates of the products concerned; with regard to the latter, a Codex committee was in process of developing a standard.

Professor AYRES (Portugal) said that the draft resolution was very important; her delegation wished to be included among the co-sponsors. With regard to the amendment proposed by the delegate of Jamaica, her view was that the term "bacteriological content" failed to include certain major contaminants that were not bacteria. She therefore proposed that those words should be replaced by "hygienic conditions".

Dr BRYANT (United States of America) agreed that "bacteriological content" was too narrow; it could perhaps be replaced by "microbiological content".

The delegate of Algeria had been correct in his understanding that the reference to the Codex Alimentarius Commission had not been intended as an amendment.

Dr PATTERSON (Jamaica) also agreed that "bacteriological content" was too narrow; "pathological microorganisms" would be a more comprehensive term.

Dr HADJ-LAKEHAL (Algeria) did not agree with that suggestion; yeasts and moulds could not be considered pathological. He preferred "microbiological", as suggested by the United States delegate.

Dr PATTERSON (Jamaica) said that the United States proposal was acceptable, or possibly it might be sufficient merely to refer to contaminants.

Professor AYRES (Portugal) repeated her preference for "hygienic conditions".

The CHAIRMAN suggested that the delegates of Algeria, Jamaica and Portugal elaborate an acceptable compromise.

Mrs NGUGI (Kenya) wished her delegation to be added as a co-sponsor of the draft resolution; it also supported the proposed addition of a reference to hygienic conditions as well as nutritional value of products.

Dr BORGOÑO (Chile) warned against making the scope of the resolution too broad. The group nominated by the Chairman should be left to find a satisfactory specific solution.

Dr BAJAJ (India) proposed leaving the phrase "nutritional value" unchanged, as it gave the resolution the intended emphasis.

Dr HADJ-LAKEHAL (Algeria) said that contacts with WHO's Nutrition unit had led him to believe that it would be possible to study not only the nutritional value of products but also bacteriological and microbiological aspects. He thought that including contaminants would complicate the task unnecessarily.

Professor HALTER (Belgium) spoke in favour of leaving the text unchanged, as nutritional value could be considered to include questions of composition or contamination.

Professor DOGRAMACI (Turkey) supported that view.
Dr BEHAR (Nutrition) said that the words "nutritional value" alone would be acceptable, but it would be safer to add to them either "hygienic conditions" or "bacteriological content". He said WHO was prepared to cooperate with countries both on nutritional and on food safety aspects, including bacteriological contamination.

Dr KPOSSA-MAMADOU (Central African Republic) said that the text of operative paragraph 1, which referred to "changes . . . in nutritional value", covered food hygiene and safety as well as composition of products.

Professor DOGRAMACI (Turkey) stated that if a phrase had to be added after the words "nutritional value", it should be "and safety of products" since that would cover chemical and other contaminants rather than just bacteriological ones.

Dr PATTerson (Jamaica) favoured the addition of the words "and safety".

The CHAIRMAN recalled the Jamaican delegate's earlier proposal to add a fourth operative paragraph to the draft resolution and the Netherlands delegate's proposal to add a fifth operative paragraph.

Professor WALTER (Belgium), Dr HADJ-LAKEHAL (Algeria), Dr PATTerson (Jamaica), Dr KPOSSA-MAMADOU (Central African Republic), and Professor AYRES (Portugal) expressed agreement with both those proposals.

Dr BRYANT (United States of America) expressed his delegation's support for adding the concept of safety of products. However, he did not fully understand the meaning of "control of the quality of food products" in the fifth operative paragraph proposed by the delegate of the Netherlands; he thought this idea went far beyond the objective of the study as stated.

Mr LOGGERS (Netherlands) explained that his delegation's aim had been to request the Director-General to assist in establishing, at the request of Member States, quality control of infant foods. Knowledge of nutritional requirements and storage conditions was not sufficient to assure that a country was receiving the right products. Studies had to lead to action.

Dr ALSÉN (Sweden) opposed inclusion of the Netherlands delegate's proposal; quality control was a separate step to be taken after the studies had been completed.

Mr LOGGERS (Netherlands) withdrew his proposal. He believed, however, that quality control was vital to the final purpose of the resolution, since behind it was the concern for countries that were receiving poor-quality products, and studies would not solve their problems.

Dr BORGOÑO (Chile) stated that the programme budget related to food safety could be interpreted to mean that financing for the objective stated in the resolution could be requested from WHO if necessary.

Dr TEJADA-DE-RIVERO (Assistant Director-General) said that the implementation of operative paragraph 4 as proposed by the delegate of Jamaica was implicit in operative paragraph 5(1) of resolution WHA33.32. The Secretariat was already acting on this paragraph. If the proposed paragraph remained, it might include a reference to resolution WHA33.32.

The CHAIRMAN recalled the proposed amendments: addition of the words "and safety" of products after the words "nutritional value" in the title and in the third and fourth preambular paragraphs and operative paragraph 1; and addition of operative paragraph 4 as proposed by the delegate of Jamaica.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) recalled the addition to operative paragraph 1 concerning mention of FAO/WHO Codex Alimentarius Commission proposed earlier by his delegation.
Dr HADJ-LAKEHAL (Algeria) said that operative paragraph 2 mentioned "other international, governmental and nongovernmental organizations", which encompassed all interested organizations. He feared that if reference was made to Codex Alimentarius, UNIDO and several other agencies would also have to be mentioned.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that in view of that clarification he would withdraw his proposal.

The draft resolution, as thus amended, was approved.1

The meeting rose at 18h30.

1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA34.23.

The CHAIRMAN pointed out that the tentative budgetary projections provided an indicative trend, and were not intended as a commitment to or limitation of the level of the WHO regular budget eventually to be recommended by the Executive Board and approved by the Assembly. He invited Dr Álvarez Gutiérrez to introduce the item.

Dr Álvarez Gutiérrez (representative of the Executive Board) said that, in order to give the Director-General early guidance on the programme budgeting cycle for 1984-1985, the Executive Board at its sixty-seventh session had considered the question of the appropriate growth rate of the WHO programme budget, on the basis of the Director-General's report (document EB67/1981/REC/1, Annex 3). The Board's discussion was summarized in document EB67/1981/REC/2 on pages 216-223 and 249-250.

The question of the appropriate growth rate of the WHO regular budget was complex, being affected on the one hand by the current world economic situation and, on the other, by the needs arising out of WHO's catalytic role in promoting action to attain health for all by the year 2000. The Director-General's report accordingly contained information from official United Nations and World Bank sources on current and projected real growth rates of the economies of Member States, since that was one factor among many others to be taken into account in considering the question. It also explained how the Director-General had kept within the real increase limit of 4% established by resolution WHA32.29 for 1982-1983, and how he had calculated and presented the effects of inflationary costs and currency fluctuations on the level of the proposed WHO programme budget for 1982-1983 contained in document P8/82-83.

The Board had considered that the formula providing for a 4% real increase, plus clearly presented and reasonably estimated cost increases, had worked out well, and it had accordingly recommended extending that approach to the programme budget for 1984-1985. It had emphasized that the 4% figure was a ceiling, and not a target. The Director-General's proposed programme budget for 1982-1983 had kept to a real increase of 2.25% instead of the full 4%, and cost increases had been conservatively estimated. The Board had pointed out that in recent years WHO had had the lowest percentage growth rate in its regular budget of all the larger organizations of the United Nations system.

In making its recommendation for 1984-1985, the Board had been concerned that the Director-General should have sufficient flexibility of resources to make adjustments for any imbalance or deficiencies identified after review of the proposed programme budget document by the Board and the Health Assembly. At its sixty-eighth session the Board would be considering the Director-General's proposals for accomplishing that in the future.

The Board's recommendation on the budget level for 1984-1985 was also based on an awareness of the importance of the qualitative development of the WHO programme. That depended largely on the seriousness of the attitude of the Secretariat and the Member States to collaborative planning, and especially to programme budgeting at country level.

In its resolution EB67/R10 the Board had recommended that the Thirty-fourth World Health Assembly adopt a draft resolution deciding "that the regular programme budget for 1984-1985 should be developed within a budgetary level that will provide for a real increase of up to 4% for the biennium, in addition to reasonably estimated cost increases, the underlying factors and assumptions of which should be made explicit".
Dr IKENOUCHI (Japan) said that, in view of the current world economic situation and the financial difficulties of Japan, her Government wished to see no real growth in the 1984-1985 budget. It would apply that restrictive budgetary policy in all the United Nations organizations. It recognized, however, that different consideration could be given to Japanese voluntary contributions for the benefit of developing countries.

Mr VOHRA (India) said that resolution EB67.R10 sought only to indicate that the programme budget for 1984-1985 should be developed within a budgetary level providing for a real increase of up to 4% for the biennium, or an annual growth rate of approximately 2%. In strict mathematical terms the 2% per annum would not actually be 2% when viewed post facto. The figures showing the details of net growth for past years were before the Assembly in the various documents. The representative of the Board had referred to the Board's concern about the major responsibilities of WHO and its Member States in the forthcoming years. For the 1982-1983 programme budget the annual real growth rate had in fact been kept down to 1.125%. It should be remembered, moreover, that the projections were based on the assumption of stable exchange rates and a peaceful world. Resolution EB67.R10 in fact represented little more than aspirations and advice to the Director-General to do all he could to keep the real increase in the budget within the 4% limit for the biennium. The Director-General could perfectly well do without such advice in considering the real problems he faced; he would act within an institutional framework to give indications to Regional Directors and through them, to Member States in the building up of programmes. There seemed to be no reason for alarm on the part of the developed countries, which were trying to restrict the United Nations bodies to zero growth in the interest of economy. The views expressed at the Health Assembly should not be regarded as precluding the Director-General from judging what was best for the Organization in the planning of programmes to attain WHO's goals. Whatever was said would not provide the Director-General with money or improve the Organization's performance; it could only encourage him to follow certain lines of action. According to the Financial Regulations the Director-General, as the chief executive of the Organization, needed no specific directive from the Health Assembly to take certain action in the best interests of a sound budget; he would know how to make the best use of the available resources. Even if there was a majority view in favour of zero growth, the Director-General could only listen to those views and do his best. If the developed countries did not wish to support the draft resolution recommended by the Board there was no need for any resolution, since what had happened in the past would provide adequate guidance for the Director-General.

Dr ZIESE (Federal Republic of Germany) said that the real increase of 4% proposed for 1984-1985 was much above the growth rate in his country's medium-term financial planning, in which the idea of real growth had had to be abandoned. In view of those financial restrictions, which affected many other countries, there should be a corresponding restrictive budget policy for international organizations, even if that meant a zero rate of real growth. The budget policy of international organizations should take account of the current economic situation and the limited resources in the national budgets of Member States. Like Member States, those organizations should do everything possible to avoid any increase in the budget, seeking as little growth as possible, and the maximum absorption, by savings, of additional costs due to inflation.

International organizations should accordingly examine their existing programmes and administrative areas, particularly when drawing up new programme budgets, to see how far they tallied with the politically decided priorities. All doubtful activities should be reduced or cut out. The medium-term plans could be useful in reviewing priorities and eliminating obsolete programmes, so that by reducing marginally useful activities the way could be paved for real growth in more relevant programmes.

His country had already adopted that policy in its national budget estimates. The 1981 budget reflected a growth smaller than the rate of inflation, so that there was no real growth in the federal budget. The same applied to the medium-term financial plan. Everything should be done to ensure that the international organizations adopted a similarly restrictive budget policy.

Because of these special circumstances, mentioned earlier by his delegation, it could accept a real growth of 2.25% for the 1982-1983 programme budget, but for the 1984-1985 budget it could accept only zero real growth. Beyond that his Government did not see any possibility of full compensation for price increases due to inflation, but would expect WHO to absorb part of the increases by rational use of resources without reducing the real programme volume. His delegation was therefore unable to support the resolution recommended by the Board.
Mr BOYER (United States of America) said that his delegation had referred previously to the need for budgetary restraint in the current international economic situation. International organizations could not be shielded from the economic conditions besetting Member States; current unfavourable economic conditions required them to curtail programme growth and cease passing on to their Members the costs of inflation.

Over the years a pattern of steady growth had developed, and some might find it difficult to give up that idea, but the United States Government was not the only one obliged by economic circumstances to reduce domestic programmes and services. Such reductions meant that a comparable position must be taken in the international organizations, and his delegation therefore believed that cost increases should be absorbed in the budgetary projection for 1984-1985.

The United States was not opposed to new programmes where necessary, or to the growth of existing high priority programmes, but that should be accomplished within existing expenditure levels. It could be done through better management to achieve higher productivity and savings, and by identifying and eliminating low priority items.

The United States Government believed that continued growth as in previous years was unacceptable in the United Nations system as a whole, and would be adopting that position in other organizations. That view did not reflect any lack of confidence in WHO or in the Director-General, as had been suggested in some publications distributed to Member States. On the contrary, the United States had expressed its great satisfaction with the financial management of WHO and the steps taken by the Director-General to reduce the impact of the 1982-1983 budget on Member States. His Government had accordingly been able to vote for that budget, but it believed that the effective working budget for 1984-1985 should not exceed US$ 468.9 million, the level approved for 1982-1983. If there was a vote on the resolution recommended by the Board his delegation would be obliged to vote against it. However, he agreed with the delegate of India that there was no real need for a resolution, and that the Director-General could merely take note of the comments made at the present meeting.

Dr ALSÉN (Sweden), speaking on behalf of the five Nordic countries, said that in times of constraint in national economies there was a corresponding need for careful management in international organizations. At the same time, he emphasized the importance of WHO's work in implementing the strategies for health for all. To channel the necessary resources for that purpose, the Organization would have to streamline its activities. The Nordic countries recognized that some increase in WHO's resources might become necessary in 1984-1985 over and above compensation for inflation and other cost increases, but considered that real growth should not exceed that proposed by the Executive Board, which should be regarded as the maximum. The actual real growth rate would, of course, depend on both the programmes planned and the economic situation at the time when the budget was adopted. There must be due regard for the need for savings and rationalization.

Mr WIDDOWS (Australia) said that the resolution recommended by the Board would have the effect of deciding in May 1981 that the regular programme budget for 1984-1985 should provide for a real increase of up to 4%. Australia's views on the growth rates of the budgets of international organizations were well known. Those organizations should not be isolated from international economic developments or from the need for austerity in budgeting and rigorous control over spending.

Australia had voted for the 1982-1983 budget in recognition of the Director-General's praiseworthy achievement in producing a budget with a growth rate of 2.1% - well below the ceiling rate of 4% that had been set. He agreed with the United States delegate that WHO was to be congratulated on its financial management. However, in the current period of restraint on government expenditure Australia could not endorse a real growth rate of up to 4% for 1984-1985, and if a vote were taken on the draft resolution Australia would abstain from voting. In general, his delegation endorsed the views of previous speakers and believed that international organizations should aim at zero growth. It had every confidence in the ability of the Director-General to draw up a budget plan for 1984-1985 in the light of the comments made at the present meeting, and doubted the need for a resolution on the subject.

Dr GALAHOV (Union of Soviet Socialist Republics) said that the position of his delegation was well known. It supported stable budgets, in conjunction with improved efficiency, rational mobilization of resources and improved working methods, instead of increases in the budget. The Organization had a given amount of resources, and must make the best use of it through efficiency, better planning, definition of priorities, more effective implementation of projects, better
management and control, and the dropping of obsolete programmes. He shared the view of the delegate of India; there was no need to adopt a resolution on the question. If there were a vote, his delegation would have to abstain from voting.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) endorsed the views of previous speakers. International agencies could not be sheltered from the economic difficulties of national States, and would have to take account of the world economic situation. Economies could be achieved through careful management, and a review of programmes with a view to cutting out some low-priority programmes to make room for more essential projects. He agreed with what others had said about the good housekeeping achievements of the Director-General and the Secretariat, and was confident that they could maintain a record that was the envy of all other international organizations. He agreed with the delegate of India; there should not be a vote on the resolution, since the Director-General and the Secretariat had had sufficient guidance and were sufficiently experienced in budget planning, to make such a vote unnecessary.

Mr VAN KESTEREN (Netherlands) said that his Government followed the principle that the budget should be drawn up in the light of the programmes being undertaken. It was difficult to be specific about expenditure for a period so far ahead, when very little was known about the programmes to be carried out then. On other occasions the Netherlands had voted for such resolutions, but that had been in a very different economic climate, and in current conditions a more cautious approach was justified. If a vote were taken on the resolution his delegation would therefore abstain.

However, to avoid any misunderstanding, he emphasized that that attitude did not imply support for zero growth. His delegation rejected that idea because it would involve a reduction in the budget by a purely arbitrary figure - the inflation rate for the years concerned. He agreed with previous speakers who had suggested that no decision was necessary. The Director-General could draw conclusions from the debate and act on those conclusions in the planning process, since he had the wisdom to strike a balance between the various options proposed during the debate. His delegation hoped that no decision would be taken, so that it would not have to abstain from voting - which would not be in line with the constructive attitude it wished to take in WHO.

Professor GIANNICO (Italy) said that his delegation regretted that it could not accept any increase in the budget for 1984-1985 in view of the economic difficulties in Italy - especially in the health field, where, as in many countries, rising costs called for attention. Italy's position did not apply merely to the budget of WHO, but to those of all the international organizations. Italy fully believed in the priority requirements of WHO and its humanitarian and health aims, but account must be taken of world economic difficulties. He was convinced that the Director-General's keen intelligence and skill would enable him to achieve the results all Member States hoped for.

Dr ALSÉN (Sweden) said that his delegation supported the proposal that no decision be taken at present with regard to the growth rate for the financial period 1984-1985. It should be left to the Director-General to work out the 1984-1985 programme budget in the light of delegates' comments.

Dr SEBINA (Botswana) referred to the many congratulations that had been offered to the Director-General in the past few days regarding the financial management of the Organization. He believed that, after the expression of such confidence, it would be incorrect not to give the Director-General some indication of a growth rate, so that he could plan his future programme budget meaningfully. It had been suggested in the past that the growth rate of WHO's budget should not be more than that of Member States' budgets. The maximum real growth rate for the 1982-1983 programme budget had been set at 4%; in fact the Director-General had managed to present a programme budget with a lower rate of growth. He agreed that the Director-General should note the consensus and that any programmes which had outlived their usefulness should be phased out. He doubted whether WHO could be run on a zero growth rate principle; to his knowledge, no country operated on that basis.

Dr BEAUSOLEIL (Ghana) stated that his delegation opposed any attempt to have the draft resolution withdrawn. He believed that there had been adequate discussion of the item; in accordance with Rule 63 of the Rules of Procedure, therefore, he would move the closure of debate.
The CHAIRMAN indicated that, according to Rule 63, a maximum of two delegates could speak against the motion. He asked if there were any speakers who wished to take the floor.

Mr BOYER (United States of America) said that, if he had interpreted the Rule correctly, should the motion for closure of debate be accepted, the Director-General and the Secretariat would not be able to reply to the comments made by delegates on this particular item. He therefore moved against the closure of debate.

Dr NKANDAWIRE (Malawi) seconded the motion against the closure of debate.

The CHAIRMAN invited the Committee to proceed to a vote.

The motion for closure of debate was rejected by 60 votes to 6, with 11 abstentions.

Professor JAKOVLJEVIĆ (Yugoslavia) said that his delegation had always favoured a rational use of WHO's budget, and a few years ago it had proposed a radical cutting down of administrative and other avoidable expenditures. However, it felt that if the Director-General were to develop a stable and sound programme he had to know the approximate budget level for the coming years. A real increase of 2% per year seemed realistic and he would therefore support the draft resolution. Otherwise it would be very difficult to draw up a proposed programme in line with the policies adopted.

Dr BORCONO (Chile) said that Member States had adopted the goal of health for all, and had to be consistent. He agreed that it might be difficult to fix a specific percentage increase for the programme budget, in view of the world economic situation. However, he believed that there should at least be a consensus on the need for an increase; whatever the actual figure - even if it were only 0.5% or 1% - there should be an increase in real terms.

Dr KALILANI-ALFAZEMA (Malawi) expressed his support for granting the Director-General some freedom of action. The Director-General should be asked to develop the 1984-1985 programme budget in the light of the comments made at the current meeting, and in that perspective he would best judge what budget level to finally recommend. His delegation opposed the zero growth principle, believing it to be unrealistic.

Dr TOURÉ (Senegal) noted that everyone had recognized the Organization's scrupulous good management, an essential element of planning. It was not fair, however, to ask for the impossible and requesting the Director-General to be still more rigorous might well be to the detriment of planning. The Director-General needed the Committee's guidance in order to make projections.

He (Dr Touré) did not believe that the international economic situation was going to stagnate; there would be growth. In order to be realistic, some indication of a growth rate had to be given, so that the growth rate on which the 1984-1985 programme budget was developed could not be called into question after the programme budget had been prepared. His delegation would therefore support the draft resolution recommended by the Executive Board.

Mr PAGÉS PIÑEIRO (Cuba) opposed the adoption of a zero growth rate recommendation. That would mean, in effect, a reduction in the budget, which was not realistic in the light of the Organization's goals that had been discussed in such laudatory terms during the past weeks. He believed that the target figure of 4% should be maintained as it would allow the Director-General some flexibility in the development of the programme budget. His delegation would therefore also support the draft resolution recommended by the Board.

Mr TEKA (Ethiopia) also believed that the Director-General needed to have some firm guidance in order to plan for the coming proposed programme budget. Zero growth could not be considered to be a figure, nor adequate guidance for the Director-General. His delegation felt that the 4% real growth, which had been the trend in WHO in the past few years, should be maintained and approved by consensus.

The CHAIRMAN invited the Director-General to comment on the debate.
The DIRECTOR-GENERAL said that he did not propose to make an analysis of the world economic situation. While it was true that many countries, and first and foremost the poorest of the poor, were going through incredibly difficult times, it was also true that, for whatever reasons, some of the industrialized countries were relatively speaking not so well off as in the recent past. For his part, he maintained that the wellbeing of the poor and the rich countries was intimately interlinked, that the dialogue between the two would indeed lead to the necessary preconditions for an accelerated growth in the world, and that ultimately such dialogue would lead to a new economic and social order in the world. That of course was the subject of intensive discussion in other, economic forums of the United Nations, and not the concern of the present discussion. He hoped, however, that he would be permitted to make a remark without being accused of demagogy: Indeed, there was an economic crisis, but that did not seem to prevent nations from spending ever-increasing amounts on defence. For that, there seemed to be no limit to escalation. That parallel inevitably sprang to mind when the question of reducing social expenditures was raised. It was a reflection on the contemporary world.

It was extremely important not to lose sight of one’s vision in WHO. He believed that everyone had to be a "pragmatic visionary" - but if one was pragmatic without the vision one tended to lose the dynamic orientation of programmes. Clearly one had to have such visions, and WHO visionary orientations had been expressed by the adoption of the goal of health for all by the year 2000, through primary health care, and by the Global Strategy. That was the framework within which one had to be pragmatic - or realistic, if one preferred - without, however, losing sight of those visions.

The discussion had been very important in that it had revealed that a few countries - the Nordic countries and Japan, especially - had committed themselves to supporting health with extrabudgetary resources. Indeed, some of those countries had already been remarkable contributors in the past - others perhaps less so, up to now - but, for his part, he could only express his delight at having witnessed the strong, affirmative commitment on the part of those countries.

It would indeed be sad if the delegates of the developing countries returned home from the Assembly, after having discussed health for all and the Global Strategy, knowing that that was to be achieved with a zero growth budget. However, it was not the level of the regular budget that concerned him; his concern was that in the coming years WHO, through a judicious performance of its regular budgetary resources, should be able to challenge, and generate, from those countries that could afford it, a massive transfer of resources to those countries which, although they could generate nationally 90% to 95% of resources for health, nevertheless urgently needed and depended on another 5% to 10% from external resources to be able to move forward. The real crux of the matter regarding WHO's regular programme budgetary performance was whether it could go on maintaining, as had been the case in recent years, an almost exponential growth of extrabudgetary resources. That was precisely why he had proposed to set up the Health Resources Group - in order to be sure that the Organization was making the most effective and efficient use of its regular programme budgetary resources and generating those additional resources. To some extent the transfer of resources from North to South already existed, but it was believed that that could be rationalized and increased and, in conformity with the priorities agreed upon by Member States, better directed towards primary health care.

Thus a debate that focused on what the growth rate of the regular programme budget should be could not, by itself, be interpreted as any great commitment. What was of vital importance was whether Member States, through their performance at national level and cooperation among themselves in the health field, would be able to make use of their Organization's regular budgetary resources in such a manner that those countries that could afford it could be challenged to recognize health as an important ingredient in socioeconomic development. Thus they would be able to continue the momentum and increase the resources available to those countries that could least afford it. The Organization was not a supranational body: the coordinating and cooperating roles of WHO were interlinked in such a way that Member States decided on policies and programme priorities from the country level up. After policies and priorities had been collectively decided upon at the regional and global levels, they were in turn filtered down to the national level. In that way the Organization was continuously acting as the conscience of its Members, at all levels. Therein lay WHO's uniqueness.

With regard to managerial performance - which had been discussed in Committee B - there was surely always scope for improvement, whether at national or international level. He believed that the Organization had a creditable performance in managerial efficiency. As to the budget level, it was for Member States to decide on the form of guidance they wished to give him. It would be his duty to come forward with a programme budget for 1984-1985 which would serve the overall interest of all Member States.
On the question of that overall interest, he sometimes had a feeling that those countries which, economically speaking, were better off, had some doubts about the investment value of their contribution to WHO. He urged the delegates of those countries, upon their return home, to spend some time analysing what return they had had for every dollar invested in their Organization. He invited them to do that for all programmes - not only for the smallpox eradication programme which, in itself, had justified, with interest, all investments made by all the major contributors throughout the existence of the Organization. He cited the example of the research done on tuberculosis in India: how many billions of dollars had been saved by the industrialized countries as a result of that research, which had established that ambulatory chemotherapy could be reduced to one-quarter of what it had previously been. The findings of such research had also made it possible to prevent some thousands of hospitals from being built unnecessarily. It was important for all Members to realize the benefits they were getting from their Organization. It was precisely in that spirit that one had to approach the difficult issue of the projected level of the 1984-1985 programme budget.

The climate in which additional resources were to be generated, from whatever source, was very much related to that in WHO where collectively its membership was strengthening the identification of all Member States with the fundamental social goals of the Organization. It was for that reason that he had in the past few years been somewhat conservative with regard to the growth of the regular programme budget.

Whatever the final guidance of the Committee might be, it would be his obligation to take responsibility for proposing a programme budget for 1984-1985 that would take into account most carefully all the reflections made during the present discussion. It was imperative to avoid generating a contradiction between the social aspirations and the resources that would be made available to attain them. The regular programme budget had to be the great catalyser that would enable countries that could afford it to be challenged to transfer massive resources to the developing countries, so that they too could participate in the movement towards health for all. It would indeed be very sad if some of those countries felt they had been abandoned on the way.

The CHAIRMAN noted that no delegates wished to comment any further. In the light of the comments made, he believed that the Committee would prefer not to vote on the draft resolution recommended by the Board. By consensus, therefore, the Committee might decide to request the Director-General to take due note of what had been expressed, and to ensure that the 1984-1985 programme budget was developed in such a way as to take into account all the points raised.

It was so agreed.

Dr Al-Ghassany took the Chair.

2. SECOND REPORT OF COMMITTEE A (Document A34/42)

At the CHAIRMAN's request, Dr KASONDE (Zambia), Rapporteur, read out the draft second report of the Committee.

Dr POPOVIĆ (Yugoslavia) wished to explain, for the record, that his delegation, through a misunderstanding of procedure, had mistakenly abstained during the vote on the draft resolution on the International Code of Marketing of Breast-milk Substitutes. His delegation had intended to support the resolution fully, and would do so in plenary session.

Dr BULLA (Romania) also wished to have it placed on record that his delegation had mistakenly abstained during the vote on the resolution on the draft International Code. It had intended to vote in favour and would do so in plenary session.

The DEPUTY DIRECTOR-GENERAL assured the delegates of Yugoslavia and Romania that their explanations would be noted; furthermore, they could repeat their explanations in plenary if they so wished.

The report was adopted (see document WHA34/1981/REC/2).

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board), introducing the item, recalled that, the previous day, Committee B had discussed the Global Strategy for health for all by the year 2000. The role of WHO as presented in that strategy was the very embodiment of the Organization's constitutional mission for international health work. For it was WHO that had launched the Global Strategy and, on the basis of national and regional strategies, had coordinated its development, and finally adopted it as a framework within which Member States should move towards health for all by the year 2000. However, it was also WHO that was responsible for cooperating with its Member States and promoting cooperation among them so as to ensure the implementation of the strategy. Why, then, was it now necessary to discuss the meaning of WHO's international health work through coordination and technical cooperation? There were several reasons. Some people had wished in the past, and perhaps still wished, to separate "technical cooperation" activities from the other activities of WHO, with a view to denying regular budget funding for technical cooperation or assistance or to allocating a certain percentage of WHO resources to such activities. Furthermore, there had been some evident misunderstanding over WHO's role and functions, particularly when technical cooperation had been regarded merely as improved technical assistance, and when it had been imagined that there was no difference between WHO's technical cooperation in international health work and the technical cooperation activities of any other bilateral or multilateral institution.

Yet WHO's technical cooperation differed radically from traditional technical assistance: indeed, it was impossible to lay too much stress on the fundamental difference between the concept of "technical assistance" and that of "technical cooperation".

The assistance concept consisted of a "donor" and a "beneficiary" - one side that acted (and, what was more, acted as the "boss"), and one side that was acted upon, in a subordinate position. There was no dialogue, or at least no real dialogue. The donor did the planning and programming, drew up the strategies, determined the priorities and the means that had to be brought to bear, and, finally, decided what he would give, and how he would give it.

The interests at stake were in no way shared. First of all came the interests of the donor; the rest was secondary. It was the donor who did the evaluation and the replanning, in accordance with his own interests and priorities. Naturally, the beneficiary did not blossom forth. His dignity was constantly assailed.

In the case of cooperation, on the other hand, there was first of all a dialogue. He who was in need expressed his requirements, did the planning and programming, and drew up his priorities and action strategies with due attention to the social, economic and cultural situation and the priorities of the people to be served, and if in the preliminary work he required a contribution from a third party he took responsibility for it. Moreover the two partners sat round a table and decided jointly what activities should be undertaken, bearing in mind the contribution of the one and the other, and bearing in mind also - a very important point - the interests of the one and the other. In other words there was a community of objective, of strategies, of activities, and of interest. These were extremely important basic notions that were lacking in the concept of assistance.

What was the position in WHO? First of all, the Organization had completely substituted the concept of cooperation for that of assistance. He referred, for example, to the new mechanisms, particularly the new machinery for programme budgeting WHO resources at country level, through which the countries decided on the allocation and utilization of the funds made available for them under the WHO programme budget - a unique and revolutionary procedure. In addition, there was all that had been done in the last few years to promote and encourage the participation of nationals in the Organization's work. Also noteworthy were the unique experiment of using nationals as WHO coordinators and the phenomenon of technical cooperation among developing countries. With all those mechanisms, and many others that had not been mentioned, WHO could truly be considered as a model in regard to international cooperative action.

Annex 8 of document EB67/1981/REC/1 contained information on technical cooperation in WHO - both between WHO and its Member States and among the States themselves. It also contained an account of WHO's coordinating function and of its international health work, which, ultimately, included the functions of coordination and technical cooperation. Annexed were some specific examples concerning smallpox eradication, research on human reproduction, and research on malaria. Those examples proved that in international health work success resulted from the
balanced and integrated performance of WHO's coordination and technical cooperation functions and close correlation between the work of WHO and its Member States. On the basis of this document, the Board had concluded that the unique constitutional role of WHO in international health work, essential for achieving health for all by the year 2000, comprised in essence the inseparable and mutually supportive functions of coordination and technical cooperation.

The Board, in resolution EB67.R19, had recommended that the Health Assembly adopt a draft resolution along the lines he had just indicated. This draft resolution stressed that no distinction should be made between the inseparable functions of coordination and technical cooperation, whether they were carried out at country, regional or global levels, and whether they were financed by the WHO regular budget or from other sources. It laid down the scope of coordination and technical cooperation in the international health field, and outlined the extent of WHO's international work. It urged Member States to formulate appropriate international health policies and principles within WHO, and to take full account of the experiences of technical cooperation between WHO and its Member States when taking collective decisions.

Finally, the draft resolution requested the Director-General, inter alia, to emphasize WHO's unique constitutional role in all appropriate forums, and particularly within the United Nations system and other international and bilateral organizations.

In his opinion, it was an extremely important resolution, and he asked the Committee to accord it all the attention it deserved.

Dr CASTELLON (Nicaragua) supported the draft resolution recommended by the Board. Member States should give full support to any WHO policy designed to promote international cooperation. The Board's recommendation sought to bring up to date the commitments made and should strengthen mutual respect among Member States with a view to solving their health problems on a basis of equality. It would also encourage them to develop health policies consonant with the evolution of their various economic and social structures. His delegation welcomed the emphasis on mutual responsibility between WHO and Member States, and among Member States themselves, in combating protectionism and dependence - an approach that was consistent with the aim of establishing better communication in order to achieve health for all. It fully endorsed operative paragraph 3 of the draft resolution and the request to the Director-General to emphasize WHO's role in all appropriate forums.

Dr BAJAJ (India) fully supported the draft resolution.

Dr BRYANT (United States of America) said that his delegation also fully supported the draft resolution, and drew attention in particular to operative paragraphs 3 and 4, in which the topic of development of technical cooperation was very well described. The subject of operative subparagraph 5(2) was one of continuous concern to the Director-General. His delegation congratulated the Secretariat on clarifying the often confusing differences between technical assistance and technical cooperation.

Dr BULLA (Romania) said that, in his delegation's view, it was of paramount importance to change the outmoded concept of technical assistance and to promote activities on the basis of equal partnership. His delegation was convinced that the draft resolution could serve to facilitate cooperation between States, and felt that one prerequisite was the careful identification of problem priorities in each country. The draft resolution was a useful statement which would serve as a basis for action that would lead to a more rational partnership between Member States and was more closely related to real priorities. In addition, it would serve to increase WHO's contribution to the development of national health services. His delegation would therefore vote in favour of the draft resolution.

Dr LIANG Jimin (China) said that his delegation fully supported the draft resolution, which showed that, from the historical and constitutional viewpoints, technical cooperation was a well-defined function of WHO.

Relationships between countries were becoming closer and more varied in nature, and cooperation between WHO and Member countries, as well as between Member countries themselves, was developing strongly in the context of the aim to achieve health for all by the year 2000. Technical cooperation provided countries with a means of benefiting from the experience and expertise of others in particular fields. WHO and its Member States should strive to strengthen technical cooperation and to expand it vigorously so as to attain the short- and long-term objectives.
Dr BEAUSOLEIL (Ghana) said that his delegation would vote in favour of the draft resolution. It fully supported operative subparagraph 5(2). There were situations in which the role of WHO programme coordinator was vital, but problems sometimes arose under the current system, which involved three types of coordinator: one who was a permanent WHO staff member; one working on contract, being a staff member neither of WHO nor of the government concerned; and one who was an employee of the national health service. Such a system could give rise to unsatisfactory situations, particularly if the WHO coordinator lacked sufficient powers. His delegation therefore urged that a review be made of the role and responsibilities of WHO coordinators.

Dr LOCO (Niger) said that his delegation, bearing in mind all the statements made at the Health Assembly and sessions of the Regional Committee for Africa, as well as the various health agreements concluded with Member States and the United Nations agencies, supported the draft resolution and congratulated the Board on the text.

Mr VARGAS (Colombia) congratulated the representative of the Board on his clear introduction of the item. His delegation fully supported the draft resolution, which shed light, particularly in operative paragraph 3, on the role of international bodies, reaffirmed the sovereignty of all countries, and strengthened their cooperation for the achievement of the goal of health for all by the year 2000.

Dr ÁLVAREZ GUTIÉRREZ (representative of the Executive Board) said that he was gratified to note that the proposed draft resolution appeared to be approved by consensus.

With regard to the observations made by the delegate of Ghana, the Board had in fact set up a working group to evaluate Secretariat activities at all levels, including involvement in tasks carried out at national level; as part of its evaluation activities it had already visited a number of countries in Africa and South-East Asia. The working group was expected to report to the Board at its January session, at which time the points raised by the delegate of Ghana would be discussed.

The draft resolution proposed by the Executive Board in resolution EB67.819 was approved unanimously.1

4. PROPOSED PROGRAMME BUDGET AND REPORT OF THE EXECUTIVE BOARD THEREON: Item 19.1 of the Agenda (Resolutions WHA33.17, para. 4(1) and WHA33.24, para. 3; Documents PB/82-83, EB67/1981/REC/3, Chapters I and II, and A34/INF.DOC./2 (continued from the twelfth meeting, section 1)

Mrs RUMJANEK CHAVES (Brazil), referring to the proposed programme budget for 1982-1983 (document PB/82-83) said that, whilst her delegation was basically in agreement with the contents, it was surprised to note, with regard to the section on the analytical framework, and in particular the first table on page 15, that the smallest increase in real terms was for the Region of the Americas, for which the figure was a mere 0.41%. The explanation might partly be the important role of PAHO; nevertheless, her delegation would welcome more information from the Secretariat, the more so since the summary of regional activities by source of funds (page 262) also indicated a decrease for that Region with regard to extra-budgetary funds.

The CHAIRMAN said that the request would be noted in the summary record, and that the Secretariat would provide the delegate of Brazil with an answer in due course.

1 Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA34.24.
International Drinking Water Supply and Sanitation Decade: consideration of a draft resolution (Document A34/4)

The CHAIRMAN invited the Committee to consider the following draft resolution, sponsored by the delegations of Argentina, Belgium, Chile, Egypt, Finland, Ghana, Ivory Coast, Nigeria, Saudi Arabia, Sweden, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America and Upper Volta.

The Thirty-fourth World Health Assembly,
Having considered the report of the Director-General relating to the International Drinking Water Supply and Sanitation Decade (1981-1990);
Stressing that the provision of safe drinking-water and sanitation services is one of the essential elements of primary health care, and one of the essential global targets for health for all;
Noting with concern that progress made in the 1970s in improving drinking-water and sanitation services was slower than expected;
Considering that wide acceptance by Member States of the International Drinking-Water Supply and Sanitation Decade offers a new incentive to provide people with these essential services; and that maximum use should be made of all opportunities afforded by the Decade to promote the attainment of health for all;
Recognizing the need to monitor specific measurable indicators of the impact on health of improved water supplies and sanitation developed during the Decade, so as to help mobilize the substantial necessary resources, foster community participation and further encourage international support for that programme;
Aware that the Decade presents an opportunity to eliminate dracunculiasis (guinea worm disease) as a public health problem in affected areas, where the prevalence of the disease could serve as a uniquely visible and measurable indicator of progress for the Decade;
Restating the principles endorsed by the Thirty-third World Health Assembly that Decade efforts will contribute to health for all through:
- complementarity of sanitation with water supply development;
- focus on both rural and urban underserved populations in policies and programmes;
- achievement of full coverage through replicable, self-reliant and self-sustaining programmes;
- use of socially relevant systems applying an appropriate technology;
- association of the community with all stages of programmes and projects;
- close relation of water supply and sanitation programmes with those in other sectors;
- association of water supply and sanitation with other health programmes;

1. NOTES with appreciation the report of the Director-General;
2. RECOMMENDS to its Member States:

(1) to accelerate substantially the pace of their programmes for drinking-water supply and sanitation through the adoption of relevant policies and their implementation through plans aimed at covering the total population;
(2) to strengthen or establish suitable mechanisms, such as national action committees, to facilitate policy formulation, the elaboration of national Decade plans, the strengthening of relevant programmes of all involved national agencies and their active participation at all levels, and the best use of available external resources, recognizing the appropriate local representatives as focal points for international action at the country level;
(3) to focus programmes on their national priority health problems and monitor resulting impact on health, giving particular attention to the reduction of diarrhoeal diseases and in specifically affected countries, to other preventable water- or sanitation-related infections such as schistosomiasis, dracunculiasis, etc.;
(4) to incorporate activities for the improvement of drinking-water supply and sanitation services into their national programmes for primary health care, particularly in respect of people's education and involvement, training of community workers, and strengthening the support capacity at all levels of referral; and
(5) to strengthen the ability of national health agencies to take an active role in planning and implementing programmes for the Decade;

3. FURTHER RECOMMENDS TO MEMBER STATES

(1) to promote the International Drinking Water Supply and Sanitation Decade in international intergovernmental organizations in such a way as to make coordination more effective at the country level;
(2) to propose relevant water supply and sanitation programmes and projects for external support in a manner consistent with the principles set forth above;

4. INVITES the multilateral and bilateral agencies concerned to support national plans by giving priority to programmes and projects consistent with the above principles;

5. REQUESTS the Director-General:

(1) to further develop and implement WHO's strategy of support of the Decade in conformity with resolutions WHA29.47, WHA30.33, WHA31.40 and WHA32.11 as well as decision (17) of the Thirty-third World Health Assembly;
(2) to ensure the effective fulfilment by WHO of its central technical role with respect to the International Decade, including support to the coordinating mechanisms of the United Nations system and continued collaboration with Member countries to specify achievable health-related targets for the Decade;
(3) to cooperate with Member States, the other agencies in the United Nations system and with the multilateral and bilateral agencies concerned in exchanging information and facilitating support to relevant projects and programmes for which external resources are sought;
(4) to cooperate with Member States in assessing experience accruing from the implementation of national programmes and particularly information pertaining to impact of these programmes on the health of communities; and to disseminate this information widely among Member States, the other agencies of the United Nations system and multilateral and bilateral agencies;
(5) to report on these matters periodically to future Health Assemblies during the Decade.

Dr HOPKINS (United States of America), introducing the draft resolution on behalf of the co-sponsors, said that the Secretariat should be commended on the action taken since the Thirty-third World Health Assembly towards implementing the goals of the International Drinking Water Supply and Sanitation Decade.

He endorsed the statement in the report by the Director-General (document A34/4) that "The decade and the strategy for health for all are very closely linked. . . the question is whether those responsible for health improvement at the national level and at the international level will make maximum use of the opportunities of the Decade. . .".

His delegation wished to draw the attention of the Committee and the Health Assembly to the unprecedented opportunity offered by the Decade to promote better health and accelerate development, particularly with regard to the problem of guinea worm disease - dracunculiasis - or dracunciosis, which occurred in some rural areas of Africa, India and the Middle East, affecting an estimated 10 to 48 million people. Emergence of the worm through the skin, where it was sometimes rolled up on a stick, caused severe local pain and even at the present moment the disease was incapacitating more than 30 to 40% of farmers and villagers in some areas for periods averaging from one to three months during the annual harvest or planting season. According to one study conducted in Upper Volta, 7% of villagers with guinea worm disease died of secondary tetanus. In some villages, up to one-third of the school-children could not attend school because of temporary disability due to dracunculiasis. Although the guinea worm did not usually kill, and for that reason had been relatively ignored, the misery it caused was substantial.

Serious as the disease was, however, there was no need to include it in the Special Programme for Research and Training on Tropical Diseases, because the means to control it were already known. It was the only communicable disease that could be completely eliminated by use of safe drinking-water instead of contaminated water, since no other mode of transmission existed. Infections disappeared within one or two years after safe drinking-water was introduced, as had been amply demonstrated in Tashkent and Samarkand in the USSR in the 1940s, when endemic guinea worm disease had been eliminated by filling in "step wells" and providing protected bore and tube wells. More recently, provision of piped water to a Nigerian
town of 30,000 persons had reduced the incidence of guinea worm disease from over 60% to zero within two years. Control of the disease should be one of the objectives of the International Drinking Water Supply and Sanitation Decade although if the Decade achieved its goal of providing safe drinking-water to all by 1990, the disease would disappear. Early in the Decade priority should be given to developing safe water sources in endemic areas since the additional benefits to be gained would thereby cover a longer period and progress against such a visible, measurable indicator early in the Decade could help to increase support for the Decade at all levels.

Although sporadically distributed, the target population affected by the disease, was less than 6.2% of the rural populations of the African, Eastern Mediterranean and South-East Asia Regions which did not have safe drinking-water. The elimination of dracunculiasis in extensive areas was thus an attainable target, even if the overall goals of the Decade were not reached within 10 years.

The advantages of the strategy were many, not the least of which was that it would require no new resources in WHO or affected countries beyond what was already necessary to achieve the goals of the Decade. In exchange, establishing control of the problem as one of the priority objectives of the Decade would provide affected villagers with a visible incentive to help build, maintain, and use safe water supplies and it would provide national and local health authorities with a useful opportunity to educate communities on health-related behaviour in general. Those benefits would be in addition to, not instead of, other less easily measured health benefits of the Decade, such as for example reduced incidence of diarrhoeal diseases and schistosomes to which attention was already being paid. It would offer the international supporters of the Decade, particularly WHO, an opportunity to improve the health and quality of life of millions of poor people in rural areas and would demonstrate once more the direct relevance of health to development. In addition, it would help some countries to take one more, highly visible step towards the goal of health for all.

The proposal to adopt the control of dracunculiasis as one specific target of the Decade had been endorsed by the meeting of the Interagency Steering Committee of the Decade held in Geneva in April 1981, and received with enthusiasm at the Technical Conference of the OCECR, the public health organization of French-speaking West African States, which had met in Bamako.

He did not wish to involve WHO in another global eradication campaign at the present time, since prudence dictated that more experience in dealing with the problem under different conditions should be acquired before deciding whether or not to undertake such a commitment, but there was no better way to help discharge WHO's technical responsibility for the Decade within the United Nations system than for the Health Assembly to endorse the control of guinea worm disease as one of the Decade's targets in affected areas. Other health-related aspects of the Decade should also be identified. Such action would give meaning to the Director-General's vision stated in his Introduction to the proposed programme budget for 1982-1983 (document P8/82-83), namely, "WHO's fundamental role will be to make sure that water and sanitation relate to people and to their use by people as part of primary health care, rather than merely to impersonal pipes and pumps".

Dr BORGONO (Chile) emphasized the importance of the International Drinking Water Supply and Sanitation Decade and the work carried out in that respect. Chile was a co-sponsor of the draft resolution, but he wished to propose that the fifth line of subparagraph (2) of operative paragraph 2 should be amended in order to specify that the local representatives referred to were UNDP resident representatives, in accordance with subparagraph (4) of operative paragraph 2 of resolution WHA32.11 and paragraph 21 of the report by the Director-General to the Thirty-third Health Assembly (document A33/15) which stated that "The focal point at country level is the UNDP resident representative . . . ".

Dr ALBORNIZ (Venezuela) expressed his support of the draft resolution. In Venezuela specialized bodies were responsible for providing drinking-water in the large cities and certain rural areas and it was hoped that by the end of the Decade the whole country would be provided with safe drinking-water.

He endorsed the remarks made by the delegate of Chile concerning UNDP resident representatives because WHO had already specified in previous documents that the UNDP resident representative should be responsible for coordinating activities in the field.

The efforts made at the global level to solve the problem of drinking-water supply would help in solving other problems, not only in the field of communicable diseases but also in relation to personal hygiene and habits that were closely linked to availability of drinking-water.
Dr BAJAJ (India) informed the delegate of the United States of America that guinea worm disease was only found in localized areas in India and that it was in the process of being eradicated. He concluded by supporting the draft resolution.

Dr BEAUSOLEIL (Ghana) drew attention to the importance of the fifth preambular paragraph on the need to monitor indicators of the impact on health of improved water supplies.

Dr LEPOPO (Finland), speaking on behalf of the delegations of the Nordic countries, said that the history of public health in the industrialized countries was to a large extent the history of improving water supply and sanitation. Undoubtedly, the future of public health in the developing countries would to a very large extent be determined by the development of safe water supplies and excreta disposal. According to some estimates, up to 80% of morbidity in the least developed countries was water-related. Consequently, the attainment of the targets set for the Decade was a necessary prerequisite for attaining the overall health target set for the end of the century.

The report by the Director-General (document A34/4) gave cause for concern because the figures in tables 1 and 2 showed very slow progress in the coverage of safe community water supply from 1970 to 1980 and a deteriorating situation regarding sanitation.

The challenge presented by the Decade was therefore immense at the country level where the action must take place and the role of WHO as the organization with central technical responsibility within the United Nations system was extremely demanding. He endorsed the Director-General's statement on WHO's fundamental role as quoted by the delegate of the United States of America.

Massive investment was needed, approximately US$ 100 thousand million during the Decade, of which the major part would have to come from the countries concerned. It was clear that in financial terms WHO's contribution would necessarily have to be used to catalyze activities in the promotion and development of basic sanitary measures. The major thrust and effort in the water and sanitation strategy, as in the strategies for health for all, came from the Member States, WHO's role being confined to guidance, coordination, and technical support.

In view of the tremendous task faced by WHO and Member States during the Decade and the very limited funds available to WHO, attention should be paid to the idea expressed in paragraph 9 of the Director-General's report (document A34/4), where it was stated that the Decade and the strategy for health for all were very closely linked. Perhaps the most important way in which WHO could promote the water and sanitation programmes was to give them the priority they deserved in the Global Strategy for health for all thereby emphasizing the role of basic sanitary measures in country and regional strategies that were being developed.

It was a complex area both technically and administratively and it called for intersectoral collaboration. There was a danger that, despite the fact that the primary health care concept adopted by WHO included basic sanitary measures as an integral part, not enough attention would be paid by the health sector to water supply and sanitation, because medical thinking easily narrowed the comprehensive concept down to personal health services. He therefore urged that in strategic planning particular emphasis should be given to basic sanitary measures as an integral part of the primary health care approach. He joined the delegate of the United States of America in endorsing the Director-General's statement in his report (document A34/4) that the question was whether those responsible for health improvement at the national level and at the international level would make maximum use of the opportunities of the Decade, incorporating its aims into their own objectives and actions, and support it through resources and management.

The other Nordic countries also endorsed that statement and fully supported the view expressed in the report emphasizing that basic sanitary measures were an integral part of primary health care strategy and an important contribution to the Decade. The delegations of Denmark, Iceland, Norway and Sweden, as well as his own, also expressed the wish to be listed among the co-sponsors of the draft resolution.

Dr KALILANI-ALFAZEMA (Malawi) endorsed the draft resolution. In Malawi safe drinking-water was available in urban areas but in rural areas that was not always the case. A "self-help" scheme had been instituted whereby villagers dug a trench half way to the next village whereupon the latter continued the trench and the Government then laid the pipes.

Dr WILLIAMS (Nigeria) said that his delegation fully supported the proposed draft resolution.
Guinea worm was endemic in Nigeria and its socioeconomic impact in endemic areas was very serious. He therefore endorsed the remarks made by the delegate of the United States of America that it was one disease that could be completely eradicated by providing adequate quantities of safe drinking-water.

In his view, the programme for the Decade did not lay sufficient emphasis on the basic sanitation component and he hoped that more attention would be paid to improvement of environmental sanitation. Any visitor to major cities in Third World countries could not fail to notice the appalling sanitation problem posed by uncleared refuse and the absence of basic sanitary facilities.

The CHAIRMAN said that the delegations of Netherlands, Senegal and Sudan also wished to become co-sponsors of the draft resolution.

The draft resolution, as thus amended, was approved.1

Promotion of prevention of adverse health effects of disasters and emergencies through preparedness (Resolution EB67.R11)

The CHAIRMAN put to the Committee the draft resolution recommended by the Executive Board in resolution EB67.R11.

Dr PATTerson (Jamaica) said that her delegation supported the draft resolution. In many parts of the world funds were readily available in times of disaster but to be prepared, within a country or region, was a more cost-effective procedure. In times of disaster it took more than 48 hours for help to arrive so it would be more logical for help to be available within the country itself.

In order to emphasize the strengthening of organizational support, she proposed that a new preambular paragraph be added to read: "Reaffirming that the Organization should assume a leadership role in disaster preparedness." She also proposed that, after the words "its capacity" in the second line of operative paragraph 3, the following words be inserted "and increase its resources whether from budgetary or extrabudgetary sources".

In the fourth line of the same paragraph the words "to a future Health Assembly" should be replaced by the words "to the Thirty-fifth World Health Assembly".

Dr HADJ-LAKEHAL (Algeria) reiterated his Government's gratitude to the whole world for the solidarity which it had displayed with Algeria, and also to WHO for the promptness with which it had acted, on the occasion of the recent earthquake. His delegation fully supported the draft resolution as amended by the delegate of Jamaica.

The really important factor was the capacity of the country concerned to respond to disaster situations, and every country should therefore have a minimum degree of disaster preparedness. Algeria, with outside help, had been able to put into operation a relief system very quickly, and in only five hours a large part of the medical supplies had reached the disaster area situated 220 km from the capital. His Government had made an honest effort to take stock of both the positive and negative aspects of its experience, which it was ready to make available to others. He suggested that, under the aegis of WHO, work should be commenced, in the form of a meeting or of seminars, for the pooling of disaster experiences and the development of an appropriate strategy.

Mr PAGÉS PINÉIRO (Cuba) endorsed the comments made by the delegates of Jamaica and Algeria and expressed his support for the draft resolution. The countries of the Caribbean and Central America had certainly had very disagreeable disaster experiences, and every effort should be made to improve disaster preparedness. He supported the amendments proposed by the delegate of Jamaica.

Dr GURMUKH SINGH (Malaysia) said that his delegation fully supported the draft resolution. He suggested that the words "adverse health effects of" should be inserted after the words "prevention of" in the third line of operative paragraph 3.

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA34.25.
Dr BAJAJ (India) said that his country had had disagreeable experiences of disasters and fully realized the importance of disaster preparedness. His delegation therefore fully supported the draft resolution.

Professor GIANNICO (Italy) said that in both Committee A and the plenary meeting his delegation had already thanked WHO, especially the Regional Office for Europe, and all those countries which had provided assistance on the occasion of the earthquake of November 1980. Italy had extensive experience of both natural and technological disasters and therefore fully supported the draft resolution. However, it should be borne in mind that disaster relief operations entailed not only the provision of aid in the form of personnel, equipment and medicine; proper coordination was also important. He therefore proposed that the words "and to coordinate the aid sent by other countries" should be inserted after the word "disasters" in the fourth line of operative paragraph 3.

Mrs BRÜGEMANN (Secretary) read out the amendments proposed.

Dr BAJAJ (India) said that the amendment to the end of operative paragraph 3 proposed by the delegate of Jamaica would restrict the Director-General's reporting to only one year. He therefore suggested that the Director-General be requested to report "to future Health Assemblies".

Dr HADJ-LAKEHAL (Algeria), referring to the Italian amendment to operative paragraph 3, proposed that the words "coordinate the aid sent by other countries" should be replaced by the words "participate in the coordination of aid", since it was the country concerned that was responsible for coordination, although WHO could certainly participate.

Professor GIANNICO (Italy) accepted that sub-amendment, it was for the country to take the responsibility for immediate response but WHO could play a most useful role in coordinating aid sent from other countries.

Dr HOPKINS (United States of America) suggested that the words "the health aspects of" should be inserted before the word "disaster" in the additional preambular paragraph proposed by the delegate of Jamaica.

Dr ANDERSON (Australia) agreed with the delegate of Algeria that responsibility for coordination must lie with the Member State concerned, although WHO had a role to play in it. It was, moreover, essential that there should be a single coordinating body.

Dr PATTERSON (Jamaica) agreed that the need for coordination should be mentioned in the draft resolution; WHO certainly had a role to play in that respect. However, coordination was indeed essentially a matter for the country concerned. She agreed with the amendment proposed by the delegate of Malaysia to operative paragraph 3, but it should be borne in mind that "health effects" needed to be construed very broadly to cover such matters as lack of shelter and food. Technological disasters also occurred, and WHO might be able to play a role in their prevention. The suggestion made by the United States delegate concerning the proposed additional preambular paragraph was acceptable, but there again "health" should be construed in the widest possible sense, since it was the Ministry of Health which took the leading role when disasters occurred, while the nongovernmental organization most concerned was the Red Cross. The Indian delegate's suggestion regarding the need to avoid a specific reference to the Thirty-fifth World Health Assembly was also acceptable.

In reply to the CHAIRMAN, Dr PATTERSON (Jamaica) confirmed her acceptance of the suggestions made by the delegates of India and the United States of America.

Mr PAGÉS PINEIRO (Cuba), referring to the amendment proposed by the United States delegate as clarified by the delegate of Jamaica, said that the proposed wording might lead to some confusion and limit the concept of health. Disaster relief was an intersectoral problem and although the Ministry of Health was the main coordinating body, other departments were necessarily involved. He was therefore not in favour of that amendment in view of the importance of retaining as broad an interpretation as possible. As regards the Italian amendment, when disasters occurred WHO operated from a distance; so that its coordinating role could basically be that of furnishing guidance from both headquarters and the regional offices regarding the kind of items to be supplied and the avoidance of duplication, though it would be better for national preparedness to be such that no coordination was required from headquarters.
Dr BAJAJ (India) expressed the hope that, on the question of reporting to Health Assemblies, the delegate of Jamaica accepted his suggestion.

Dr PATTERSON (Jamaica) confirmed her acceptance and withdrew that part of her proposal.

The DEPUTY DIRECTOR-GENERAL said that it was almost impossible to tailor the draft resolution before the Committee to meet the individual needs, ideologies and mechanisms of any particular nation. WHO had an extremely good record in the field of disaster relief, and the draft resolution would strengthen the Organization's capacity to improve upon it. National governments were of course completely free to set up additional mechanisms, while religious bodies, the Red Cross and other nongovernmental organizations also had important roles to play. WHO had given a great deal of thought to the very difficult question of coordinating the disaster relief efforts of the United Nations system, national governments and nongovernmental organizations. Nevertheless, the main responsibility in coordinating the various inputs would entirely depend on each country's national capacity to do so.

Mr PAGES PINEIRO (Cuba) expressed his appreciation of the Deputy Director-General's reply which had not however allayed his doubts; in his opinion inclusion of the word "health" could lead to confusion when activities were coordinated in specific areas.

The DEPUTY DIRECTOR-GENERAL said that, as far as the Secretariat's interpretation was concerned, health aspects only were involved, although the latter were construed in the broadest terms. The Organization's role was therefore clearly defined.

Dr PATTERSON (Jamaica) said that it was not clear to her whether the delegate of Cuba wished the word "health" to be included or not.

Mr PAGÉS PINÉIRO (Cuba) said that it had not been his intention to propose a sub-amendment to the amendment. He had merely wished to draw the Committee's attention to the possibility of the amendment creating confusion. If it was clearly understood that the amendment would not restrict such intersectoral cooperation as might exist and would not prevent a broad view being taken of health problems, he could agree to the amendment.

The draft resolution proposed by the Executive Board in its resolution EB67.R11, as thus amended, was approved.\(^1\)

The meeting rose at 12h40.

\(^1\) Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA34.26.
1. TECHNICAL ACTIVITIES AND QUESTIONS IDENTIFIED FOR ADDITIONAL EXAMINATION DURING THE REVIEW OF THE PROPOSED PROGRAMME BUDGET AND OF THE EXECUTIVE BOARD'S REPORT THEREON: Item 24 of the Agenda (Resolution WHA31.9, para 1(1) (continued))

Use of SI units in medicine: use of the kilopascal for blood pressure measurement

The CHAIRMAN drew the attention of the Committee to the following draft resolution which was co-sponsored by the delegations of Finland, Federal Republic of Germany, Ireland, Italy, Kuwait, Malta, New Zealand, Swaziland, United Kingdom of Great Britain and Northern Ireland and United States of America:

The Thirty-fourth World Health Assembly,
Having considered the international difficulties being encountered in attempting to introduce the kilopascal, the unit of the Système international d'Unités (SI) for the measurement of blood pressure;
Noting the attitudes and resolutions of international scientific bodies objecting to the precipitate replacement of the millimetre of mercury by the kilopascal;
Further noting with concern the ensuing difficulties encountered in communication between the scientific community and the population in a number of Member States;
Mindful, nevertheless, of the desirability of a unified international system of units as expressed in earlier resolutions;
Recalling the caution expressed in resolution WHA29.65 regarding the difficulties that might arise through the precipitate introduction into medical practice of certain units of the SI, with particular reference to the substitution of the kilopascal for the millimetre of mercury in the measurement of blood pressure;

1. CONSIDERS that there is no compelling need to replace the millimetre of mercury by the kilopascal in medical practice at the present time;
2. RECOMMENDS that no time be set for the replacement of the millimetre of mercury by the kilopascal;
3. REAFFIRMS the recommendation of the Thirtieth World Health Assembly that the millimetre of mercury and the kilopascal be used simultaneously for as long as the relevant scientific bodies and nongovernmental organizations consider this useful for the undisturbed delivery of health care and the interchange of scientific information;
4. REQUESTS the Director-General to draw attention to the present resolution in the Organization's journals as well as through the media of the relevant nongovernmental organizations.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that the Thirtieth World Health Assembly had considered the use of SI units in medicine and, in resolution WHA30.39, recommended their adoption by the medical community throughout the world. Even at that time, a number of delegations had expressed their concern that confusion might arise if the new SI unit, the kilopascal, were to replace the millimetre of mercury, and in fact resolution WHA30.39 had recommended that "in addition to the scale in kilopascals, the millimetre (or centimetre) of mercury and the centimetre of water be retained for the time being on the scales of instruments for the measurement of the pressure of body fluids pending wider adoption of the use of the pascal in other fields".
As had been feared, confusion had arisen in certain Member States, where the millimetre of mercury had been replaced by the kilopascal in a rather precipitate manner. That circumstance had prompted various scientific bodies, including the International Society of Hypertension and the Society for the Preservation of the Millimetre of Mercury to appeal to national and international authorities to endorse the retention of the millimetre of mercury as the unit of measurement for arterial blood pressure. Certain national bodies, such as the Health Protection Branch of the Department of National Health and Welfare in Canada and the American Heart Association had in fact opted to retain the millimetre of mercury as the standard unit for arterial blood pressure measurement. In the United Kingdom, the Royal College of Physicians had also expressed serious reservations in regard to the adoption of the kilopascal on the grounds that it was too crude a unit of measurement for blood pressure readings. He drew attention also to the statement by the WHO Expert Committee on Arterial Hypertension which met in March 1978 (published in the WHO Technical Report Series, No. 628) that "Since arterial pressures are universally recorded in terms of the millimetre of mercury (mmHg), the Committee is of the opinion that the kilopascal is not appropriate for clinical practice or epidemiological use and the millimetre of mercury should therefore be retained for the time being."

The delegations which had co-sponsored the draft resolution set out above felt strongly that there was no compelling need to replace the millimetre of mercury by the kilopascal in clinical practice at the present time and recommended that no time be set for its replacement. Although conscious of the recommendations of the Thirtieth World Health Assembly and of the fact that the kilopascal was being used already in certain Member States they believed that, in countries where the kilopascal was adopted, both units of measurement should be used in parallel.

Since drafting the resolution, he had been approached by some delegations which, while endorsing its general principles, had expressed some reservations in regard to the wording of operative paragraph 3. After consultation with some of the co-sponsors of the resolution he therefore now proposed the following amendments to it:

1. Fifth preambular paragraph:

   after the words: "in resolutions WHA29.65"

   insert: "and WHA30.39";

2. Delete operative paragraph 2;

3. Reword operative paragraph 3 as follows:

   2. Recommends that the millimetre of mercury and the kilopascal be used simultaneously until a future World Health Assembly considers the retention of the millimetre of mercury unnecessary for the undisturbed delivery of health care and the interchange of scientific information;

4. Renumber operative paragraph 4 to become operative paragraph 3.

Professor HALTER (Belgium) said that legislation had been adopted in many countries, imposing the use of SI units without taking any account of the practical problems involved, especially in medicine. The medical authorities in his country had experienced great difficulty with the departments of economic affairs, which were responsible for the implementation of standards set by the International Organization for Standardization (ISO), in ensuring that proceedings were not taken against those who failed to use the statutory SI units. In addition to the draft resolution, which he fully supported, he would like to see the Director-General, and perhaps the Executive Board, submit to the Thirty-fifth World Health Assembly a more far-reaching document on the use of SI units in medicine. He quoted as an example of the problems that might arise the use of calories for measuring the energy content of a diet, which were now to be transposed into kilojoules. The problem affected most closely the younger generation of doctors and medical students, who found themselves in a state of confusion over the introduction of the new SI units.

He therefore urged the adoption of the draft resolution. Moreover, he considered that WHO should make clear the risks entailed by the establishment of units by the ISO and their mandatory introduction in countries by other irresponsible metrologists who delighted in physical measures that satisfied them intellectually but did very little good to patients.
Dr ANDERSON (Australia) said that cardiovascular and cerebrovascular disease were major factors in the mortality pattern in Australia. A large-scale prospective study had recently been undertaken over several years by the National Heart Foundation of Australia, to determine whether there was any advantage in treating minimal levels of arterial hypertension; the benefits of treatment were unequivocal and great emphasis was now placed in health promotion activities on early diagnosis and treatment. It would be quite wrong to endanger patients and complicate the task of the primary health care workers responsible for them by an arbitrary change from mm Hg to the kilopascal. He strongly supported the draft resolution.

Professor MODAN (Israel) emphasized the importance of arterial hypertension as one of the killer diseases in modern society. The problem was already serious enough without confusing both doctor and patient by a change in terminology. He fully supported the draft resolution and wished to propose the insertion of a further preambular paragraph:

Considering the high prevalence of arterial hypertension, its deleterious effects and the high probability of prevention by early screening;

Dr GALAHOV (Union of Soviet Socialist Republics) said that the question was one for experts in the field and he was fully persuaded by the arguments put forward by the delegate of the United Kingdom of Great Britain and Northern Ireland and other speakers. He particularly liked the laconic and flexible wording of the operative part of the draft resolution, which he fully supported in its amended form.

Dr H. SYLLA (Guinea) said that his country was greatly concerned at the prospect of changing units. The change-over from mm Hg to kilopascals would affect not only measurement in the control of cardiovascular disease, but also the measurement of intraocular pressure. It would be necessary both to relearn the relevant units and recalibrate the instruments. He supported the draft resolution.

Dr LOCO (Niger) said that in Africa there were many requirements of higher priority than changing units of measurement. The traditional training of doctors and nurses could only be impeded thereby. He saw no reason to fix any date for the change-over to the kilopascal. He fully supported the draft resolution.

Dr SUVANNUS (Thailand) and Dr SADRIZADEH (Iran) also supported the draft resolution.

Dr LENFANT (United States of America) said that, as a co-sponsor of the draft resolution, his delegation endorsed the amendment proposed by the delegate of the United Kingdom. In addition, it reaffirmed its support for the draft resolution by pointing out that the cost of changing the blood pressure unit from the millimetre of mercury to the kilopascal would be high to Member States of WHO and to voluntary health organizations as well.

The CHAIRMAN put to the Committee the draft resolution with the amendments proposed.

The draft resolution, as thus amended, was approved.1

2. THIRD REPORT OF COMMITTEE A (Document A34/43)

At the CHAIRMAN's request, Dr KASONDE (Zambia), Rapporteur, read out the draft third report of the Committee.

The report was adopted (see document WHA34/1981/REC/2).

3. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 16h20.

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA34.27.
COMMITTEE B

FIRST MEETING

Thursday, 7 May 1981, at 17h00

Chairman: Dr Z. M. DLAMINI (Swaziland)


The CHAIRMAN drew attention to the third report of the Committee on Nominations, in which Dr L. Sánchez-Harguindey (Spain) and Dr A. Hassoun (Iraq) were nominated for the offices of Vice-Chairmen of Committee B and Dr Deanna Ashley (Jamaica) for that of Rapporteur.

Decision: Committee B elected the following officers:

Vice-Chairmen: Dr L. Sánchez-Harguindey (Spain) and Dr A. Hassoun (Iraq)

Rapporteur: Dr Deanna Ashley (Jamaica)

2. ORGANIZATION OF WORK

The CHAIRMAN reminded the Committee of the role of the Executive Board in the work of the Organization and of the expanded role of its representatives in the Health Assembly and its committees.

He drew attention to the Rules of Procedure governing the work of the Health Assembly and to the terms of reference of Committee B, which were contained in paragraph 1(2) of resolution WHA31.1. He also drew attention to paragraph 1(1) of resolution WHA32.36, which provided that "neither main committee of the Health Assembly shall meet during plenary meetings of the Health Assembly, and that this provision supersedes paragraph II.1 of resolution WHA28.69".

He proposed that the Committee should normally meet from 9h30 to 12h30 and from 14h30 to 17h30.

It was so agreed.

Dr BEN SLAMA (Tunisia), raising a point relating to the agenda in accordance with the Rules of Procedure, requested that, for reasons of efficacy, consideration of item 37 - Transfer of the Regional Office for the Eastern Mediterranean - be advanced from Saturday, 16 May, as currently scheduled, to not later than Wednesday, 13 May. The item was an important one on which the decisions to be taken required the presence of the heads of delegations, many of whom would be unable to remain in Geneva until the later date.

The CHAIRMAN said that it had in any case been his intention to raise the question of the order in which to take the items on the Committee's agenda, and suggested that in principle they should be taken in the order in which they appeared in the agenda.

He invited comments on the proposal of the Tunisian delegation regarding item 37.

Dr BASSIOUNI (Egypt) said that the financial position of the Organization (item 26) and the financial items that followed, the study of the Organization's structures in the light of its functions (item 35), and the periodicity and duration of Health Assemblies (item 36) were of greater interest in the life of the Organization as a whole and for all Regions than the
proposed transfer of the Regional Office for the Eastern Mediterranean (item 37). The schedule of work as currently proposed left ample time for discussion, since after 16 May there would remain a week before the end of the Assembly, and he did not think that the efficacy of the Assembly's work would be affected by the movements of some delegation members. The item would, however, call for contacts between delegations. He therefore opposed the proposal of the Tunisian delegation.

Mr JAAPAR (Kuwait) supported the Tunisian proposal and urged the Committee, in the light of the Chairman's last statement, to adopt it.

Dr ABDULHADI (Libyan Arab Jamahiriya) considered the proposal of the Tunisian delegation to be in the interests of the efficacy of the Assembly's work. The item was one of the most important before the Assembly; it was of deep interest to one Region, and so of interest to all delegations, and deserved the fullest discussion at the highest level. However, it was not new and the early days of the Assembly would have allowed ample time for inter-delegation contacts. For those reasons he urged the Committee to adopt the proposal of the Tunisian delegation and advance the date of the discussion.

Mr McKINNON (Canada) recalled that the work of Committee B had to be coordinated with that of Committee A and asked how the adoption of the proposal of the Tunisian delegation might affect the work of Committee A.

Mr FURTH (Assistant Director-General) confirmed that there was, indeed, a connexion between the work of Committees A and B. Resolution WHA31.1 (May 1978) in effect provided that Committee A could not take up item 19.2 (Budget level and Appropriation Resolution for the financial period 1982-1983) until Committee B had completed consideration of the financial position of the Organization, including the Financial Report and the report of the External Auditor; the status of contributions and status of advances to the Working Capital Fund; the amount of casual income to be used to help finance the budget; and the scale of assessments (items 26 and 29). In particular, Committee B had to report to Committee A on the amount of casual income to be used to help finance the budget (after consideration of item 26.4) before Committee A could consider the budget level and the Appropriation Resolution for 1982-1983 (item 19.2). It was naturally advisable for that report to reach Committee A some time before the discussion on item 19.2 took place. Finally, the Committee might wish to bear in mind that it was customary for the External Auditor, or his representative, to be present during the discussion of his report, and the necessary arrangements had already been made for the following Tuesday, 12 May. While he saw no organizational difficulty in advancing discussion of item 37 to some extent, he would suggest that the financial items he had enumerated be considered fairly early in the following week in order to avoid holding up the work of Committee A.

Dr VENEDIKTOW (Union of Soviet Socialist Republics) said that, although he was aware of the need for coordination between Committees A and B and of the arrangements already made, he could see no real obstacle to bringing forward the discussion of item 37, which was of great interest to so many delegates.

Dr RUBIN (United States of America) said that there were valid arguments on both sides of the question. His delegation sympathized with the desire of some ministers of health to have the issue discussed while they were still present. However, his delegation believed that the Committee had to accord overriding importance to the financial and administrative issues before it. The present order of the agenda was logical in that regard and should, therefore, be respected.

The CHAIRMAN asked whether, in the light of the Secretariat's explanations, the Committee could agree to take up item 37 after the discussion of items 26 to 29.

Dr BASSIOUNI (Egypt) asked whether the suggestion was that the Committee should consider item 26 and its subitems, go on to items 27 and 29, and then take up item 37.

The CHAIRMAN confirmed that interpretation and invited further comments.

There being none, 'it was so agreed.'

The meeting rose at 17h40.
SECOND MEETING
Tuesday, 12 May 1981, at 9h30
Chairman: Dr Z. M. DLAMINI (Swaziland)

REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION: Item 26 of the Agenda

Interim financial report on the accounts of WHO for 1980 and comments thereon of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Health Assembly: Item 26.1 of the Agenda (Financial Regulations 11.5 and 12.9; Document EB67/1981/REC/1, resolution EB67.R24; Documents A34/9, A34/25 and Add.1, and A34/30)

Mr FURTH (Assistant Director-General) introduced the interim financial report for the year 1980 (document A34/9) and the Report of the External Auditor (documents A34/25 and Add.1). While in some respects 1980 had in financial terms been an even better year for WHO than 1979, he thought it unlikely that the favourable circumstances of 1980 would recur in the near future. First, the exchange rate of the Swiss franc used for budgeting purposes for the biennium 1980-1981 had been set at 1.55 Swiss francs per US$. Under resolution WHA32.4, the Director-General was authorized to use casual income up to a maximum of $15 million during 1980 and 1981 in order to meet any additional costs arising under the regular budget resulting from differences between the exchange rate used for budgeting purposes and the actual accounting rates of exchange. Conversely, he was requested to transfer to casual income any savings resulting from such differences, also subject to a maximum of $15 million. In 1979 the Director-General had been obliged to use casual income for this purpose to the extent of $11 million, owing to unfavourable movements in the rates of exchange. In 1980, and so far in 1981, the accounting rates of exchange of the US dollar in relation to the Swiss franc had been higher than the budgetary rate of Sw.fr. 1.55 per US$; hence it appeared likely that there would be savings under the regular budget for 1980-1981 as a result of the application of resolution WHA32.4. Those savings, in the form of a budgetary surplus, would be credited to casual income at the end of the two-year financial period - but only if the collection of assessed contributions for 1980-1981 exceeded the obligations incurred during that period.

Another favourable development during 1980 had been the earnings in casual income by the Organization. The table on page 16 of document A34/9 showed that casual income during the year 1980 had been some $16.6 million, of which $12.2 million had been due to interest earnings. Those figures were higher than they had ever been in the Organization's history. Such high interest earnings were largely due to the practice of keeping the cash-in-hand not required for immediate disbursement in deposits, which during the year 1980 had been earning interest at rates sometimes as high as 20% per annum. However, that was a development which would probably not be repeated for some time. The Organization's ability to place its cash-in-hand on deposit was dependent upon governments paying their contributions promptly - and unfortunately the record of contributions during 1980 had been less favourable than in previous years: at the end of 1980 only 94.43% of assessed contributions had been collected, as compared with 98.4% at the end of 1979. In spite of that decline however, the Director-General had not had to withdraw funds from the Working Capital Fund or to borrow from other internal sources.

Another satisfactory development had been the growth of extrabudgetary resources. The table on page 4 of document A34/9 showed that, although increases and decreases in individual funds might have varied from one year to the next, the overall growth had been remarkably continuous for the four-year period 1977-1980. Details of all extrabudgetary resources were given on pages 19 to 116 of the document in the form of an Appendix. He recalled that the previous year the Health Assembly had agreed that whereas the interim financial report itself would be brief, it would contain an appendix on extrabudgetary resources giving full details.
of expenditure under the various accounts in the Voluntary Fund for Health Promotion and in major special accounts such as those for the Onchocerciasis Control Programme, the United Nations Development Programme, the Trust Fund for the Special Programme for Research and Training in Tropical Diseases, the United Nations Fund for Population Activities, and the Sasakawa Health Trust Fund. The data in the Appendix covered contributions received, listing the donors, as well as the application of the funds to programme activities.

The Thirty-third World Health Assembly had also decided that, in order to save time and money, the interim financial report would not contain accounts certified by the External Auditor, it being understood that the External Auditor would continue his ongoing audit activities throughout the biennium. It had also been decided that, whereas a report by the External Auditor would not normally be required for the first year of a financial period, the External Auditor would be free to submit a report should he feel the need to do so. The External Auditor had in fact submitted a report on this occasion.

Although the External Auditor, Sir Douglas Henley, was unable, to his regret, to attend the Committee in person, Mr John Collens, the Deputy Secretary of the Exchequer and Audit Department immediately responsible to Sir Douglas for the WHO audit, was present and was prepared to answer any questions relating to the External Auditor's report (documents A34/25 and Add.1).

Dr Mork (representative of the Executive Board) introduced the first report of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Thirty-fourth World Health Assembly (document A34/30). That Committee, in accordance with its terms of reference, had reviewed the interim financial report for the year 1980 submitted by the Director-General and also the report presented by the External Auditor (documents A34/25 and Add.1). It had considered that, whereas the very detailed presentation of data on extrabudgetary resources given in the Appendix to the interim report might not be essential for the Health Assembly's assessment of the financial situation in 1980, it was extremely useful in enabling donors of extrabudgetary funds to recognize the payments made by them and the projects on which those funds had been spent. Furthermore, the data contained in the Appendix formed part of the External Auditor's routine review of WHO's income and expenditure.

The Committee had found that the financial situation of the Organization was generally favourable, largely as a result of two developments: (1) the very substantial amount of casual income earned during 1980, as a result of which the balance of casual income available had been in excess of $26,000,000; and (2) the favourable movement in the exchange rate between the US dollar and the Swiss franc, which was likely to lead to a substantial budgetary surplus at the end of the current biennium. It should not be forgotten that, should the exchange rate of the Swiss franc for the US dollar be higher than the budgetary rate used for the current biennium 1980-1981, the Director-General was required to surrender the corresponding funds as a budget surplus to casual income at the end of the financial period, subject to a maximum of $15,000,000.

The External Auditor's report contained a number of comments on the management of projects in two of the regions. The Committee had agreed that those comments could be of interest to other regions as well, and had suggested that the regional directors should be encouraged to bring the problems raised by the External Auditor to the attention of their regional committees.

He drew attention to the draft resolution contained in paragraph 5 of the committee's report.

Mr Collens (External Auditor's office) introduced documents A34/25 and Add.1. Although the External Auditor was not required to produce a report on an interim year, he had felt that it would be helpful to draw attention to a number of matters arising out of the audit process, considering that WHO would like an assurance that the operational audit was continuing during the interim year as in previous years. In particular, he had thought it important to inform the Health Assembly as soon as possible of a case of serious irregularity (paragraphs 2 and 3 of the report) in which a university had been misusing part of a substantial grant provided by the Organization. The case had been considered significant because of its implications for controls over a wide range of grants made to other bodies. The External Auditor would be following the course of the investigation still being carried out into the matter, and would probably comment more fully in his report on the biennial accounts.

In 1980, the auditors had concentrated on schemes related to the improvement of water supply and sanitation facilities, since, on the threshold of the International Drinking Water Supply and Sanitation Decade, they had felt that such investigation might prove useful.
for other projects which were to start during the Decade. They had continued during 1980 a programme of regional visits begun in 1979, and had visited the Regional Offices for Europe and for South-East Asia. Thus, the cases referred to in the report had been drawn from the two regions visited, and had not been selected because those regions were more open to criticism than others. Paragraphs 8 and 17 summarized the External Auditor's conclusions. A common theme of those conclusions was that, if projects involving cooperation between WHO and national governments were to succeed, there must be realistic estimation of the resources that governments could provide, proper planning of how objectives could be realized, and effective supervision by the Organization to ensure cooperation between experts, national authorities, and executing contractors.

Paragraphs 23 to 27 concerned duplication between the work of FAO and WHO. Where there was risk of such duplication, the External Auditor concluded that efforts should be made to achieve coordination before projects started in order to avoid difficulties later on.

He was encouraged to note the interest shown in the report by the Committee of the Executive Board, and welcomed that Committee's suggestion that regional directors might bring the points in it to the attention of their regional committees.

Dr GALAHOV (Union of Soviet Socialist Republics) noted with appreciation that the Director-General had not found it necessary to resort to internal borrowing, even from the Working Capital Fund. Nor had the casual income facility provided for in resolution WHA32.4 been called into play. He hoped that the Organization would continue to be able to meet its financial obligations without recourse to internal borrowing, and that casual income would resume its direct function of financing the Organization's budget. He was concerned at the decline in the rate of collection of assessed contributions, noting that the proportion collected in 1980 had fallen to 94.43%. Although in the first four months of 1981 the situation had somewhat improved, it was still not as good as at the comparable date in the previous year. The Committee of the Executive Board had drawn attention to that situation in its report, and had urged that it be remedied. In the opinion of the Soviet delegation, the poor collection of contributions was a result of the swift rise in the Organization's budget, the need for stabilizing which had been noted in the plenary meeting by a number of delegations.

He urged that any available casual income (paragraph 6 of the Introduction to the interim financial report) should be used to finance the regular budget. He also asked for more information on what facilities were made available by WHO on a concessionary basis (page 10 of the interim report, sixth paragraph from bottom of page). In view of the requirements for headquarters accommodation (document EB67/1981/REC/1, resolution EB67.R20 and Annex 7), it would be interesting to know what premises were rented out. The matter could perhaps be reverted to when agenda item 33 was considered.

With reference to the External Auditor's report, he recalled that many delegations had emphasized the need for strengthening controls by the Board and the Health Assembly on the implementation of projects. Experience had shown them to be right, and it was a matter that should be further considered.

As regards the presentation of the interim financial report, he drew attention to paragraph 8 of the Introduction (page 4). Extrabudgetary resources were there shown in a different form from those in the programme budget for 1982-1983 (document PB/82-83, page 1), which gave a longer list of extrabudgetary sources. More uniformity in the presentation of the programme budget and financial report would be desirable.

Professor VANNUGLI (Italy) was gratified to note the favourable financial situation and particularly welcomed the increase in casual income. As to the difficulties in project implementation referred to in paragraph 4 of document A34/25 Add. 1, he wondered whether these were isolated cases, or whether the problem reappeared in other areas of WHO's activities.

Dr BROYELLE (France) said that Table 1 of the interim financial report (page 7) showed a balance of some US$ 30 million for the regular budget, i.e., some 14% of the total income had not been utilized. She would like some explanation of why such a large portion of budgetary resources had remained unused, since usually it was complained that those resources were insufficient. In regard to the mention made in the report of the External Auditor of the effectiveness of controls over grants made by WHO, she asked how those controls operated and whether any improvements were envisaged.
Dr BASSIOUNI (Egypt) was concerned to note the decrease in the collection of contributions in 1980 and notably in the rate of payment of contributions in advance. There should be a review of the methods used in the collection of these contributions.

He thought that the marked rise in the maintenance of liquid assets was to be deplored. As would be seen from Table 2 they had risen from $4 million at the end of 1979 to some $12 million in 1980—a growth rate of more than 200%. Such a high rate immobilized money that could be earning interest, and in his opinion did not constitute a proper use of the Organization's resources.

Mr BOYER (United States of America), commending in particular paragraph 27 of the External Auditor's Report concerning the prevention of duplication of effort between WHO and other United Nations agencies, expressed the hope that WHO and the External Auditor would be constantly on the watch for potential duplication and waste of resources.

He endorsed the External Auditor's comments on the need for thorough examination of all aspects of a project before entering into an agreement for its implementation. The External Auditor had identified several instances in which host governments had not extended the necessary cooperation and where the result had been an apparent waste of WHO resources. It was important therefore to emphasize that governments should propose only projects which they were fully willing to carry out and which the Organization had a substantial chance of completing within a reasonable period.

He welcomed the amount of detail contained in the interim financial report. It was not enough however to look only at the flow of money into and out of the Organization, the purposes for which it was contributed, and the programmes that it supported. The real test was the "health outcome", namely, the improvements in health standards that were the chief intent of the expenditure. Effective programme monitoring and evaluation systems were therefore needed. He was pleased that the Executive Board and its Programme Committee had begun a systematic consideration of medium-term programming and hoped that all Members would give serious attention to such efforts. It was only by a thorough examination of both financial operations and programme results that it would be possible to determine the true effectiveness of current operations and make sound recommendations for the future.

He had noted, along with the previous speakers, that more than $30 million in regular budget contributions had remained unexpended at the end of 1980; and that nearly $13 million in assessments had not been collected. It would therefore seem that about $43 million of the 1980 assessments, i.e., 20%, had not been utilized during 1980. He recognized that, in a biennial system, the financial objective was to spend all income by the end of the two-year period and not necessarily to spend half of it by the end of the first year; but he would be interested to have the Secretariat's comments on the apparently slow rate of expenditure, on the pace of implementation of the approved programme, and in particular on whether WHO could perhaps operate with smaller assessments in the first year and larger assessments in the second.

The explanatory notes to Table 2 showed that WHO had more than $184 million in hand, much of it in the Voluntary Fund for Health Promotion and other extrabudgetary accounts. Such a large sum of assets raised the question of the rate of implementation of the voluntarily funded programmes as well as of the regular budget. He asked whether it was normal for WHO to have so much money in hand at all times, or whether it was an extraordinary circumstance at the end of a calendar year.

In 1980, the United States and United Kingdom delegates had suggested that more information, including financial details, should be given on the use of fellowships in the various WHO programmes. The United Kingdom delegate had also requested more information on staff costs. Such documentation had not been included in the 1981 report and he therefore repeated his suggestion that it be provided, bearing in mind the comments made by the External Auditor.

Table 1 showed that assessments under the regular budget had accounted for less than half of the total funds received in 1980 because of the substantial amount of the voluntary contributions. The question therefore arose as to the impact on the regular budget of the operation of such extensive extrabudgetary programmes. It was certainly valuable to the health community for WHO to operate those various voluntarily funded programmes. If, however, the regular budget was required to bear part of the cost of operating voluntary programmes, then the priorities and specific activities established by the Health Assembly when it determined the regular budget programme for the biennium might be diverted from their original purpose and the impact of regular budget activities diminished. He would welcome the comments of the Secretariat on the financial impact of those voluntarily funded programmes on the regular budget.
Several of the trust funds itemized on page 22 of the interim financial report (in particular for the Special Programme for Research and Training in Tropical Diseases, the United Nations Development Programme, and the United Nations Fund for Population Activities) showed a deficit. The United Nations Fund for Drug Abuse Control even showed a deficit in the "income" column. He would appreciate an explanation of those deficit figures and their possible impact on regular budget operations.

The figures in Table 1 for the Special Account for Operation of Concessions at Headquarters revealed relatively small amounts of money. He wondered whether the charges on those concessions were adequate, bearing in mind the excellent space provided and the captive audience of WHO staff, who had no alternative to those services.

In the course of the Health Assembly, his delegation would make further comments aimed at limiting the growth of the regular budget and at maximizing its impact. In general, however, it was well satisfied with the financial management of the Organization and noted with pride that its finances were in very good order.

Dr KAPRIO (Regional Director for Europe) said that, as one of the regional directors whose regions had been audited, he had welcomed the visit of the External Auditor in that it provided an opportunity to discuss in detail some of the difficulties which had to be faced in the field.

The Regional Office for Europe had been an executing agency for UNDP for some time past. Projects normally involved an initial survey of the facilities available both to the government concerned and to the agency. That was followed by a feasibility study. It was at that stage that delays had been encountered in the past. Experience had helped to bring about a better balance in that regard. The final test however was the health outcome of the project. If there was delay at the feasibility study stage, the achievement of the final objective would be postponed but was still possible. On the other hand, there had been cases where good feasibility studies had not been implemented because of political considerations or because loan arrangements had not been approved. The interest of the External Auditor in studying managerial problems would help the regional offices to improve their work.

Mr FURTH (Assistant Director-General), replying to questions raised, said that the delegate of the Soviet Union had expressed concern at the decline in the rate of collection of contributions in 1980 as compared with both 1979 and 1978. There were indications that the decline was likely to be further accentuated in 1981 and future years, and this was a matter of deep concern to the Director-General.

The delegate of the Soviet Union had also referred to the possible use of casual income to help finance the regular budget; there would be an opportunity to discuss the issue at greater length later in the session. More details of the income and expenditure of all extrabudgetary funds were contained in the table on page 22 of the interim financial report and supplemented the overview given in paragraphs 8 and 9 of the Introduction to the report.

The delegates of France and the United States had drawn attention to the cash balance under the regular budget of more than $ 30 million which appeared in Table 1, and had asked why such an amount had remained unspent. The expenditure of over $ 171 million under the regular budget represented disbursements only and did not include a further $ 143 million in respect of unliquidated obligations, referred to in footnote b of Table 1. Firm commitments or obligations therefore amounted to over $ 314 million at the end of the first year of the financial period and represented 73.6% of the total effective working budget for the biennium. The implementation of the regular budget was thus proceeding at quite a satisfactory rate. Considering the large amount of unliquidated obligations outstanding at 31 December 1980, the cash balance of $ 30 million could not be considered to be very large.

In reply to the delegate of France, he said that WHO was continuing its investigation into the question of grants, bearing in mind in particular that the External Auditor had drawn attention to certain irregularities. Both technical and financial controls were exercised over such grants. The institutions concerned were required to produce technical reports, and technical staff visited the institutions. Regular financial reports were also required from institutions which, in addition, were visited from time to time by the External and Internal Auditors. The methods employed for the transfer of funds were also under scrutiny.

Extrabudgetary funds were spent faster than they were received; as shown on page 22 of the report, income had been $ 131 million in 1980 against expenditure of $ 139 million. There was therefore no problem as regards the rate of implementation of programmes financed from extrabudgetary funds.
The question of fellowships had been raised at the Thirty-third World Health Assembly and the Director-General had promised to submit an evaluation report on WHO's fellowships activities to a future session of the Executive Board. That report would be submitted to the Board at its sixty-ninth session, in January 1982.

There would be opportunities to discuss the impact of extrabudgetary funds on the regular budget when the Committee came to consider two other agenda items. Only 14% of project and programme expenditures financed from extrabudgetary funds were allocated to programme support. Technical cooperation programmes however required 21% on average for programme support. The regular budget therefore supported extrabudgetary activities to the extent of the difference, although such extrabudgetary activities represented an invaluable support to regular budget programmes. It was important that no waivers or reductions in respect of programme support costs should be permitted. The Director-General would welcome the support of all governments in that regard.

Attention had been drawn to the smallness of the sums entered under the Special Account for Operation of Concessions at Headquarters. In a report which had been submitted to the Executive Board several years earlier, the Joint Inspection Unit had pointed out that WHO obtained more from such concessions than other agencies. Fees to concessionaires were reviewed on a continuing basis; for example, the rent paid by the bank in the headquarters building was revised upwards every three years.

Mr COLLENS (External Auditor's office), referring to the request of the delegate of France for information on the effectiveness of the controls exercised over grants, said that he was concerned at the irregularities which had taken place but would prefer to await the result of the Organization's investigation before commenting further.

The delegate of Italy had inquired whether the cases in two regions where project implementation had been adversely affected were isolated or were symptomatic of more widespread failings. When carrying out an audit, the auditor looked for signs that things might be going wrong and then went into details. The cases in question did not seem to be isolated. The External Auditor was trying to identify areas where difficulties might arise and to draw lessons from them which could be applied generally so that management could be improved.

Mr FURTH (Assistant Director-General), replying to the delegate of Egypt who had asked why cash at banks, in transit and on hand had increased from slightly over $4 million at the end of 1979 to more than $12 million by the end of 1980, said that the increase was due to the fact that one large contributor to the regular budget had paid a significant proportion of its contribution for 1980 only in the last few days of that year.

The delegate of the United States had asked for an explanation of the negative balances shown by certain trust funds. In most cases the reason had been that, at the end of the year, WHO had spent more than it had received in the form of advances from the agencies concerned and, in the case of the Special Programme for Research and Training in Tropical Diseases, from the World Bank. The balance would have been made up early in the following year. In the cases of the negative income figures shown under the United Nations Fund for Drug Abuse Control and the United Nations Emergency Operation, the advances made by the Funds in 1979 had been too large and had therefore been reimbursed in 1980; subsequent advances had not reached WHO before 31 December 1980. Therefore these negative balance and income figures had no impact whatsoever on regular budget operations.

Mr BOYER (United States of America) asked whether the Organization would normally have on hand an amount as large as $184 million. Perhaps a portion of such funds could be used elsewhere.

Mr FURTH (Assistant Director-General) said that details of cash, deposits and securities were given on page 9 of document A34/9. The uses of the funds detailed were unfortunately not interchangeable, as there were very specific limitations and constraints on each of them. Added together they represented a considerable sum that might be larger or smaller at other periods during the biennium, but nevertheless the Organization was often short of cash for specific purposes.

The draft resolution contained in paragraph 5 of document A34/30 was approved.  

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA34.1.
Mr FURTH (Assistant Director-General) said that at 30 April 1981, total collections of 1981 contributions in respect of the effective working budget had amounted to US$ 61 151 369, representing 28.4% of the assessments on the Members concerned (compared with 33.9% at the same date in 1980). Since the issue of document A34/10, partial or full payments totalling $ 30 257 615 had been received from 13 Members (Albania, Argentina, Bulgaria, China, German Democratic Republic, Guyana, Ireland, Israel, Japan, Liberia, Switzerland, Thailand and Yemen), raising the proportion of 1981 contributions collected to 42.4% at 1 May 1981 (compared with 43.1% as at 13 May 1980). In addition, since 30 April, payments totalling $ 197 469 in respect of arrears of contributions had been received from seven Members (Democratic Yemen, Haiti, Ireland, Liberia, Nicaragua, Sierra Leone and Yemen).

The draft resolution contained in paragraph 5 of document A34/10, with the inclusion of the date of 12 May 1981 in operative paragraph 1, was approved.

Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution: Item 26.3 of the Agenda (Document EB67/1981/REC/1, resolution EB67.R24 and decision EB67/r); Document A34/31)

Dr MORK (representative of the Executive Board), introducing document A34/31, said that at 28 April 1981 five Members had been in the position whereby the provisions of Article 7 could be invoked but by the time of meeting of the Committee to Consider Certain Financial Matters prior to the Thirty-fourth World Health Assembly, one of them - Sierra Leone - had arranged for an additional payment sufficient to remove it from the Committee's consideration.

The Committee had reviewed the action taken by the Director-General in his attempts to arrange for settlement of the arrears of the four remaining Members, and had requested him to communicate with them by cable on behalf of the Board, urging prompt payment of arrears, or information on their plans to regularize their position, by 11 May 1981. The Committee recommended to the Health Assembly that the four Members should be urged to regularize their position but that meanwhile they should retain their voting rights at the Thirty-fourth World Health Assembly.

Mr FURTH (Assistant Director-General) said that, in accordance with the Committee's request, the Director-General had on 4 May 1981 sent cables to the Central African Republic, Grenada, and Mali, urging them to make payment or to provide the requested information by 11 May. It had not been possible to transmit the cable prepared for Chad since all postal and telegraphic communications with that country continued to be suspended.

No payments had been received from the Members concerned. The Secretariat had however been advised by the WHO national programme coordinator in Mali that the Government had made arrangements to transfer to WHO the equivalent of US$ 78 000, which amount exceeded the sum of $ 69 113 due from Mali in respect of prior years' arrears. The amount in question had not yet been received by the Organization. In addition, a cable had just been received from the Ministry of Health of the Central African Republic informing the Director-General that a banking transfer equivalent to US$ 34 952.88 had been made on 11 or 12 May 1981.

Dr KONARÉ (Mali) confirmed that his country was committed to making payment in respect of arrears. If the amount in question had not already been received, immediate steps would be taken to ensure transfer of the sum.

The draft resolution contained in paragraph 8 of document A34/31 was approved.2

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA34.2.

2 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA34.3.

Dr MORK (representative of the Executive Board) said that, in the course of its review of the proposed programme budget for the financial period 1982-1983, the Executive Board had examined two aspects of the casual income estimated by the Director-General to be available for assisting in financing the programme budget. In the first place, the Director-General had proposed that an amount of $12,000,000 of available casual income should be so used for the 1982-1983 programme budget. (A preliminary estimate had put the amount of casual income available on 31 December 1980 at approximately $23,000,000, of which the Board had recommended the appropriation of a little over $2 million to the Real Estate Fund). The Director-General's proposal had represented a significant increase over the amounts appropriated for previous programme budgets by the Health Assembly. Inasmuch as sufficient casual income appeared to be available, the Board had endorsed the proposal, which would have the effect of reducing assessed contributions from Members.

The Director-General had also reviewed the use of casual income to meet possible adverse effects of currency fluctuations on the programme budget. In spite of the difficulty of forecasting movements in the rate of exchange between the Swiss franc and the US dollar for as much as three years ahead, the availability of casual income for that purpose would make it possible to implement the approved programme budget for 1982-1983 even if the value of the US dollar in relation to the Swiss franc fell below the budgetary rate of exchange. If, on the other hand, the average accounting rate for 1982-1983 was higher than the budgetary rate of exchange, the resulting surplus would be credited at the end of the financial period to casual income and would again become available for use by the Health Assembly. The Board had concurred that in respect of the financial period 1982-1983 the Director-General should again be granted the facility of using casual income up to an amount of $15,000,000 in order to cope with any differences between the budgetary rate of 1.63 Swiss francs per US dollar and the monthly accounting rate.

However, in the light of developments since the sixty-seventh session of the Board, the Director-General had made revised proposals both as regards the use of casual income and the budgetary rate of exchange. These were contained in document A34/11.1

Mr FURTH (Assistant Director-General), introducing document A34/11, said that the main budgetary and financial data used in the preparation of the budget document had been those available in October 1980, when the document had been sent to the printer and when the accounting rate of exchange for the Swiss franc had been 1.63 per US dollar for the fourth consecutive month. Although the rate had risen to 1.71 Swiss francs per US dollar in November and December, by the time the Executive Board met in January 1981 the situation had not significantly changed. Subsequently, however, and particularly from the latter part of January, the dollar had strengthened considerably, moving into a range of 1.90 to 2.05 Swiss francs per US dollar. It had therefore been considered necessary to review the earlier proposals. With regard to the availability of casual income, the actual amount after closure of the 1980 interim accounts had been $26,461,296, as compared with the earlier estimate of $23,036,749 reported to the Executive Board in January 1981. The Board had recommended the appropriation of some $2,000,000 for the Real Estate Fund and $12,000,000 to help finance the proposed 1982-1983 programme budget, which would leave a total of some $12.4 million as an unappropriated balance. However, in view of recent developments in the US dollar/Swiss franc exchange rate, it no longer appeared necessary to maintain in 1981 an unappropriated balance of casual income to protect the Organization's current programme against what had become an unlikely possibility that the average accounting rate of exchange for the current biennium would be lower than the budgetary rate of exchange (Sw.fr. 1.55 per US$) used in the 1980-1981 budget. Indeed, as the accounting rate had so far been continuously higher than the budgetary rate, it seemed almost certain that a budget surplus would arise at the end of the current biennium and could be translated into casual income to the extent that assessed contributions for 1980-1981 were collected as planned. Consequently, the Director-General was proposing that an additional amount of casual income available as at 31 December 1980 should be appropriated to help finance the programme budget for 1982-1983, bringing the total amount of casual income to be appropriated for that purpose to $24.4 million, i.e., virtually all the casual income available after the requirements of the Real Estate Fund had been met.

1 See document WHA34/1981/REC/1, Annex 1.
The Director-General had also reconsidered the budgetary rate of 1.63 Swiss francs per US dollar used in preparing the proposed 1982-1983 budget. It had been the accounting rate of exchange prevailing from July to October 1980 and, although it was impossible accurately to forecast the average rate during 1982 and 1983, the recent rise in the value of the US dollar in relation to the Swiss franc had been so significant that some adjustment in the budgetary rate might be considered appropriate. It did not appear to the Director-General that the April or May accounting rates of respectively 1.91 and 2.02 Swiss francs per US dollar should be applied to a programme covering a two-year period that was likely to see substantial changes in the US dollar/Swiss franc relationship. The manner in which the Director-General had arrived at his proposal that the budgetary rate for 1982-1983 should be adjusted from 1.63 to 1.78 Swiss francs per US dollar was outlined in document A34/11, paragraph 10. Assuming that over the remaining seven months of 1981 the average accounting rate of exchange remained at the level of the April rate (Sw.fr. 1.91 per US$), the average accounting rate of exchange for the whole financial period 1980-1981 would become 1.78 Swiss francs per US dollar and thus the budgetary rate for 1982-1983 would be based on that hypothetical average rate for 1980-1981.

The use of a rate of 1.78 Swiss francs per US dollar for 1982-1983 would not appear to be imprudent, particularly if the Health Assembly combined the upward adjustment of that rate with an increase in the casual income facility which the Director-General could use to meet fluctuations in the rate of exchange. As was stated in document A34/11, paragraph 11, the Executive Board had proposed that the Health Assembly should again authorize the Director-General to use up to $15,000,000 from available casual income to meet any needs under the regular programme budget which might arise from differences between the budgetary rate of exchange and the accounting rates of exchange prevailing during the financial period 1982-1983. However, as a result of an adjustment of the budgetary rate of exchange to 1.78 Swiss francs per US dollar, a situation might arise whereby $15,000,000 might not be sufficient to protect the Organization's programme. The Director-General was therefore proposing that, concurrently with an increase in the budgetary rate of exchange, the maximum amount of casual income which he would be authorized to use for that purpose should be increased from $15,000,000 to $20,000,000 during the biennium 1982-1983. Naturally, should the average of the accounting rates of exchange during 1982-1983 exceed the revised budgetary rate of exchange of 1.78 Swiss francs per US dollar, the amount of net savings to be transferred from the regular budget to casual income could also be as much as $20,000,000. Whereas a facility of $15,000,000 with a budgetary rate of exchange of 1.63 Swiss francs per US dollar, as originally proposed, would have protected the Organization's programme even if the average rate of exchange in 1982-1983 turned out to be as low as 1.46 Swiss francs per US dollar, increasing the budgetary rate of exchange to 1.78 Swiss francs per US dollar, and at the same time increasing the casual income facility to $20,000,000, would offer protection down to an average accounting rate of exchange of only 1.52 Swiss francs per US dollar. It would also guarantee that as much as $20,000,000 would be saved from the regular budget and returned to Members in the form of casual income if the average accounting rate of exchange during the biennium should turn out to be 2.10 Swiss francs per US dollar or more.

Lastly, the arrangements proposed by the Director-General would be advantageous to Member States for two reasons: (1) the effective working budget would be reduced from $484,300,000 to $473,629,400, representing an increase over the effective working budget for the current financial period of 10.8% as compared with 13.3% under the original proposal; and (2) to increase the appropriation of casual income for the regular budget by $12.4 million to a total of $24.4 million would have the effect of further reducing Member States' assessed contributions to the effective working budget. Consequently, the increase in assessed contributions for the period 1982-1983 over the period 1980-1981 would be only 5.14%, whereas the earlier proposals would have involved an increase in those contributions of 10.6%.

Although the immediate financial advantages for Member States would not be insignificant, it might not be possible to make available the same large amounts of casual income to help finance the programme budget for 1984-1985. That would have the effect of increasing assessed contributions for that period even if the effective working budget level remained the same as in 1982-1983. In addition, there was no certainty that the budgetary rate of exchange of 1.78 Swiss francs per US dollar would be appropriate for 1984-1985; should it be lower than 1.78, it would lead to an automatic cost increase, a higher effective working budget, and ultimately higher assessments than in 1982-1983. However, although those risks should not be ignored, the Director-General felt that the changes presented in document A34/11 represented a balanced package of revised financial proposals which would pass on immediately to Member States the financial benefits which had come within the reach of the Organization, while being at the same time prudent enough to protect the Organization's programme for 1982-1983.
The CHAIRMAN observed that the item under discussion appeared to revolve around three issues: (1) the amount of casual income to be used to help finance the budget for 1982-1983, (2) the rate of exchange to be applied to the programme budget for that biennium and (3) the casual income facility to be granted to the Director-General to meet fluctuations in the exchange rate during 1982-1983.

He invited comments on the amount of casual income to be used to help finance the 1982-1983 budget.

Mr BOYER (United States of America) said that his delegation welcomed the proposal to use a substantial amount of additional casual income, which would have the effect of reducing the assessments of all Member States. WHO appeared to be the only United Nations agency willing to use casual funds for this purpose. The possibility of cutting the effective working budget of the Organization by US$ 24.4 million was a tribute to the financial management of the Secretariat.

Mr ABBASSI TEHRANI (Iran) said that his country's assessed contribution for 1982-1983, as indicated in document A34/11, Annex 3, was based on incorrect figures regarding Iran's per capita income and gross national product which had been submitted by the pre-revolutionary regime. The economic difficulties and national disasters that had followed the Islamic Revolution, together with the war that had been imposed on the country, had reduced economic activity to a level where Iran could no longer meet the proposed United Nations rate of assessment. His delegation therefore requested a general review of its country's assessment for 1982-1983.

The CHAIRMAN said that the remarks of the delegate of Iran would be taken into account when the scale of assessments was being considered.

If there were no further observations, he would take it that the Committee agreed to recommend to Committee A that a sum of $24.4 million of casual income should be used to help finance the budget for 1982-1983.

It was so agreed.

The CHAIRMAN invited comments on the budgetary rate of exchange between the US dollar and the Swiss franc to be used for 1982-1983.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that, in view of the difficulties which had been encountered as a result of adverse exchange rates in previous years, WHO should be prudent in fixing the rate of exchange for its 1982-1983 programme budget. His delegation therefore supported the Director-General's proposal that the rate be fixed at 1.78 Swiss francs per US dollar.

Dr ZIESE (Federal Republic of Germany), while agreeing that the rate of 1.63 Swiss francs per US dollar that had originally been set was far too low, felt that to increase the rate merely to 1.78 Swiss francs was insufficient. The budgetary rate for 1982-1983 should be based on the current rate of exchange, which stood at more than 2 Swiss francs per US dollar.

Mr BOYER (United States of America), agreed with the views expressed by the previous speaker and advocated that the budget should be calculated at the official United Nations exchange rate for May 1981 of 2.02 Swiss francs per US dollar. Although there was an obvious need to protect the Organization against currency losses, it seemed altogether excessive to propose that its programme budget should, by virtue of the $20 million casual income facility described by the Assistant Director-General, be protected against a decline from the correct current exchange rate of 2.07 Swiss francs per US dollar to a figure as low as 1.52 Swiss francs.

The United States delegation therefore proposed that the Committee should recommend to Committee A that the budget be calculated at the official United Nations rate for May 1981 of 2.02 Swiss francs per US dollar, thereby saving Member States a total of some $15 million in contributions.

Professor VANNUGLI (Italy) said that a perennial problem in the recent past had been how to cope with the combined effects of a decline in the value of the dollar and inflation. With the dollar now steadily rising in value, the situation had radically changed and the
Organization could look forward to carrying out its work without any major financial difficulties. However, the rise in value of the dollar as against the Swiss franc and other currencies meant that the contributions of Member States would be correspondingly higher. While the Organization might protect itself against a possible decline in the exchange rate by setting aside a certain portion of available casual income for the purpose, he wished to know what measures were being taken to protect Member States in the event of a continuing and substantial rise.

Mr WIDDOWS (Australia) associated his delegation with the suggestion of the delegates of the Federal Republic of Germany and the United States of America that a more equitable and appropriate exchange rate would be that prevailing during the month the budget was adopted, a system which was already being used by other international organizations. He therefore supported the United States proposal that the proposed programme budget should be recalculated at that rate, bearing in mind a casual income facility of $20 million.

Mr NYGREN (Sweden) said that, although his delegation was prepared to support the revised exchange rate proposed by the Director-General, it would prefer a rate much closer to the current figure of more than two Swiss francs per US dollar. Six months ago, the General Conference of UNESCO had settled upon an exchange rate very close to that prevailing at the time of adoption of its budget; that appeared to be a practical way of fixing the rate which avoided controversial debate, although he was fully aware of the differences in budgetary systems between the various organizations. His Government was of the opinion that there should be objective, precise criteria for setting the exchange rate for the 1982-1983 budgetary period. It would accordingly be approaching the United Nations Advisory Committee on Administrative and Budgetary Questions with a view to discussing the feasibility of devising a scheme which could be uniformly applied to all United Nations organizations.

Mr VAN KESTEREN (Netherlands) said that his delegation supported the proposals contained in document A34/11. However, in view of the objections raised by certain speakers, and since few things were as unpredictable as exchange rates, some adjustments might be made in the light of recent developments. Consequently, he suggested that the period over which the hypothetical average rate of 1.78 Swiss francs per US dollar had been calculated might be extended to include May 1981, so as to give an average rate of 1.83 or 1.84 Swiss francs. To overcome the difficulties of certain delegations, the figures for the 1982-1983 programme budget might be modified accordingly.

Mr LO (Senegal) said that a proposal to raise the exchange rate from 1.78 to 2.02 Swiss francs per US dollar was liable to place small countries in a highly unfavourable position, as it might result both in a reduction in the quantity and volume of WHO projects and in an increase in contributions. The victims of such a proposal would be the same countries as always and his delegation could not go along with it.

There were various possible solutions to the problem. One was the suggestion mooted by his own delegation in the past, namely that a currency loss account be created under the regular budget, funded by a fixed subsidy or by surpluses accruing from favourable exchange rates.

The meeting rose at 12h35.
THIRD MEETING
Tuesday, 12 May 1981, at 14h30

Chairman: Dr Z. M. DLAMINI (Swaziland)

1. REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION: Item 26 of the Agenda (continued)

Report on casual income and budgetary rate of exchange between the US dollar and the
Swiss franc for 1982-1983: Item 26.4 of the Agenda (Document EB67/1981/REC/1,
resolution EB67.R5 and Annex 2; Document EB67/1981/REC/3, Chapter III, paras 205-207;
Document A34/11) (continued)

Dr GALAHOV (Union of Soviet Socialist Republics) welcomed the recalculation of the
proposed budget estimates for 1982-1983 in document A34/11, on the basis of an exchange rate
of 1.78 Swiss francs to the US dollar. Taking that change a step further, he proposed that
the exchange rate to be applied to the budget should be that prevailing at the time of its
adoption. An upward adjustment of the budgetary exchange rate appeared fully justified.

Mr NAKAMURA (Japan) welcomed the proposal to increase the amount of casual income which
the Director-General was authorized to use to counter exchange rate fluctuations from
US$ 15 million to US$ 20 million. He supported the proposal made by the United States
delagate as to the budgetary exchange rate.

Mr JEANRENAUD (Switzerland) said that there was no doubt that the exchange rate of
1.63 Swiss francs to the US dollar which had been used in calculating Swiss franc expenditure
in the 1982-1983 budget was too low. The Director-General had therefore been well advised
to recalculate the budget on the basis of another rate. It was somewhat artificial to opt
for the rate on a particular day, since fluctuations in the exchange rate between the
US dollar and Swiss franc were unpredictable. It was therefore preferable to use an average
rate over the entire biennium. In principle, therefore, Switzerland supported the exchange
rate of 1.78 chosen by the Director-General. In view of the subsequent further rise in the
dollar exchange rate, however, his delegation had been interested by the Netherlands proposal
to determine the rate for the 1982-1983 budget by taking into account a rate of 2.02 or 2.06
for the remaining months of the current biennium instead of the rate of 1.91 mentioned in
paragraph 10 of the Director-General’s report.

Dr HOUÉNASSOU-HOUANGBÉ (Togo) agreed that the Director-General’s report analysed the
situation clearly. In the area of currency fluctuation prediction was impossible. The
report had even made mention of an exchange rate of 1.85 Swiss francs to the US dollar.
Paragraph 8 of the report showed exchange rates from November 1980 to April 1981. The
average of those rates came to about 1.80 or 1.81, and he therefore suggested that the
exchange rate be kept at 1.78 as the report proposed, or at least somewhere between 1.78
and 1.85.

Dr BROYELLE (France) welcomed the favourable exchange rate position with regard to the
WHO budget. As to the rate to be selected, the point was closely linked to the upper limit
for casual income which the Director-General was authorized to use to counteract dollar
exchange rate fluctuations. Her delegation would support the proposal to adopt an exchange
rate of 2.02 on condition that the proposal to increase the casual income facility of
US$ 15 million to US$ 20 million was also adopted, so that there would be a wider margin of
security against possibly larger currency fluctuations. On the other hand, if the rate of
1.78 was chosen, rather than 2.02, it did not seem useful to raise the casual income ceiling,
since the fluctuations would be considerably reduced and the situation could always be remedied the following year. Her delegation therefore favoured the rate of 2.02, provided that the casual income facility was increased to US$ 20 million.

Dr SEBINA (Botswana) recalled that the United States delegate had mentioned that WHO was unique among United Nations agencies in using casual income towards regular budget expenditure, thereby reducing the contributions of Member States. He therefore did not support the proposal to use the same exchange rate as other United Nations agencies which were not comparable to WHO. If the US dollar continued at its present level of 2.04 or 2.02, which was apparently the rate that was being applied elsewhere, his delegation found no difficulty in that: it meant that more casual income would accrue to the Organization, as had already happened, and that in the next year or so, instead of applying US$ 24 400 000 towards the regular budget, the Organization might find itself applying US$ 30-40 million, and so reducing the contributions of Member States. He therefore agreed that the rate should be maintained at 1.78 as proposed by the Director-General, since whatever happened the Organization would benefit. He also agreed with regard to the casual income facility, since if more income accrued it had to be used.

Dr HIDDLESTONE (New Zealand) acknowledged the effective custody and efficient planning of the Director-General and the Secretariat and expressed support for the recommended budgetary rate of exchange of 1.78. The United States delegate had referred to the "correct" rate, but such a term could hardly be applied to indefinite prophecy. The proposal of the United States delegate related to the month of May, which seemed an apt name for the month concerned, since it implied possibility but not certainty. In supporting the rate recommended by the Director-General he also supported the delegate of Switzerland in requesting the Secretariat to consider an additional modification of the rate as suggested by the Netherlands delegate.

Mr VOHRA (India) was more than a little surprised: not long ago the dollar had been falling and the Organization had been very worried; recently the dollar had been rising, yet the Organization again seemed to be worried. He had thought that there would be an air of jubilation in the Committee, and not anxiety. In developing countries the principles of budgeting were normally based on two main considerations: even in the poorest conditions, budgeting meant organizing through appropriate fiscal means a situation permitting a forward movement in developmental efforts, yet without creating unbearable burdens. He would have expected any protests to come from the less affluent and the needy; but now there was a surplus arising from past wisdom and from following correct budgetary principles. Any budgetary principle that unnecessarily created uncertainty or that called for repeated supplementary budgets was no budget at all, and his delegation would not vote for it. Therefore, considering what had been faced in the past and in the light of the present situation, he thought it best to stick to what had proved to be wisdom and adopt the compromise proposals of the Director-General. If the dollar continued to rise, as he thought likely, it would only mean further surpluses in the years to come. He totally supported the proposals in the Director-General's report.

Dr FERREIRA (Mozambique) supported the proposal in the Director-General's report to adopt an exchange rate of 1.78. To adopt an exchange rate of 2.02, as some delegations had proposed, might be a costly adventure, leaving the Organization short of funds to carry out its programme.

Mrs EMANUEL (Nigeria) commended the Director-General's report. She had noted that while some countries had recommended that the current exchange rate of 2.02 be adopted, and others had made similar proposals, the unpredictability of the exchange rate had been acknowledged by all. Her delegation therefore shared the cautious approach of the Secretariat, and supported the adoption of the rate of 1.78.

Mr KAKOMA (Zambia) expressed his delegation's support for the exchange rate of 1.78 proposed by the Director-General. He very much feared that if a higher rate were adopted it would have adverse effects on poor countries such as Zambia, which would not benefit as much as they did at present from the Organization's programme.

Professor SADELER (Benin) thanked the Secretariat for its clear explanations regarding the budgetary rate of exchange for 1982-1983. Since most developing countries suffered a
deterioration in terms of trade when the monetary snake became disturbed, his delegation supported the proposal for a rate of 1.78 Swiss francs to the US dollar. No one could predict the currency fluctuations in the six months to come, much less over the next 12 months. That was all the more reason to support the rate of 1.78, which had been based on the average of recent rates.

Dr PLIANBANGCHANG (Thailand) joined other delegations in supporting the Director-General's proposal to use an exchange rate of 1.78 Swiss francs per US dollar in calculating the 1982-1983 budget.

Dr LAW (Canada) thought that whatever rate of exchange was adopted, its adoption would involve elements of arbitrary decision-making. There had been several proposals: the exchange rate at the time of budget preparation, the rate at the time of adoption of the budget, and some variations on an exchange rate that would reflect averaging over time. Because the decision tended to be arbitrary, she leaned towards the solution proposed by the Director-General, which took account of a possible trend rather than of a point in time. She would therefore support the recommendation of 1.78 or, better still, the alternative suggested by some delegations which would take into account the exchange rate for the month of May. Her delegation could live with the United States suggestion for a rate of 2.02, but it preferred the option of the Director-General for exchange rates over a period of time. She stressed the need pointed out by the Swedish delegate at the previous meeting for some criteria on which the setting of the exchange rate could be based in future years, so that the debate would not be repeated every year. Some standardization of approach within the United Nations system should be obtained.

Professor HALEEM (Bangladesh) supported the proposal to set the Swiss franc rate for the dollar at 1.78 because he felt that if a deficit arose the burden would fall on the poorer countries of the world. He would accept the United States proposal provided that if a deficit arose it would be borne by the developed countries and not by the developing countries. In any case, he noted that the Director-General had taken into account the ascending trend of the US dollar and had accordingly proposed increasing the rate from 1.63 to 1.78, and his Government would support that rate.

Mr FURTH (Assistant Director-General) agreed with the Swedish delegate that everyone would be more comfortable if there were objective, precise criteria for determining an appropriate budgetary exchange rate. However, he pointed out that WHO had had such a criterion. It had been that the budgetary rate should be the actual accounting rate of exchange when the budget was being finalized: in the present case that was 1.63 Swiss francs per US dollar. The concept had been that, in view of the casual income facility granted to the Director-General, that rate should remain the final budgetary rate and should not later be changed; and that the figures contained in the budget volume for 1982-1983 should remain valid for budget implementation throughout the biennium. According to the concept, if the budgetary rate turned out to be too high it would not matter, since the Director-General could use casual income to make up the shortfall, as he had had to do in 1979 to the tune of some US$ 11 million; and if the rate were too low, that would not matter either, since the Director-General would return the excess funds to governments in the form of a budgetary surplus. But concepts, no matter how good, sometimes did not pass the test of real-life situations. By April of the current year the difference between the budgetary rate of 1.63 Swiss francs per US dollar and the actual exchange rate had become so large that the Director-General had thought, quite correctly it seemed, that most Members would feel that there should be a more reasonable relationship between the budgetary rate of exchange and the current exchange rate.

He agreed with the Swedish and Canadian delegates that in principle it would be very comfortable if all United Nations organizations could adopt the same methodology in fixing appropriate budgetary rates of exchange. The Swedish delegate had referred approvingly in that connexion to the example of UNESCO, which apparently had adopted, at the UNESCO General Conference in 1980, the most recent accounting rate of exchange with respect to the French franc. But that concept of uniformity also did not stand the test of the real-life situation. Organizations were governed and managed quite differently and lived under different constraints imposed by their respective governing bodies. In organizations such as UNESCO it was very important that the budgetary rate was not fixed too low, because, if the average rate of exchange during the financial period turned out to be higher than the budgetary rate, the Director-General of UNESCO was permitted to spend the resulting gains or
savings, for example to offset inflationary costs which inevitably occurred. Those savings or gains were thus irretrievably lost to Members, as was the case, for example, in the current biennium, during which the dollar had risen far above the main budgetary rates of exchange of most, if not all, international organizations. In WHO, however, those gains or savings resulting from the rise in the exchange value of the United States dollar could not be used by the Director-General; they were returned, with interest, to governments in the form of casual income. Therefore, the paradoxical situation existed for WHO in the current biennium, when the dollar was far above WHO's budgetary rate of exchange and the Director-General was likely to return millions of dollars to governments, that the Organization had a very tight financial situation, because the inflationary rates were far above the rates originally foreseen, in Switzerland and elsewhere, and the Director-General could not use a penny of the currency exchange savings to offset additional costs arising from inflation. It was thus by no means as important to Members of WHO to ensure that the rate was not too low; on the contrary, in WHO the real risk for governments was that the budgetary rate might be too high, in which case casual income had to be used to protect the programme, as had been done in 1979, instead of helping to finance the regular budget and thus reduce assessments.

The real problem therefore seemed to be to decide what was a reasonable budgetary exchange rate in the actual circumstances prevailing at the moment or, as had been stated by Mr Boyer, how much protection was required by WHO. He was sure that the delegates would bear in mind that the question affected the financial health and security of a global health programme of nearly US$ 500 million for the biennium, which, most Committee members would agree, was very important, if not essential, in furthering the health and social policies of the Member States, and that therefore the Director-General could not take any undue risks in implementing that programme. As the chief technical and administrative officer of the Organization, the Director-General was duly bound to ensure that his proposed programme budget reflected and was based on financially prudent policies.

It seemed to him very difficult to maintain that the adoption of the current accounting rate of exchange for the month of May 1981, which was 2.02 Swiss francs per US dollar, would be financially prudent. It happened to be the highest accounting rate of exchange reached in the past three and a half years, in other words, since December 1977. Only the past month the rate had been 1.91 Swiss francs per US dollar, or 11 centimes lower than that of the current month. Only five months ago, in January, it had been 1.76 Swiss francs per dollar, or 26 centimes lower than today; and in October 1980, when the proposed programme was being finalized, it had been 1.63 Swiss francs per US dollar, or nearly 20% lower than the present month. What was the reason for this truly dramatic rise in the value of the US dollar in so short a period? By far the main reason had been the surge of interest rates in the United States to historic heights. The differences between interest rates for the US dollar and those for other main convertible currencies was now so large that billions and billions of whatever currency one might name were being drawn towards the dollar, thus raising its exchange value. The correlation between the rise or fall in the exchange value of the US dollar in relation to the Swiss franc was truly astounding, and could be verified on an almost daily basis. The rise or fall of one half per cent. in the United States prime rate (the interest rate charged by banks to their most credit-worthy customers) immediately resulted in a rise or fall of the exchange value of the dollar in relation to the Swiss franc by about six to ten centimes. For example, in February and March of the current year, when the US interest rates appeared to begin to fall slightly, the daily market rate of exchange fell steadily from 2.06 Swiss francs per US dollar on 16 February to 1.85 Swiss francs per US dollar on 19 March - a drop of 21 centimes in just over a month. That, of course, could happen again, during the current month, the next month, or later, and on a more permanent basis.

Interest rates had not always been the main factor influencing the movement of exchange rates: other economic factors and certain political events could have a fundamental impact on them. However, whatever the cause of the movement of exchange rates, experience over the past 10 years had been that the value of the dollar tended to be stable or even to increase substantially for periods as long as six months to a year, to be followed by equally long periods during which it fell significantly. He outlined the sharp fluctuations in the dollar-Swiss franc exchange rate over the past three years, which suggested that the sharp rise in the value of the dollar in the last seven months should not in itself be a firm basis for optimism about the future trend of exchange rates.

In view of the continuing volatility and unpredictability of exchange rates, many Committee members agreed with the Director-General that it would not be prudent to adopt the latest exchange rate, which happened to be the highest exchange rate in several years, as the budgetary rate for 1982-1983. Some of the same Committee members, however, appeared to
suggest that the Director-General was being too financially conservative in proposing a budgetary rate of 1.78 Swiss francs per US dollar. The reasons underlying that proposal were given in document A34/11, paragraph 10, and he stressed that it was based on the factual experience of the past and on certain reasonable assumptions as to the future.

As regards the past, it should be recalled that the previous year's average exchange rate had been only 1.67 Swiss francs per US dollar, although the accounting rate of exchange in April 1980 had been 1.85 Swiss francs per US dollar. In 1979, the average rate had been 1.66 Swiss francs per US dollar, and in 1978, despite very high accounting rates of exchange during the first half of the year (2.01 Swiss francs per US dollar in January and 1.93 Swiss francs per US dollar at the time of the World Health Assembly), the average rate for the year had been only 1.80 Swiss francs per US dollar. Even taking account of the current high rate of 2.02, the average of the accounting rates of exchange during the first 17 months of the financial period 1980-1981 had been 1.74 and thus it had not yet even reached the proposed rate of 1.78 Swiss francs per US dollar. Even if the average of the accounting rates of exchange during the remaining seven months of the financial period were to be as high as the current rate, i.e., 2.02 Swiss francs per US dollar, the average for the whole financial period 1980-1981 would be only 1.82, a shade more than the rate proposed by the Director-General. Looking at those assumptions, which must be considered extremely optimistic, he could not believe that the Director-General was being too prudent; on the contrary, he was taking a calculated, but not insignificant, risk in proposing an average of 1.78 for a financial period which would begin more than seven months from today and which would last for two whole years.

He understood very well that certain delegates were pressing for the adoption of the current rate of 2.02 as the budgetary rate of exchange for 1982-83. The adoption of such a rate would result in a further reduction in the proposed effective working budget of about US$ 15 million. And, it was argued, if actual rates of exchange in 1982-1983 should be below 2.02, the Director-General could always make up the shortfall by using casual income up to the maximum authorized amount of US$ 15 million or US$ 20 million.

In his view, to take such a position would be rather short-sighted and not in the best financial interests of the governments concerned. Apart from the fact that a budgetary rate of 2.02, even combined with the casual income facility of US$ 15 million or US$ 20 million, might not offer sufficient protection to the Organization's programme against the adverse effects of a possibly very sharp decline in the exchange value of the US dollar, he believed that it would be much more advantageous for governments to adopt a rate of 1.78, which might later turn out to have been too low, than to adopt a rate of 2.02, which might turn out to have been too high.

To illustrate that point, on the assumption that the average of the accounting rates of exchange in 1982-1983 turned out to be 1.90 - namely half the difference between 2.02 and 1.78 - he showed what would happen if the rate of exchange had been set alternatively at 2.02 and 1.78. If the rate were set at 2.02, there would be an initial saving of US$ 15 million resulting from the further reduction of that amount in the proposed effective working budget. However, if the average of the actual accounting rates of exchange during 1982-1983 were lower than the budgetary rate of 2.02, then the Director-General would have to resort to the use of casual income to make up the shortfall caused by the lower exchange rates. In other words, to carry out the programme approved under the regular budget, he would have to spend the entire regular budget plus casual income, the amount of the latter depending on the average exchange rate. If the average of the accounting rates of exchange was 1.90, some US$ 7.4 million of casual income would have to be spent in mitigating the effects of currency fluctuations rather than in helping to finance a future budget. There would thus be an increase in assessments of over US$ 7 million for the next financial period even if the next regular budget showed no growth at all. Moreover, if, as a result of lower actual exchange rates in 1982, the programme budget for 1984-1985, which had to be prepared in 1982, had to be based on a budgetary rate of exchange lower than that of the preceding biennium, there would be a budgetary cost increase even before inflationary cost increases were taken into account.

To return to his specific example, if the budgetary rate for 1982-1983 were set at 2.02, and the budgetary rate for 1983-1985 had to be set at 1.90, there would be another automatic cost increase (i.e., an increase in exchange costs) of some US$ 7-8 million even before inflationary costs were added and even if the programme showed no growth. The net result would be that the apparent initial savings of US$ 15 million would be virtually wiped out, and the programme budget for 1984-1985 would reflect exchange cost increases as well as increases in the assessments of Member States which would have no relationship to the growth, if any, in programme volume. There would thus be a recurrence of the unpleasant situation
which had persisted throughout the 1970s, when budget after budget had to be based on a lower US dollar-Swiss franc budgetary rate of exchange than that of the preceding budget.

In the same set of circumstances, what would happen if the budgetary rate for 1982-1983 were set at 1.78? If the average accounting rate of exchange was 1.90, there would be a budgetary saving of about US$ 7.8 million. In some other international organizations, that saving could be used to offset inflationary cost increases or to expand the programme, as was happening right now, but in WHO the saving had to be returned to Members as a budgetary surplus and thus as casual income, which could be used to reduce assessed contributions for a future budget. Moreover, if the budgetary rate for 1984-1985 had to be set at 1.90, as compared to 1.78 for 1982-1983, there would be a reduction of exchange costs in the 1984-1985 budget of over US$ 7.5 million, which would be used to offset at least part of the inevitable inflationary cost increases. He brought that fact to the particular attention of those governments which had been urging a policy of no budgetary growth. If such a policy should be adopted, it was essential that the Health Assembly should permit the Director-General to manage the Organization financially so that he could implement it and should not take decisions on exchange rates that would make such implementation impossible.

He hoped that he had demonstrated that, although some governments favoured the idea of making immediate savings by adopting a budgetary rate higher than that proposed by the Director-General, that was a short-sighted approach. The impact of the budgetary exchange rate on subsequent programme budgets must be taken into account, and consideration of the rate in isolation from budgetary and financial management policies was rather meaningless. The setting of the rate was but one component of the complex budgetary and financial management policies adopted by the Director-General in order to keep the Organization on an even keel during rather turbulent economic times. Discussion of those policies would raise interesting questions such as: how the Organization in the last decade had been able to show the lowest budgetary growth and the lowest growth in Members' assessments of any major international organization while still maintaining a respectable growth in programme volume; how the Director-General had been able to reduce the regular budget headquarters component by over 300 posts, resulting in a transfer of over US$ 40 million (at 1977 prices) to regional and country programmes without too drastically affecting the efficiency of headquarters; how the Organization alone among all international organizations had been able to return to Member States in 1981 casual income amounting to over $ 24 million; how the Director-General, at a time when most countries' inflationary rates were in two figures, had been able to prepare a programme budget for 1982-1983 reflecting an inflationary cost increase of only 6% per year; and how the Organization had been able in recent years to avoid requesting supplementary budgets for inflationary cost increases or the effects of currency fluctuations when virtually all other major organizations in the United Nations system had done so. If those budgetary policies, of which the setting of the budgetary rate of exchange was only one component, had not proved satisfactory, they should be reviewed and changed as a whole. On the other hand, if they had proved their worth they should be maintained as a whole and it would be unwise to risk impairing their smooth implementation by making a drastic change in one component.

The CHAIRMAN said that it appeared that in general the Committee was in favour of the Director-General's proposed rate of 1.78. He asked whether the Committee agreed to recommend that figure to Committee A.

Mr BOYER (United States of America) said that his delegation had earlier proposed recommending to Committee A that the budget be recalculated at the rate of 2.02, which was the official accounting rate of exchange for May 1981. Despite the explanations given by the Assistant Director-General, his delegation continued to believe that that would be a prudent course of action. Recalculation of the budget at the 2.02 rate would not cut into the content of programmes, as had been suggested by some delegations, and would mean that a saving of some $ 15 million could be shared among all Member States. It had been suggested that if the exchange rate remained low, the amount of casual income earnings for the next biennium would increase. That might well be true, but it was also true that if the rate were raised, that money would become available now. He believed that the proposed casual income facility of $ 15-20 million would protect the Organization against any drop in exchange rates during the next biennium and there was no need to provide double protection. He therefore asked that a vote should be taken on the exchange rate figure to be recommended to Committee A.
Dr ZIESE (Federal Republic of Germany) agreed with the United States delegate's comments. While he understood the arguments advanced by the Assistant Director-General in favour of the 1.78 rate, the latter's calculations were based on the average of rates during 1980 and 1981; if the same calculations were made on the basis of the average of 1981 rates, that would produce the higher figure of 1.90. He might have misunderstood the Assistant Director-General, but he did not consider it true to say that if the actual rate of exchange for 1982-1983 was lower than the rate used in calculating the budget then the amount of casual income used to finance the regular budget would be decreased. His delegation would therefore like a rate nearer the current actual rate to be used for the budget calculations.

Mr NYGREN (Sweden) said that he was fully aware of the complexity of the subject and of the differences between the budgetary processes in the various specialized agencies, but he thought it would be worthwhile to try to achieve some further harmonization of those processes, including the establishment of appropriate exchange rates. However, in view of the arguments advanced by the Assistant Director-General, he found the figure of 1.78 Swiss francs to the US dollar acceptable.

The DIRECTOR-GENERAL said that it had always been his policy to put the financial facts and figures clearly before the Health Assembly. A sacrifice was implicit in every choice but he had attempted to show that there was a reasonable balance in his proposals regarding the use of casual income and the adoption of a lower exchange rate. He stressed that WHO was the only specialized agency which returned to its Member States the profit arising from fluctuations in exchange rates. In his view, it would be somewhat risky to put the budgetary exchange rate up to the current actual rate but, in the interests of a unanimous recommendation by the Committee, he would be prepared to accept the slightly increased risk of raising the proposed exchange rate to 1.82.

Mr BOYER (United States of America) said that his delegation had had no instructions concerning the proposal just made by the Director-General. However, he expressed appreciation of Dr Mahler's efforts to achieve a compromise, and withdrew his delegation's insistence on a vote on an exchange rate of 2.02 Swiss francs to the US dollar, although it would have preferred such a rate. That withdrawal did not, however, preclude his delegation's raising the matter on a later occasion.

Dr GALAHOV (Union of Soviet Socialist Republics) maintained in principle his delegation's previous position, which was that the current actual exchange rate of 2.02 should be used for the budget. However, since many other views had been put forward, including a compromise suggestion by the Director-General, he suggested that no vote be taken, in order to avoid complicating the situation. His delegation would therefore agree with the adoption of a compromise rate of 1.82 Swiss francs to the dollar for the calculation of the budget, which it considered a positive step.

Mr VAN KESTEREN (Netherlands) welcomed the United States delegation's willingness to compromise. He formally proposed that a rate of 1.82 Swiss francs be adopted, this being the average rate between the months of January 1980 and May 1981.

Dr ZIESE (Federal Republic of Germany) also accepted the compromise, so as to preserve the spirit of consensus.

Dr IKENOUCHI (Japan) said that her delegation would have preferred the present exchange rate to be used, but that it would join in accepting the Director-General's compromise proposal.

Mr DAS (India), stressing the importance of a compromise solution, expressed support for the Director-General's proposal, and urged all Members to do their best to find a solution for a problem that created considerable difficulties for WHO.

Dr BOOTH (Australia) thanked the Director-General for his compromise proposal; the Australian delegation was ready to participate in a consensus based on it.

Dr BROYELLE (France) said that, taking into account her earlier statement, her delegation too was prepared to join with other delegations in supporting the Director-General's compromise proposal.
The CHAIRMAN asked the Committee if it was prepared to endorse the exchange rate of 1.82 Swiss francs to the US dollar to be applied to the 1982-1983 programme budget as proposed by the Director-General.

It was so agreed.

The CHAIRMAN then invited the Committee to take up the third issue before it, i.e., the facility to be granted to the Director-General to use available casual income to help offset any adverse effects on the 1982-1983 programme budget that might result from currency fluctuations.

Dr FERREIRA (Mozambique) said that document A34/11 indicated how different rates of exchange would affect the casual income facility to be authorized. With a new, higher exchange rate being accepted, she would welcome information on what amount should be authorized for that facility. Since the proposed exchange rate was now higher, the risk of adverse effects from fluctuations was greater. She therefore asked whether a facility of US$ 20 million would be sufficient to meet contingencies until the end of 1983 or whether the ceiling should be raised.

Mr FURTH (Assistant Director-General) noted that paragraph 12 of document A34/11 explained that a casual income facility of US$ 20 million attached to a budgetary rate of exchange of 1.78 Swiss francs per US dollar would enable the Director-General to cope with an average accounting rate of exchange during 1982-1983 as low as 1.52 Swiss francs per US dollar. A budgetary rate of 1.82 Swiss francs, together with the granting of a casual income facility of US$ 20 million, would allow the Director-General to cope with an average exchange rate in 1982 and 1983 as low as 1.55. The risk was therefore slightly larger, but the Director-General did not consider it to be so significant that a further extension of the casual income facility beyond US$ 20 million was necessary.

Mr BOYER (United States of America), on a point of procedure, asked whether the Committee was about to vote or moving towards a vote.

The CHAIRMAN said that this was not yet the case.

Mr BOYER (United States of America) took the view that, for reasons already discussed, there was more than enough protection available; his delegation would therefore oppose a casual income facility of US$ 20 million.

Dr ZIESE (Federal Republic of Germany) considered that US$ 15 million was enough to cope with an exchange rate even of 2.00 Swiss francs per US dollar, and a fortiori with a rate of 1.82.

Mr FURTH (Assistant Director-General) reminded delegates that the casual income facility not only protected the Organization if the United States dollar were to fall against the Swiss franc, but also protected Member States in case the dollar should rise. If the facility were extended to US$ 20 million, more funds might be returned to Members as casual income in the event that the dollar should rise than with a US$ 15 million facility. For example, if there were a casual income facility of US$ 15 million, and the dollar were to attain an average exchange rate during 1982-1983 of more than 2.07 Swiss francs in 1982-1983, then only US$ 15 million might be returned. If, however, the casual income facility were in the amount of US$ 20 million, and the average exchange rate for the biennium should rise to 2.16, then US$ 20 million could be returned.

Dr GALAHOV (Union of Soviet Socialist Republics) said that in his view the amount of US$ 15 million proposed by the Executive Board to protect the programme budget against exchange rate fluctuations was sufficient. He repeated that in principle his delegation did not believe that the use of casual income reserves was the best way of countering exchange rate fluctuations. It might be better to consider supplementary budget estimates.

The CHAIRMAN noted that, once the Committee had dealt with the issue, the Rapporteur would be asked to draft a resolution which Committee B would consider at a later meeting. He asked whether the Committee was prepared to recommend to the Health Assembly the use of
casual income up to an amount of US$ 20 million to offset the adverse effects of currency fluctuations, as proposed by the Director-General.

Mr BOYER (United States of America) opposed that proposal and called for a vote; his delegation would vote against the proposal.

The CHAIRMAN invited Mr Furth to clarify the procedure.

Mr FURTH (Assistant Director-General) explained that a report would be presented by Committee B to Committee A on the first two issues, i.e., on the amount of casual income to be used to help in the financing of the regular budget for 1982-1983, and on the budgetary rate of exchange between the Swiss franc and the US dollar. The third point, i.e., the amount of the casual income facility, would be included in a draft resolution to be submitted to the plenary Health Assembly. The Chairman might wish to ask the rapporteur to draft such a resolution in the light of the discussions which had taken place in the Committee, and the Committee would later review, consider and approve a draft report of Committee B to Committee A on the first two issues as well as a draft resolution on the third issue.

The CHAIRMAN said that consideration of the three issues under the agenda item was now complete. The Committee would later have an opportunity to consider its draft report to Committee A and the draft resolution to be recommended to the Health Assembly.

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

2. REIMBURSEMENT OF TRAVEL COSTS OF REPRESENTATIVES TO REGIONAL COMMITTEES: Item 27 of the Agenda (Document EB67/1981/REC/1, resolution EB67/R1 and Annex 1)

Dr RIDINGS (representative of the Executive Board), introducing the item, reported that the proposal to reimburse travel costs of a representative from each Member State to attend regional committee sessions had been first made some two years previously, and was detailed in Annex 1 to document EB67/1981/REC/1. The Executive Board's discussion on that subject at its sixty-seventh session was recorded in pages 32-36 and 68-69 of document EB67/1981/REC/2. The proposal had been prompted by the inability of some Member States to send representatives to regional committee sessions because of financial constraints; some Members had sustained financial hardship by sending representatives.

At its session in January 1981, the Executive Board had considered the views of the various regional committees on the proposal, but had found no consensus. Two committees had recommended that travel costs for attendance at regional committee sessions should not be reimbursed, one committee had recommended that the costs should be paid for only one representative of each Member State, and one had recommended that both travel and subsistence costs for one representative from each Member State should be reimbursed. The Committee that had made the original proposal, the Western Pacific Regional Committee, had suggested that the Organization should finance the cost of travel, excluding the per diem allowance, of one representative each from those Member States whose contributions to the regular budget were at the minimum rate in the scale of assessments. The Board had been informed that all costs of regional committee meetings were borne by the regional budgets as there was no other appropriation to which they could be charged.

The Board had decided to recommend to the Health Assembly, in resolution EB67/R1, that it approve payment by the Organization of the actual travel costs, excluding per diem, of one representative to a regional committee session, upon request of a Member or Associate Member whose contribution was at the minimum rate of assessment. If the Health Assembly should approve that recommendation, the Director-General would take it into account in making regional allocations for 1984-1985. Until then, however, expenses must be met from savings in the regions.

Dr POUDAYL (Nepal) said that small countries without resources considered the sessions of the regional committees to be of great importance if they were to derive advantage from WHO as an institution. If small nations were to be truly Members of the Organization, they must first be sure that the necessary funds were available. They were grateful for funds for development made available to them by richer nations, but attendance at regional committee sessions imposed an intolerable financial burden. The richer nations should give due weight
to the question. In spite of what was said at meetings of the Health Assembly countries always gave health the lowest priority. The Organization should therefore provide financial support, in view of the importance for small countries of attendance at regional committee meetings.

Dr ABDULHADI (Libyan Arab Jamahiriya) said that the principle that all Member States should be represented at regional meetings was an important one, in that it helped to reinforce the role played by the Organization and enhanced the regional spirit required for discussion of regional matters. The same could be said of the World Health Assembly. Every Member was entitled to the travel expenses of one delegate, so that as many States as possible might be represented. That was a matter of principle. Commenting on the introduction by the representative of the Executive Board, who had transmitted the views of five regional committees, he pointed out that one region had not been mentioned; it had made no proposals, since the regional committee had not met.

In resolution EB67.R1, the Executive Board suggested that the Thirty-fourth World Health Assembly should approve payment by WHO of the travel costs of one representative of a Member or Associate Member State whose contribution to the budget was at the minimum rate of assessment of 0.01%. The scale of assessments for 1982-1983 indicated that this rate was paid by 61 countries, slightly more than one-third of the membership of the Organization. If that was the case, many Members would be unable to be represented at meetings owing to their inability to pay the travel expenses involved. In view of the decision in resolution WHA30.11 that one delegate or representative from each Member or Associate Member should be reimbursed for travel expenses for attendance at the Health Assembly, and in order to meet the travel expenses of one representative of each Member State at regional committee sessions, he suggested a review of the whole question, including the decision concerning travel expenses for attendance at the Health Assembly, and that an attempt should be made to arrive at a reasonable rate, in order to allow poorer countries to send at least one person each to the various meetings. He suggested that the two procedures be linked and that an attempt be made to find out what expenses were incurred. For example, if a Member State should be assessed at, say, 0.21%, it might ask that expenses be reimbursed for one delegate either at the Health Assembly or at the regional committee. The details could be worked out by WHO's financial staff; in any case, the Organization would not be increasing its expenses, but enabling poorer countries to send representatives to the meetings. The number of Members assessed at less than 0.21% was 101. He believed therefore that the overall travel costs should not greatly exceed what the Organization was currently paying to reimburse the travel expenses of one delegate from each Member regardless of its assessment.

Mr MENALDA VAN SCHOUwenburg (Netherlands), supporting the draft resolution recommended by the Executive Board in resolution EB67.R1, observed that, if it was adopted, it would represent a distinct departure from the reimbursement principle applied to travel expenses for the Health Assembly, for which the travel expenses of one delegate of every delegation attending were paid. That matter should not, however, be reviewed at the current Health Assembly but should be studied by the Executive Board at its next session and by the next World Health Assembly.

Dr HIDDLESTONE (New Zealand) said that the representative of the Executive Board had rightly pointed out that the initiative for the proposal under discussion had come from the Western Pacific Region. When the Board had referred the matter to all regions for further consideration, the concern of the Western Pacific Region had been strengthened. Some of the smaller and newly independent States, in particular, had found that they were sometimes unable to send representatives to the regional meetings, and some of those that had done so had expressed doubts as to their ability to send them regularly. The matter was of intense concern to some Member States and he hoped that the States which considered it of little relevance for them would be generous enough to support the proposal. It was paradoxical that the Member States in greatest need were those least able to afford to attend. Those countries often had problems which required direct discussion with their regional offices and regional director. His delegation therefore sincerely hoped that the draft resolution would be adopted.

It had been urged for some years that WHO should be further decentralized and that the role of the regional committees should assume greater importance. It was therefore logical to do everything possible to ensure that all Member States could take part in regional meetings. A number of the larger, developed and financially secure Member States were rightly looking critically at financial problems. The sums involved in the case under
discussion were small but the benefits were great. He hoped the matter could be settled at the current Health Assembly and he appealed to the Committee to support the draft resolution.

Mr THAN TUN (Burma), supporting the proposal made by the delegate of Nepal, said that, because of various constraints, national organizations in some countries had difficulty in financing the cost of travel of delegates to regional meetings, particularly when frequent travel became necessary. Travel costs should therefore be reimbursed.

Mr VOHRA (India), referring to Table 2 in Annex 1 to document EB67/1981/REC/1, asked how many countries by region came within the minimum assessment rate category. The delegate of Nepal had rightly drawn attention to the problems faced by the smaller and less affluent countries.

The considerations advanced by the New Zealand delegate were pertinent. His delegation urged the Committee to review, at an appropriate time, the principles for reimbursement of travel to the Health Assembly. However, immediate action should be taken on the problems faced by delegations attending regional meetings.

The question of the structure of the Organization and the use to be made of it by Members had been under consideration for some time. It had repeatedly been stated that WHO's future largely depended on how competently and consistently the regional committees assumed their authority and jurisdiction. To enable them to do so, it was essential for all members of all regional committees to be able to attend the sessions, which were, unfortunately, held only once annually. He hoped that a changed attitude would ultimately be adopted towards the role of headquarters and the question of more frequent meetings in the regions.

Dr LAW (Canada) supported the draft resolution under discussion. She agreed that the related issue of reimbursement of the travel expenses of delegates attending the Health Assembly should be reviewed by the Executive Board. Action concerning the travel costs of representatives to the regional committees should be taken at the current session of the Health Assembly.

Professor HALEEM (Bangladesh) said that, since it had been laid down that health was a fundamental right of all peoples of the world, assistance with travel expenses should not have to depend on scales of assessment. Of the ten countries in the South-East Asia Region only four were in the category to which it was proposed to give assistance with travel costs. Delegates from the other six countries could only attend the regional meetings if they could afford to do so. Because of financial constraints, Bangladesh could only send one participant to the Health Assembly, its other delegates being members of the permanent mission, with other responsibilities. His country had no representation in Committee A.

In the absence of the full participation of States in the regional committees, the main objectives of the programme of health for all by the year 2000 would remain unfulfilled. The participation of all Members should therefore be assured by the payment of travel costs and per diem for their representatives to regional committees, irrespective of scales of assessment. A decision to that effect should be taken without delay.

Mr PERERA (Sri Lanka) observed that the matter had been under discussion for over two years; the Committee should now make a firm recommendation to the Health Assembly.

In the discussions on the study of the Organization's structure, it had been pointed out, in particular, that the regional committees should be strengthened to enable them to work effectively in formulating and implementing programmes. For that purpose full participation in regional committees was essential. Each Member State should be entitled to reimbursement of the travel costs of at least one member of its delegation.

Dr ALUOCH (Kenya) said that there was obviously no consensus on the issue, but his delegation supported the recommendation that the travel expenses of one representative from each Member should be reimbursed. He hoped that representatives would be in a position to purchase their tickets, bearing in mind that reimbursement was to be made only after they had arrived at the venue of the meeting.

Dr BOOTH (Australia) supported the New Zealand delegate's comments and the draft resolution under consideration. He was confident that small countries suffering severe financial constraints would thereby be helped to participate fully in the regional system,
which was of immense importance to the Organization. He also supported the idea that reimbursement for travel costs to the Health Assembly should be made, at their request, only to States assessed at the minimum rate. While agreeing that the Executive Board might consider that matter, as suggested by the Netherlands delegate, he hoped that the Board's present proposal would command full support.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) supported the draft resolution proposed by the Executive Board and agreed that the time had come to take a decision on the matter. Such a decision would not preclude further consideration by the Board of how the system could be improved at a later stage.

Mr QUTUB (Saudi Arabia) also supported the draft resolution recommended by the Executive Board, which showed the great importance attached by Member States to attendance at regional committee sessions for the discussion of regional health problems and for coordinating their health plans. However, the travel costs of one member of each delegation should be reimbursed only in response to a request from the Member State concerned.

He pointed out that the Regional Committee for the Eastern Mediterranean had been unable to meet in 1980, and the budget of the Region had been drawn up arbitrarily, because the Health Assembly had postponed its decision concerning the transfer of the Regional Office from Alexandria. If the Region was to succeed in implementing its health strategy and in providing well coordinated and effective health services, a decision must be taken to transfer the Regional Office from Alexandria, in accordance with the wishes of the countries concerned.

Mr BOYER (United States of America) said that his delegation was opposed to the draft resolution proposed by the Executive Board. The Organization had had a long history in which Member States had themselves paid for their attendance at regional meetings. His delegation sympathized with delegations that were facing problems in that respect, but the Organization's funds should be conserved for health programmes. Although the Executive Board had narrowed down the original proposal, the effect would still be to reduce the resources available for health purposes. His delegation also feared that any step to increase the reimbursement of travel costs might set a precedent for other organizations. It would vote against the draft resolution.

Dr RIDINGS (representative of the Executive Board) said that he was unable to give the exact number of Member States assessed at the minimum rate, although the estimate of 61 was probably near the mark. He drew attention to Tables 1 and 2 of Annex 1 to document EB67/1981/REC/1, from which it would be noted that the total cost of travel in 1981 for one representative from each Member State assessed at the minimum rate was estimated at $ 72 550.

The matter had been discussed at two Executive Board sessions and in the regions, and he agreed that the time had come for a decision to be taken.

The draft resolution was approved by 107 votes to 3, with 7 abstentions. ¹

3. PERIODICITY AND DURATION OF HEALTH ASSEMBLIES: Item 36 of the Agenda

The CHAIRMAN suggested that the Secretariat be asked to prepare two draft resolutions in connexion with agenda item 36 (Periodicity and duration of Health Assemblies) - one relating to alternative "A" and the second to alternative "B" of the proposed constitutional amendments - for consideration at a future meeting when the agenda item was taken up.

It was so agreed. (See summary record of the eighth meeting, section 2.)

The meeting rose at 17h35.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA34.40.
FOURTH MEETING

Wednesday, 13 May 1981, at 14h30

Chairman: Dr Z. M. DLAMINI (Swaziland)

1. ELECTION OF A VICE-CHAIRMAN

The CHAIRMAN said that he had received a communication from the Spanish delegation informing him that Dr Sánchez-Harguinéy, a Vice-Chairman of Committee B, had been compelled to return to Madrid on urgent business. He invited nominations for the vacant position of Vice-Chairman.

Dr BROYELLE (France) nominated Dr M. de la Mata (Spain) as Vice-Chairman.

Mr SOÓS (Hungary) seconded the nomination.

Decision: Dr M. de la Mata (Spain) was unanimously elected Vice-Chairman of Committee B.

2. REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION: Item 26 of the Agenda (continued)


In reply to a question by Mr VALDIVIESO (Peru), Mr FURTH (Assistant Director-General) said that the purpose of the Committee's draft report to Committee A (document A34/34) was to inform the latter of certain recommendations which would affect the level of the effective working budget for 1982-1983 and the appropriation resolution for that period. For example, the second paragraph of the draft report recommended an adjustment in the budgetary rate of exchange for 1982-1983 which would have a consequential effect on the level of the proposed effective working budget for that financial period and would therefore have to be examined by Committee A before it considered the appropriation resolution for 1982-1983.

Mr VALDIVIESO (Peru) said that his delegation was concerned at the recommended adjustment in the budgetary rate of exchange from 1.63 to 1.82 Swiss francs per US dollar, which would reduce the level of the effective working budget for 1982-1983 by about $14,000,000. In his view, that proposal involved a certain risk since, although the United States currency had recovered somewhat in recent months, the approximate average rate of exchange during the past year had been 1.63 Swiss francs to the US dollar. If, in the coming biennium, the rate were to drop below 1.82, the anticipated reduction of $14,000,000 would become even greater. His delegation wished to stress that fact, since there was absolutely no certainty that the United States currency would not continue to fluctuate.

He invoked the possibility of some action by the Secretariat, saying that in the programme budget recently approved by UNCTAD he understood that a different system had been followed whereby governments' contributions were kept in United States dollars at the same level as the preceding year, thereby protecting the budget from any risk due to currency fluctuations. In WHO, not only was nothing being done to counteract the risk of fluctuations, but the exchange rate recommended would produce a reduction of $14,000,000 in the effective working budget.

The report of Committee B to Committee A was adopted (see document WHA34/1981/REC/2).
The CHAIRMAN invited the Committee to consider the following draft resolution:

The Thirty-fourth World Health Assembly,

Having considered the report of the Director-General on casual income and budgetary rate of exchange between the US dollar and the Swiss franc for 1982-1983;

1. AUTHORIZES the Director-General, notwithstanding the provisions of Financial Regulation 4.1 and the terms of the Appropriation Resolution for the financial period 1982-1983, to charge against available casual income the net additional costs to the Organization under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during this financial period, provided that such charges against casual income shall not exceed US$ 20,000,000 in 1982-1983;

2. REQUESTS the Director-General, notwithstanding the provisions of Financial Regulation 4.1 and the terms of the Appropriation Resolution for the financial period 1982-1983, to transfer to casual income the net savings under the regular programme budget resulting from differences between the WHO budgetary rate of exchange and the United Nations/WHO accounting rates of exchange with respect to the US dollar/Swiss franc relationship prevailing during this financial period, provided that, having regard to inflationary trends and other factors which may affect the implementation of the regular programme budget, such transfers to casual income need not exceed US$ 20,000,000 in 1982-1983;

3. FURTHER REQUESTS the Director-General to report such charges or transfers in the financial report for the financial period 1982-1983;

4. STRESSES the importance of Members' paying their contributions to the Organization's budget in accordance with Financial Regulations 5.3 and 5.6, that is, not later than the first day of the year to which they relate, in order that the approved programme may be carried out as planned;

5. CALLS THE ATTENTION of Members to the fact that the Organization's ability to earn casual income depends largely upon the timely payment by Members of their assessed contributions to the approved budget, and that the earnings of such income could be significantly increased if Members were to pay their entire contribution to a given biennial budget prior to or at the beginning of the financial period concerned rather than in two equal annual instalments.

Dr KILLINGER (Federal Republic of Germany) asked why operative paragraph 2 of the draft resolution provided that transfers to casual income need not exceed $20,000,000 in 1982-1983.

Mr FURTH (Assistant Director-General) pointed out that WHO was the only organization in the United Nations system in which funds from the regular budget were returned to Members in such circumstances. The provision referred to was not new: it had been included in similar resolutions for previous financial periods. The basic reason for it was that as much as $20,000,000 would have to be surrendered to Members in the form of casual income at the end of a financial period for which the budgetary rate of exchange had been set at 1.82 Swiss francs per US dollar only if the average accounting rate of exchange during that financial period reached at least 2.16 Swiss francs per US dollar. Such a significant fall in the exchange value of the Swiss franc would undoubtedly be accompanied by an increase in inflationary rates in Switzerland far above those taken into account in preparing the budget estimates. It was felt that in such circumstances (i.e., only if the average accounting rate of exchange exceeded 2.16 Swiss francs and $20,000,000 were to be surrendered), the Director-General should be allowed to use any additional exchange savings to offset some of the unforeseen inflationary cost increases for which no budgetary provision had been made.

Mr BOYER (United States of America) asked that a vote should be taken on the casual income facility proposed in the draft resolution. While his Government supported the idea of having such a facility, it considered the amount proposed unnecessarily large since protection was already afforded by the difference between the present exchange rate of 2.05 Swiss francs to the US dollar and the recommended budgetary exchange rate of 1.82. His delegation therefore intended to vote against the proposal in the draft resolution.
The CHAIRMAN put the draft resolution to the vote.

The draft resolution was approved by 92 votes to 13, with 8 abstentions. 1

Dr ABDULHADI (Libyan Arab Jamahiriya) explained that his delegation had abstained in the voting because the decision dealt with arrangements and measures relating to the 1982-1983 budget and his country had taken no part in the preparation of that budget, either regionally or nationally.

3. SCALE OF ASSESSMENTS: Item 29 of the Agenda

Assessment of new Members and Associate Members: Item 29.1 of the Agenda (Document A34/12)

Mr FURTH (Assistant Director-General) introduced document A34/12, which dealt with the assessment of Saint Lucia, a new Member of WHO. Paragraph 5 of the document contained a draft resolution for the consideration of the Committee, proposing the assessment for Saint Lucia at the minimum rate of 0.01%.

The draft resolution was approved. 2


Mr FURTH (Assistant Director-General) introduced the item, saying that in implementation of the Health Assembly resolutions referred to in document A34/13, paragraph 1, the proposed scale of assessments for 1982-1983 had been calculated on the basis of the United Nations scale of assessments for the years 1980-1982, as approved by the United Nations General Assembly in resolution 34/6, adopted in 1979.

The proposed WHO scale for 1982-1983 was exactly the same as the scale approved in May 1980 by the Thirty-third World Health Assembly for the second year of the financial period 1980-1981 (resolution WHA33.14). As stated in document A34/13, the proposed 1982-1983 scale would need to be modified to provide for the assessment of the new Member, Saint Lucia.

Mr ABBASSI TEHRANI (Iran) said that the previous day he had requested a general review of his country's assessment as given in document A34/11. He reiterated his Government's dissatisfaction with the unjustifiable increase in its assessment for 1982-1983 as shown in document A34/13 and again asked that it be reviewed.

The draft resolution in paragraph 4 of document A34/13 was approved. 3

4. TRANSFER OF THE REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN: Item 37 of the Agenda (Document WHA33/1980/1, resolution WHA33.16 and Annex 2; Document A34/16)

The CHAIRMAN recalled that the Thirty-third World Health Assembly in 1980 had adopted resolution WHA33.16 by which it submitted to the International Court of Justice for its Advisory Opinion two questions relating to the provisions of Section 37 of the Agreement between WHO and Egypt dated 25 March 1951. The International Court had delivered that Advisory Opinion on 20 December 1980 and a summary of it was given in document A34/16, Annex 2. 4 A draft resolution on the subject had been tabled by a number of delegations: Algeria,  

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA34.5.
2 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA34.6.
3 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA34.7.
4 See document WHA34/1981/REC/1, Annex 2, section 1.
The thirty-fourth World Health Assembly, recalling the resolution of Sub-Committee A of the Eastern Mediterranean Region No. EN/RC-SS2 A/R.1, deciding on the transfer of the Regional Office from Alexandria to Amman; referring to resolution WHA33.16 concerning the transfer of the Regional Office from Alexandria; having noted the Advisory Opinion of the International Court of Justice dated 20 December 1980 on the interpretation of the Agreement of 25 March 1951 between the World Health Organization and Egypt; considering that every Organization has the right to choose the site of its headquarters or of its offices and to transfer them elsewhere; noting the difficulties preventing the office from fulfilling the functions assigned to it under the Organization's Constitution, and the consequent detriment to the Organization's programme in this Region and to joint activities with other regions; bearing in mind that the States of the Region have decided to cover the total costs resulting from the transfer of the Regional Office to Amman, together with the increase in the annual recurrent costs for five years; decides:

(1) to transfer the Regional Office for the Eastern Mediterranean from Alexandria, Arab Republic of Egypt, to Amman, Hashemite Kingdom of Jordan;

(2) to request the Director-General to implement this decision within a period not exceeding six months from the present date, and for that purpose authorizes him to conduct the necessary discussions with the present host country to determine the conditions and modalities of the transfer;

(3) to guarantee continued employment to the personnel working with the Office in order to continue to benefit from their experience and ensure respect for their legal rights.

Mr PHILADELPHIA (Guyana) said that the question of the transfer of the Regional Office for the Eastern Mediterranean from Alexandria to Amman affected not only that office but all the other regional offices. His delegation was concerned because the work of WHO as a whole was not being carried on as it should be. It had therefore joined with other delegations in sponsoring a draft resolution, the text of which would shortly be circulated and would, it was hoped, provide the basis for a satisfactory solution.

Mr EL REEDY (Egypt) recalled that on 23 May 1979 Dr Al-Awadi, Minister of Health of Kuwait and later President of the World Health Assembly, speaking in Committee B, had affirmed his conviction that the existing conditions in the Eastern Mediterranean Region were only temporary: the Arab community was one nation and not to be divided by differences, nor were its ranks to be destroyed by problems and dissent. He had placed on record his country's thanks to the people of Egypt for the warmth of their welcome to other Member States and to the Regional Office.

As an Arab, Mr El Reedy shared Dr Al-Awadi's sentiments, for Egypt had been and always would be a part of the Arab Nation. He endorsed the two points made at that time by Dr Al-Awadi, namely, regret that the item should ever have appeared on WHO's agenda, and a conviction that the present rift in the Arab Nation was only temporary.

The choice of Alexandria for the Eastern Mediterranean Regional Office had been the result of a thorough study. The supplementary report of the Interim Commission to the First World Health Assembly in 1948 had recommended Alexandria as the site for the Regional Office in view of its historical association with health work and its geographical position. The experience of the intervening years had only confirmed the validity of the choice. The Regional Office had benefited from the convenience of the site, and from the medical and scientific institutions of Egypt. Alexandria remained the most suitable and least expensive site for the Regional Office.

The Egyptian Government and people had faithfully met the obligations of a host country. All speeches made during the discussions had testified to this, even those by delegations that
favoured the draft resolution, and it had been the opinion of the working group established in 1980 to examine the question.

A transfer would cause disruption and would seriously affect the ongoing programme of cooperation in the area. Moreover, a financial price would be exacted for the transfer; more than $3 million of additional expenditure would be entailed in the first year alone. It was proposed that Member States in the Region should bear the increase during the first five years by voluntary contributions. Such additional expenditure was however wasteful, nor was it right that poor nations in Asia, Africa and Latin America should be asked to bear the additional costs after the five years were up.

If the present location was unexceptionable, what reason was there for causing the disruption which a transfer would entail? There was only one answer to that question - that the demand for transfer was politically motivated. If WHO were to commit itself to a course with far-reaching consequences merely in order to meet a politically motivated demand, it would be setting a precedent for yet another transfer of the Regional Office, if political vicissitudes in the new host country should suggest it. A precedent would also be established for other organizations; and potential host countries would lose confidence in the face of such a decision.

His delegation believed that the Health Assembly had the right and the duty to scrutinize carefully proposals from regional organizations if they were as momentous as the present one: the long-term interests of regional cooperation, and the interests of the World Health Organization itself, must be safeguarded. Egypt had no intention of bringing politics into the debate. But a glance at the situation in the Eastern Mediterranean over the past twelve months would show that a number of profound changes had taken place. Diplomatic and political relations had been broken off and restored. The Region was moving from an ancient into a modern era. It was a focus of international attention, plagued unhappily by serious political problems. Alexandria had been the site of the Regional Office for more than thirty years; previously it had been the home of the International Sanitary Bureau, whose origins went back to 1831. Surely it could not be wise to dismantle a service which had existed so long and functioned so well, especially when such an act would be influenced by emotions themselves transitory. Such a decision, if taken, would strike a blow at the stability and progress of WHO's work and, with the disruption it would entail, could never contribute to the attainment in the Region of health for all by the year 2000.

With respect to the Advisory Opinion given by the International Court of Justice, Egypt was gratified to note that it was in conformity with Egypt's own constantly held view. During discussions at the previous Health Assembly the view had been maintained that WHO's right to select the seat of its headquarters and of its regional offices was absolute - as if the Organization were a super-State. The International Court of Justice had rejected this opinion and set limits to such a right. WHO was bound by contractual, legal obligations and by the general principles of international law. This was an essential legal principle, serving not only the interests of the host country but also the common interests of the Organization and the maintenance of cooperation in the Region.

Egypt believed that regional cooperation was a prerequisite to overcoming the social and economic problems encountered in the Eastern Mediterranean. Such cooperation should be totally divorced from politics. Diplomatic bonds could be formed or broken at short notice, but to build a regional office capable of establishing a high level of cooperation was a work of many years. It was easier to destroy than to rebuild.

The Egyptian delegation therefore appealed to all delegates to vote against the proposal to transfer the Regional Office, and in doing so to affirm the basic principles and objectives of the Organization.

Dr GEZAIRY (Saudi Arabia) said that the subject under discussion was on the Committee's agenda in accordance with a decision of the Thirty-third World Health Assembly. A recommendation had been submitted to that Assembly, but a decision had been postponed in order that an Advisory Opinion might be obtained from the International Court of Justice. That Opinion, rendered on the 20 December 1980, had reaffirmed the right of Member countries to transfer the headquarters or the regional offices and made it clear that prior notice and settlement of conditions of transfer did not abrogate that right but simply set out the conditions under which it was to be applied. The Court, having considered the case on its merits, had come to the conclusion that two years was a reasonable period for the transfer. The Committee should therefore be guided by Section 37 of the Agreement between WHO and Egypt and by Article 56 of the Vienna Convention on the Law of Treaties, which taken in conjunction enabled the period necessary for the orderly transfer of the Regional Office to be construed as one year.
Member States of the Eastern Mediterranean Region were unable to participate in the activities of the Region, since the Office was in Alexandria. Many Member countries had broken off relations with the Regional Office and had thereby adversely affected the Office's activities. It would be desirable for the Director-General to report on the activities of the Regional Office during the previous year. Since that Office existed to provide certain services, it should be transferred to a country from which it would be in a position to provide those services.

Article 44(b) of the Organization's Constitution stated: "The Health Assembly may, with the consent of a majority of the Members situated within each area so defined, establish a regional organization to meet the special needs of such area. There shall not be more than one regional organization in each area". A majority of the Members in the area determined the location and, if necessary, the transfer of a site. It was not right that the present Regional Office should remain at its present site. It should serve the 19 Member countries in the Eastern Mediterranean area which had lacked its services for over a year. To proclaim that the host country was a founder Member of the World Health Organization or that the Regional Office had been more than 30 years in one place was not to say that the Regional Office was performing its function. Reason, logic and the democratic principle required that the wishes of Member countries of the area should be consulted and that the Regional Office should be transferred to a place chosen by them. It should be noted that several Member countries had guaranteed the expenses of the transfer.

He read out the text of his proposed amendments to the draft resolution, namely:

1. to add at the end of operative paragraph 2 the words: "and negotiate with the Government of Jordan the terms of the necessary host agreement and the material facilities to be granted";

2. to replace operative paragraph 3 by the words: "To request the Director-General to maintain in employment those staff members at present working with the Office who are willing and able to accept transfer and whose services are required by reason of their experience and qualifications".

The Health Assembly must take a decision urgently on the recommendation of Committee B. The decision was an important one since many people were concerned in the matter, many governments were interested in the outcome, and it was essential to know whether democracy was still the guiding principle of WHO.

Mrs EMMANUEL (Nigeria) said that her delegation associated itself with the statement made by the delegate of Guyana. It was important that the work of WHO should continue and that its programmes should be smoothly implemented. The Health Assembly had always shown high standards of responsibility, and it was for this reason that it had sought an Advisory Opinion from the International Court of Justice. Now that the Opinion had been received, all members of the Committee should give it due consideration and take whatever action was necessary to ensure that the people of the Eastern Mediterranean benefited from the health programmes made available to them through WHO.

Mr AL-AWAIDI (Kuwait) said that what happened in the Eastern Mediterranean Region was the concern of the Region itself. Article 50(a) of the Constitution gave the regional committee the responsibility for formulating policies governing matters of an exclusively regional character. The decision on the transfer of the Regional Office for the Eastern Mediterranean was a decision of a regional committee on a purely regional matter.

His delegation was greatly concerned at the fact that the Thirty-third World Health Assembly had treated the matter as a political one, for submission to the International Court of Justice. The decision taken had been the undemocratic decision of a political group that had sought to compel the Region to submit to its wishes. The Regional Committee, which had hitherto functioned successfully, was now prevented from doing so. It was the heart of the Region, and without it the Region was dead. The Director-General could have been spared much of the burden he had to carry if the decision to move the Regional Office from Alexandria had been implemented two years earlier.

The Eastern Mediterranean Region was composed of small Third-World countries that had little chance of withstanding undemocratic moves by the large countries to impose their will, and it had to suffer in consequence. If there was genuine concern about the health of the people of the area, the Region should be allowed some right to decide its own affairs. Those who had claimed to know what was good for it had not given the right advice. Even the move made at the current meeting by the delegate of Guyana was not in the interest of the Health Assembly or of the Region. The Arab States had tabled a draft resolution and were prepared to discuss the matter. All those who supported that draft resolution wished the matter to be
solved as soon as possible, and they resented the accusation that they were seeking to delay the work of the Health Assembly. They demanded their right to be treated with justice and dignity and to be allowed to decide for themselves.

He asked whether the Organization was satisfied with the work of the Eastern Mediterranean Region in the absence of the Regional Committee. If a region could function without its regional committee it was difficult to see why such committees had been established.

He appealed to delegations, particularly of the Third World, to support the draft resolution. Other regions might ultimately undergo a similar experience to that of the Eastern Mediterranean Region.

Mr ABBASSI TEHRANI (Iran) said that, because of the Camp David agreements, his delegation was strongly in favour of the transfer of the Regional Office from Alexandria; but it was unable to support its transfer to Amman. There could be no guarantee that the Jordanian Government would not in the future adhere to the Camp David agreements. From the beginning of the war of aggression against its own country, the Jordanian Government had supported the aggressor. His delegation therefore opposed the draft resolution, and proposed that, in accordance with the Advisory Opinion of the International Court of Justice, WHO and the Member States of the Region should study the case more carefully with a view to finding a more durable solution. His delegation could not agree that Member States of the Region should bear the total costs referred to in the preamble to the draft resolution.

Dr ABDULHADI (Libyan Arab Jamahiriya) did not share the view of the Egyptian delegate that the matter was itself political, although it had stemmed from a political decision taken by heads of State in exercise of their sovereign rights. The Committee had to take stock of the situation and see what the repercussions of its decision would be on health in the Region. Attention had rightly been drawn to Article 44 (b) of the Constitution. He further drew attention to Article 50, describing the functions of the regional committees. Because the Regional Office for the Eastern Mediterranean was located in Alexandria, the Regional Committee had been unable to meet in 1980, and those functions had consequently been paralysed.

The discussions that had taken place on the structure of WHO and on its role as coordinator of the programme of health for all by the year 2000 had shown that priority must be given to decentralization, and that regional offices and regional committees would have to play a more prominent role in decision-making and implementation.

Drawing attention to Article 51 of the Constitution, he said that all the work of the Regional Office for the Eastern Mediterranean in 1980 had been hampered by its inability to function in the Region. Any further delay in giving effect to the decision of the majority of Member States of the Region to transfer the Regional Office to Amman would impede the work of WHO and isolate a Region that wished to play its part in fulfilling the Organization's objectives. It was the politically motivated delegations that would carry the responsibility for any further delay and for consequent isolation of the Region.

Comparison of the work of the Region in 1980 with that of earlier years would show that it had fallen off considerably. It had been argued that the transfer of the Regional Office from Alexandria would entail vast expenditure. The countries of the Region were aware of that problem and had expressed a willingness to bear the cost. WHO funds would certainly not be put to the best use by allowing a region to remain paralysed.

The law of hospitality in Arab countries required that there should be some agreement between the host country and its guests. The majority of Members had indicated that they could no longer be guests in the host country. The transfer was crucial to the implementation of the Organization's work, the cohesion of its Member States, and the achievement of health for all by the year 2000.

Professor BENHASSINE (Algeria) said that, although it was not a Member of the Eastern Mediterranean Region, his country had co-sponsored the draft resolution on the transfer of the Regional Office from Alexandria. It had done so as a member of the League of Arab States, which had taken a decision at the highest level in favour of the transfer from Egypt of all regional or international organizations situated in that country. The headquarters of the League of Arab States itself had been transferred to Tunis without any detriment to its functioning or activities.

The arguments advanced against the transfer were specious and paternalistic, and they showed some contempt for the judgement of the majority of sovereign States in the Region. The Arab States had acclaimed the contribution of the Egyptian people to civilization, to Arab culture, and to the emancipation of the people of the Region and of the world at large. The
draft resolution should therefore not be viewed as an act of enmity towards the Egyptian people. It was, on the contrary, designed to protect the interests of all the Arab peoples and to promote their health and wellbeing.

In sponsoring the draft resolution, his country had kept faith with the spirit of the recent recommendation of the non-aligned developing countries that the problem now under discussion should be solved without delay, in accordance with the wishes of the people of the area.

A question of ethics was involved. It was difficult to see how a body of the standing of the World Health Assembly could refuse to heed the almost unanimous wish of the Members of one of its regions. To do so would be an abuse of power. If the Health Assembly was empowered to establish a regional organization in accordance with Article 44 of the Constitution, it could surely decide to transfer the regional headquarters when the majority of Members of the area so desired.

In order to avoid expressing an opinion, some delegates had argued that the problem was a political one. In fact, it went well beyond politics. To persist in ignoring the desires of the majority of Members of the Region was to paralyse an entire area that was suffering from serious public health problems, and to endanger the unity and integrity of the Organization. His delegation would support any action taken by the Arab States on the subject.

Mrs LUETTGEN (Cuba) said that the question should be decided by the countries concerned, since it was they who were affected by the situation in the Region. The vast majority of them rejected the present location of the Regional Office. Any delay would further prejudice the smooth operation of the Organization in the area. Her delegation would therefore vote in favour of the draft resolution.

Dr LUBANI (Jordan) said that, in view of the fact that the Regional Office had been unable to function for a considerable time, there should be no further delay in settling the issue. The Office should be transferred to any location agreed upon by all States of the Region.

The Arab countries had agreed to pay the full costs of the transfer. The request for such a transfer was not unreasonable and was in keeping with the regulations of the Health Assembly. Support for it would be in the interest of the countries of the Region and of the Organization as a whole, while lack of support would be detrimental to them - and he could not believe that any delegation would wish to harm their interests. He asked whether those who argued that the transfer would hamper the achievement of health for all by the year 2000 considered that the maintenance in Alexandria of the Regional Office, which was boycotted and ineffective, would serve that objective.

Mr BENAVIDES (Peru) deplored the opposition between brother countries that shared not only a geographical area but also a historic past and a culture; and also the fact that those countries had been unable to bring to the Health Assembly a negotiated solution satisfactory to all rather than a family conflict that did not necessarily concern other countries. As his delegation had stated at the meeting of the non-aligned developing countries, it was convinced that the most suitable solution of the problem could only be one agreed to by the countries of the area and which took into account the interests and the will of all parties concerned. Any other approach would be undemocratic, unless it were proven that the minority position was a direct cause of detriment to the legitimate interests of the entire group. The matter has been discussed in the Health Assembly precisely because the problem affected an entity of the Organization.

What was the problem in so far as it concerned all Members of WHO? It was that a regional office of the Organization was impeded in carrying out its functions simply because of its geographical location. The draft resolution before the meeting referred to "the difficulties preventing the Office from fulfilling the functions assigned to it under the Organization's Constitution, and the consequent detriment to the Organization's programme in the Eastern Mediterranean Region and to joint activities with other regions". That consideration was followed by a proposal to transfer the Regional Office to another country in the area, a proposal that appeared to the sponsors of the resolution to be the solution to the problem they stated. Their reasoning seemed to be as follows: the Regional Office did not function correctly; it did not function correctly because of its location in a particular country; therefore it must be moved to another area in order to operate smoothly. Thus presented, the conclusion seemed logical but it did not reflect all the elements to be considered.

The draft resolution had to meet two requirements to be acceptable: (1) it must provide an effective solution to the problem that had arisen; and (2) that solution must be designed
to cope with the real cause of the problem. To judge by the statements that had been made, it would be unwise to count on the proposed solution being effective. Transferring the site of the Regional Office would change the nature of the difficulties and perhaps their magnitude, but it would not make them disappear unless one party to the conflict should totally reverse its position or itself disappear - both unlikely possibilities.

There was another matter equally important: respect for justice. What was in fact incapacitating the present Regional Office? Was it the unsuitability of its location? The Advisory Opinion from the International Court of Justice had stated that that was not the case. Was there some shortcoming in the services provided attributable to an intrinsic characteristic of the geographical location? No one had said so. Was it the poor quality of management? That did not seem to be the case either; indeed the draft resolution spoke of guaranteeing employment to the personnel of the Regional Office in order to continue to benefit from their experience. It was clear that what was involved was not a technical problem which could be resolved through administrative measures such as the one advocated.

The present location did give rise to difficulties. But the difficulties had originated in an act for which those who denounced them were themselves responsible. The Regional Office for the Eastern Mediterranean was suffering because of a majority decision of a group of Members of that area to boycott the activities of the Office. The reasons underlying that decision were of a political nature, as various delegations had made clear. The countries should not be reproached for having such reasons: each country was sovereign in taking its decisions. But the fact that the reasons were legitimate for them did not mean that other States should attach universal validity to them. The issue was not one arising between the Organization on the one hand and the host country of the Regional Office on the other, it lay rather between a State and a group of States, all of which belonged to the same Region. It did not hinge on the fact that the Regional Office was in site X rather than elsewhere, but on the fact that countries A, B, C, and D objected to the Regional Office being situated in country X and wanted to transfer it to country Y. The situation that had to be dealt with was the boycott itself, and the task was one for the countries operating the boycott and the country suffering from it. It was a cause of concern that the victim of the situation was WHO itself, an Organization in which the neediest part of humanity had placed its hopes for a better life.

As regards the legal technicalities, the International Court of Justice had made it clear that the country in which the Regional Office was located at present had legitimate rights which must be taken into account in modifying the status quo. Otherwise WHO’s action might become an unfortunate precedent.

Finally, with reference to the last paragraph of the preamble to the draft resolution, he did not believe that the offer to cover the total costs of the transfer, together with the increases in annual recurrent costs for five years, made the proposal any fairer or more attractive. The problem was not a financial one.

Mr EL HAFDH (Tunisia) was particularly concerned about the way the Regional Office in Alexandria was operating or, more accurately, not operating, since there was almost complete paralysis of its activities. There was no hiding the fact that the Regional Office could not function as long as it stayed where it was - to the detriment, unfortunately, of the immediate and vital interests of millions of men, women and children, who could not easily do without the support they had a right to expect from WHO. The fate of those millions, whom their governments were faithfully representing by asking for the transfer of the Alexandria office, could not be a matter of indifference to an international organization as conscious of its responsibilities as WHO. He fervently hoped that the Health Assembly would on the one hand show realism by recognizing objectively the situation, and, on the other hand, would accede in a spirit of justice to the request of practically all States in the Region.

Fully understanding as he did the desire not to base decisions of the Organization on purely political motives, he was _a fortiori_ concerned to avoid political arguments as vain as they were sterile. Objectively to recognize the existence of a prevailing political situation in a region did not necessarily mean engaging in politics. The Tunisian Government was concerned first and foremost with defending the legitimate interests of its people, interests which in the present case coincided with those of the other countries of the Eastern Mediterranean Region. In that context political considerations - or policy - could be said to be involved. But the Health Assembly was being asked to believe that politics or policy could exist in an abstract state. For him that approach was curious. All human action was necessarily situated in a given context and necessarily had some kind of political impact. One spoke in fact of health policy, housing policy, educational policy and so on. He was not asking for a decision on a political dispute as dramatic and complex as that of the Middle East. He did
Mr HEILMAN (United States of America) recalled that the item under discussion had been debated for a number of years. If the reasons for its first being brought before the Health Assembly were reviewed, along with the debates of past years and even the statements of many supporters of the present draft resolution, it became obvious that the item was before the Health Assembly for political reasons. There was no reason in international law or international practice, no technical reason, and no reason in the attitude of the Egyptian Government to prevent the Regional Office in Alexandria from being used fully by all Member States of the Region.

All Members had an interest in the item under discussion, and all valued the integrity of WHO. His Government did not want to see the beginning of a process that would weaken WHO and its programme by introducing various political considerations. If one regional office were moved today, how would it be possible to argue against another regional office being moved tomorrow or a third the following week - for whatever political reason countries commanding a majority in the Health Assembly might put forward?

There were also budgetary considerations. A regional office in Amman would have running costs 75% higher than the one in Alexandria. After the few years for which certain Member States of the Region were willing to cover some of those costs, it was all the Members of the Organization that would shoulder the burden.

The Thirty-third Health Assembly had asked the International Court of Justice for an Advisory Opinion on several precise questions. The Court had responded with exemplary speed and had specified what steps might be taken to move ahead in a fashion consistent with international law and the rights of all Members of the Organization. His Government urged that any action taken by the Health Assembly be based upon the decision of the International Court of Justice.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) said that his delegation had studied the Advisory Opinion of the International Court of Justice and the draft resolution submitted by 19 countries. It had also listened closely to the statements of other delegations and had concluded that no substantially new facts had been advanced since the last Health Assembly regarding the transfer of the Regional Office for the Eastern Mediterranean or the functioning of the Regional Committee, in particular its Sub-Committee B.

The position of the Soviet delegation as stated at the Thirty-third World Health Assembly had not changed. Its substance was that the Soviet Union was not part of the Eastern Mediterranean Region and did not feel entitled to tell other countries or other regions what they should do. The Soviet Union was however concerned with WHO as a whole and with making it possible for the countries of each region to solve their problems. And it firmly adhered to the view that the transfer of the Regional Office came under the heading of matters that should be resolved by the countries of a given region, and that the Health Assembly should take account of the opinion expressed by those countries.

The present issue concerned the Eastern Mediterranean. In the future similar issues might arise in other regions, and the Health Assembly might not always face a situation where all or nearly all the countries of the region agreed. No one could guarantee that all regional offices would stay for ever where they were located at present. Further situations might arise making it difficult for regional offices to function. Since the overwhelming majority of the countries of the Eastern Mediterranean Region were demanding that the Regional Office be transferred from Alexandria to Amman, he saw no reason why the Health Assembly should not take a decision that would satisfy that majority. The overriding democratic principle of which certain delegations reminded the Health Assembly from time to time was that it should accede to the will of the majority. Further procedural or other delays would not serve the interests of the Organization and certainly not those of the Eastern Mediterranean Region, where they had already brought about the virtual paralysis of the Regional Office. The Regional Committee was no longer meeting, and the Health Assembly was deprived of its opinion on such important issues as the
proposed programme budget for 1982-1983, the constitutional amendments on the periodicity of Health Assemblies, and the regional strategies for achieving health for all by the year 2000. It was clear from the documentation and from the statements of delegates that the operations of the Regional Office had practically come to a standstill, with considerable financial loss to the Organization.

Reference had been made to political overtones. The discussion had indicated how closely linked political and technical problems were. The Organization could work successfully only in a favourable political climate and not when political pressures were applied to delay the solution of technical matters. It was a poor policy that prevented the majority of countries in a region from cooperating on health problems in their region and in the world.

Taking all that into account, the Soviet Union was prepared to vote for the draft resolution on the transfer of the Regional Office.

(For continuation, see summary record of the sixth meeting.)

The meeting rose at 17h30.
FIFTH MEETING

Thursday, 14 May 1981, at 14h30

Chairman: Dr Z. M. DLAMINI (Swaziland)


Dr RIDINGS (representative of the Executive Board) recalled that the Board had confirmed amendments to the Staff Rules by which a portion of the post adjustment was consolidated into base salary, and had wished this measure to be extended to the remuneration of ungraded posts and of the Director-General. It had adopted resolution EB67.R17, recommending to the Health Assembly that new figures be established for the gross and net salaries of the Director-General, the Deputy Director-General, the Assistant Directors-General and the Regional Directors. The changes proposed were to be effective from 1 January 1981. The United Nations General Assembly had approved identical changes on the recommendation of the International Civil Service Commission.

Mr VOHRA (India) pointed out that EB67.R17 referred only to certain categories. In paragraph 1.2.1 of Annex 6, part 2 (document EB67/1981/REC/1), it was stated that application of the assessment rates was based on the principle of "no gain/no loss". He asked whether this referred only to assessment rates. Since the proposed procedure was in line with the procedures in other organizations, might it be taken that the date established was also in line with some general decision?

Mr FURTH (Assistant Director-General) explained that section 1.3 of Annex 6, part 2, indicated that the consolidation of 30 points of post adjustment into net base salaries, with consequent changes in assessment rates, required increases in salary schedules and reductions in post adjustment rates, so as to reflect the principle of "no gain/no loss" in staff members' remuneration. This principle applied also to the salaries and post adjustment rates for ungraded posts, although as a result of certain technical considerations, and of some rounding-off, certain salaries showed a very slight loss, others a very slight gain. These losses and gains, however, were of a temporary nature and would disappear as soon as the post adjustment index changed.

Mr BOYER (United States of America) observed that the proposal shifted 30 points of post adjustment into the base salaries of some senior officials of the Organization. The United States, in keeping with its general desire to reduce costs in the United Nations system, was concerned about the post adjustments which gave higher compensation to officials living in cities where the cost of living was high. The post adjustment was a percentage of the entire salary. Senior officials earned a very high salary, and it was not to be expected that they spent it all: part of it they would save or invest. He considered that a post adjustment should not be paid on the full salary but on the amount an official was compelled to spend at his post.

The present proposal legitimized and made concrete an unwarrantable increase in compensation. The new salary would itself be used to calculate further post adjustments, pensions and other benefits, and a compensation already inappropriate would be compounded, the costs for all Member States being thus raised. He realized that the proposal had been put forward by the International Civil Service Commission, but regretted that the United Nations agencies had adopted it before the completion of the study to improve ways of measuring the cost of living of United Nations employees and another study regarding the total
remuneration of United Nations staff. He therefore suggested that WHO should postpone consideration of the proposal until these two studies were complete.

Another point he wished to make was that not all salaries in WHO were in accord with the United Nations system. He requested that all such salaries should be brought into line with that system.

Mr FURTH (Assistant Director-General) said that the arguments put forward by the United States delegate had also been put forward by the representative of the United States Government in the Fifth Committee of the General Assembly within the last two years. The International Civil Service Commission was acquainted with the arguments, was considering them, and had already rejected some of them. He was surprised that the United States delegate wished the Organization to defer implementation of a decision taken in the United Nations on a matter concerning the common system of salaries and allowances, as usually the United States Government and other governments were anxious that WHO should immediately follow United Nations practices in these matters.

With respect to the post adjustment system, the International Civil Service Commission was carrying out a comprehensive review of its purpose and operation, and had already provided the General Assembly with an explanation of the system's principles, purposes and present operation, outlining its complexities and pointing out differences from similar systems for compensating national civil servants working outside their own country. A working group of the Advisory Committee on Post Adjustment Questions had been set up to study the methodology of cost-of-living calculations and measurements. The results of the study would be submitted to the session of the International Civil Service Commission to take place in summer 1981, and to the thirty-sixth session of the United Nations General Assembly (1981).

Fears that pensions would be distorted by the incorporation of 30 points of post adjustment into salaries were groundless, as pensionable remuneration was virtually identical before and after consolidation. Future post adjustments would not be distorted by incorporation, since incorporation per se had no effect on them. If distorting factors were to arise, however, they would undoubtedly be reported by the International Civil Service Commission to the United Nations General Assembly later in 1981.

Finally, all the salary figures in the Board's resolution were supplied to WHO by the International Civil Service Commission and thus presumably applied throughout the system.

The DIRECTOR-GENERAL said that he had been surprised to hear the delegate of the United States suggest that staff members were highly remunerated to an extent that they were in a position to invest money. Living standards varied according to persons. He invited the United States delegate to come to Geneva with his family, attempt to live a normal life there, and then ask whether WHO staff were able to invest as he had indicated. Regional Directors and other staff found it difficult to make ends meet, and he would assure the United States delegate that there were no millionaires in their ranks.

The draft resolution proposed by the Executive Board in resolution EB67.R17 was approved.¹

Mr BOYER (United States of America) stated that his delegation had opposed the principle in question in the Fifth Committee of the United Nations General Assembly and indeed throughout the whole United Nations system. He was not reproaching the staff, but was concerned at the high salaries paid throughout the United Nations. The United States position remained unchanged. Had a vote been taken, his delegation would have voted against the resolution.

2. APPOINTMENT OF EXTERNAL AUDITOR: Item 31 of the Agenda (Resolution WHA32.9; Document A34/14)

Mr FURTH (Assistant Director-General) recalled that Sir Douglas Henley, Comptroller and Auditor-General of the United Kingdom, had been appointed External Auditor for the accounts of WHO for 1978 and 1979. His appointment had been extended by the Thirty-second World Health Assembly to cover 1980 and 1981. Since the External Auditor's tasks relating to the current financial period would be completed before the Thirty-fifth World Health Assembly in May 1982, the Director-General felt that it would be desirable for the Health Assembly to make an appointment now for the financial period 1982-1983.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA34.8.
Sir Douglas was due to retire in 1981 and his successor had not yet been nominated, but he had suggested that the holder of the office of Comptroller and Auditor-General of the United Kingdom could be appointed as External Auditor. The Financial Regulations of the Organization permitted this, and the Director-General suggested that the proposal, as embodied in a draft resolution in his report on the subject (document A34/14), be adopted. An advantage of the proposal was that the Comptroller and Auditor-General's Department in the United Kingdom had many staff expert in auditing the accounts of United Nations organizations, since the Comptroller and Auditor-General was also External Auditor for FAO, UNESCO and several smaller organizations in the United Nations system.

Dr GALAHOV (Union of Soviet Socialist Republics) observed that, if Sir Douglas Henley's successor was not yet known, the Organization would be electing a person of unknown capabilities. Since the office of External Auditor was of importance to the Organization (as was shown by documents submitted by Sir Douglas himself) it was questionable whether an External Auditor should be elected in this manner. However, he had no specific proposal to make.

The draft resolution in paragraph 4 of document A34/14 was approved.1


Dr MORK (representative of the Executive Board), introducing the item, said that the Executive Board had considered the Director-General's report (document EB67/1981/REC/1, Annex 9), which gave the status of approved projects from 1 June 1974 to 31 May 1981, the estimated requirements for the period 1 June 1981 to 31 May 1982, and the tentative long-term requirements of the six regional offices, in response to operative paragraph 3 of resolution EB65.R15. The Board had been informed in addition of an urgent and exceptional need for housing and offices for a programme coordinator and staff in Equatorial Guinea.

Projects for the period up to 31 May 1981 were either complete or proceeding satisfactorily. The Board had examined the estimates for the period 1 June 1981 to 31 May 1982, including the requirements for accommodation in Equatorial Guinea, a building for the WHO/PAHO publications and documentation service for the Spanish language in Mexico City, an extension of the Regional Office in South-East Asia, and other projects listed in paragraph 11 of the Director-General's report. The Board had also examined tentative long-term requirements. There were no identifiable requirements for the financing by the Real Estate Fund of accommodation for the six regional offices. The Director-General confirmed that he would continue to observe the situation and report as necessary to the Board.

The discussions of the Executive Board were summarized in document EB67/1981/REC/2, pages 359-364 and 385-386. The Board had adopted resolution EB67.R20 recommending that the Thirty-fourth World Health Assembly authorize the financing of the envisaged expenditure from the Real Estate Fund, and proposing that US$ 2 044 000 be appropriated to the Real Estate Fund from casual income.

Mr VOHRA (India) observed that part of the report related to the demolition of building V in Geneva, avenue Appia. He asked whether that building had been constructed with the approval of the cantonal authorities, and if so whether they should not compensate the Organization for its demolition.

Dr GALAHOV (Union of Soviet Socialist Republics) noted with satisfaction the Executive Board's comment that there were at present no identifiable long-term requirements for financing the construction of accommodation at any of WHO's regional offices from the Real Estate Fund. That made it possible to conclude that all the regional offices were functioning well in their existing accommodation.

Since Executive Board resolution EB67.R20 concerned a financial matter, its wording should be more precise. The reference in subparagraph (1) of the operative part to "the expenditures

1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA34.9.
Mr BOYER (United States of America) shared the satisfaction expressed by the Soviet delegate at the statement that there were at present no identifiable long-term requirements for financing the construction of accommodation at any of WHO's regional offices from the Real Estate Fund.

Before it was agreed to use funds for construction costs, his delegation would like to be assured of the actual need for the proposed projects. He referred to the large sums requested for staff housing in Brazzaville (US$ 322 000) and for extension of the office building in the South-East Asia Region (US$ 675 000), and expressed particular concern at the item of US$ 480 000 for construction of office space and housing in Equatorial Guinea. The office building was for a country programme, which made it a new departure. Once the construction of office space in individual countries was embarked upon, there was a danger of a constant drain on WHO resources.

He did not doubt the need for a health programme in Equatorial Guinea. The Executive Board had endorsed a Regional Committee resolution urging cooperation with that country, which his delegation intended to support. Neither did his delegation doubt the need for office space in Equatorial Guinea, since it had been confirmed that there was no space available for rent or purchase. It was nevertheless concerned about the precedent of constructing a new office building for a country programme, particularly at a cost of half a million dollars. He understood that a donors' meeting of United Nations and bilateral assistance agencies was to be convened in Madrid in October 1981 to discuss programmes of cooperation with Equatorial Guinea at the request of the United Nations General Assembly. Any new programme would clearly encounter a similar lack of available quarters. It therefore appeared reasonable for WHO to coordinate its office and staff housing needs with those of other United Nations agencies operating, or planning to operate, in Equatorial Guinea.

He therefore proposed that, while money should be authorized for the project, WHO should be requested to coordinate its needs with those of other participating agencies to avoid engaging in any unnecessary expense. If that was acceptable, he would suggest the wording for a resolution urging the Director-General to minimize the cost to WHO within the amount specified and to coordinate WHO's needs with those of other agencies.

Dr QUENUM (Regional Director for Africa), referring to the essential buildings required for the implementation of the special programme of cooperation with Equatorial Guinea, said that, having considered the seriousness of the health situation in that country, the Regional Committee for Africa at its thirtieth session had urged him to take a number of measures. Prior to the Executive Board session, he had visited the country and seen the situation for himself. He had reported to the Director-General, who in turn had informed the Executive Board of the situation. The Board had considered it necessary to recommend to the Health Assembly the construction of a small administrative building and staff accommodation at Malabo, in view of the seriousness of the health situation in Equatorial Guinea, and of the special programme of cooperation to be established with that country. On being informed of the consultations that had taken place on the spot, and before proposing such measures, the Director-General had consulted New York, and particularly the United Nations Development Programme, as to the feasibility of joint action. Taking all those factors into account, the Board had become convinced that the expenditure was essential.

The United States delegate had urged that no precedent should be created; but a precedent already existed in the African Region. There was an emergency situation, and an appeal had been made to the international community not to remain indifferent to that situation. Reference had been made to the meeting of donors that was to be held in Madrid and the need to wait for the measures that would be taken. But time was being lost in the face of an emergency situation. He hoped that the amendment proposed by the United States delegate would not lead to delay in implementation of the emergency programme.

Mr FURTH (Assistant Director-General), replying to the delegate of India concerning the possibility of compensation from the Geneva cantonal authorities for the demolition of part of the headquarters premises at Geneva, said that, shortly after the completion of the main WHO building in 1966, additional office accommodation had been required. The Canton of Geneva had made available, on a purely temporary basis, an adjacent piece of land on which it had authorized the erection of a temporary building. That arrangement, which had originally been intended to last for a period of about five years, had now continued for about 15 years, and the Canton had
finally been obliged, under a long-standing plan, to reclaim part of the land for its road construction project. A little over one-fifth of the temporary building had to be demolished, but since the temporary nature of the building had been made clear from the outset, there could be no question of compensation; on the contrary, WHO should consider itself fortunate in having been able to enjoy the use of the land so long.

As concerned the USSR delegate's point regarding lack of precision in resolution EB67.R20, that resolution merely made recommendations in general terms to the Thirty-fourth World Health Assembly. At the conclusion of the discussion the Rapporteur would probably be requested to prepare a draft resolution for adoption by the Committee and thereafter by the Health Assembly in plenary session, in which the points made by the USSR delegation could be taken into account.

The CHAIRMAN asked the Rapporteur to prepare a draft resolution taking into account the views expressed by the Committee, which could be considered at a later date.

(For continuation, see summary record of the eighth meeting, section 1.)


Dr MORK (representative of the Executive Board) said that the Board had considered the report of the Director-General reproduced as Annex 7 in document EB67/1981/REC/1. In his report, the Director-General had outlined the need for the construction of an extension to the third prefabricated building and had made proposals for its financing. Section 1 of the report outlined the reasons that had led the Director-General to formulate the proposal for the construction of additional office and storage space. Section 2 described the development of the staffing situation at headquarters between December 1976, when the third prefabricated building had been occupied, and October 1980. Section 3 gave details of the utilization of the present office space at headquarters. Section 4 indicated the storage space at present available, the use to which it was assigned, and the additional requirements to meet foreseen storage needs. Section 5 provided a brief description of the proposed building extension, and section 6 gave an estimate of the cost and described the proposed method of financing for the building extension.

The Board had been informed that there was a serious shortage of office and storage accommodation at headquarters at Geneva resulting from three main causes.

First, despite a substantial reduction in the number of staff financed from the regular budget, there had been a net increase in the number of staff and other persons for whom the Organization was required to provide office accommodation at headquarters. That increase was attributable to a net increase in the number of staff financed from extrabudgetary sources, short-term staff, consultants, and other persons requiring to be accommodated by the Organization.

Secondly, while the number of persons for whom office space was provided had increased, the number of offices available had decreased. Part of one of the annex buildings had had to be demolished to permit the construction of a public road. It had also become necessary to accommodate computer terminals, word-processing equipment, documents and reference material, subregistries, and telex and telephone communication facilities in offices previously used for staff accommodation.

Thirdly, the quantity of items - particularly publications - for which storage space was required had grown constantly over the years and continued to grow. That had led to an increase in the requirements for storage space at headquarters.

The Board had been informed that, although every effort had been made to make do with available facilities (including the reduction of standards of office occupancy, which were already lower than those elsewhere in the United Nations common system at Geneva), there was an urgent need for additional accommodation. Arrangements were again being made to rent office accommodation in the nearby ILO building, but ILO could only make such rented premises available up to the end of 1982.

The Board had been informed that the Director-General was proposing a series of measures by which the estimated cost of construction of the building extension, Sw.fr. 9 800 000, would have no implications for the regular budget of the Organization or the assessments of its Member States. Moreover, it was not proposed to use any casual income for the purpose. The details of the proposed financing were given in section 6 of the Director-General's report.
Having heard further details concerning the need for construction of an extension to the third prefabricated building, the Executive Board had adopted resolution EB67.R18, in which it recommended that the Thirty-fourth World Health Assembly should authorize the Director-General to proceed with the construction of additional facilities at headquarters at an estimated cost of Sw.fr. 9 800 000 and should approve the financial arrangements proposed by the Director-General for the purpose.

A summary record of the Board’s discussion on the item would be found in document EB67/1981/REC/2, pp. 364-368.

Mr Furth (Assistant Director-General), referring to the deferment of reimbursement of the Swiss loan to which reference was made in paragraph 6.2 of the Director-General’s report, said that the Director-General had been informed by the Head of the Swiss Federal Department of Foreign Affairs that the Federal Parliament had approved the proposed deferment of the repayment of the remaining seven annual instalments of the loan from the period 1981-1987 to the period 1988-1994.

Dr Galahov (Union of Soviet Socialist Republics) said that, on reading the document under consideration and looking around at the present accommodation, he found it difficult to agree on the need for the construction of a new building. The sum of Sw.fr. 9 800 000 for such construction was considerable, entailing the repayment of Sw.fr. 1 325 000 annually from the regular budget for the next seven years. The accommodation requirements for temporary staff and consultants appeared excessive; they should be averaged out, taking account of the number of such persons at Geneva at any given time, and their turnover. It should be possible for the same offices to be used by a succession of occupants. The number of staff had been reduced: thirty units of office space would be freed in 1981 and a number had also become vacant during the period 1977-1980. During the Committee’s consideration of the interim financial report and the question of casual income, Mr Furth had mentioned that the number of staff at headquarters had been reduced by some 300.

Perhaps office space should be rented outside headquarters to accommodate staff paid from extrabudgetary funds. Setting up a special fund to extend the headquarters building and repay the Swiss loan was unjustified. Without a firm guarantee of financing, the Organization would be forced to increase its already high regular budget level.

Headquarters office space could not be increased indefinitely: the process must be stabilized at some point. Payment for the main building had not yet been completed. The interim financial report showed that instalments had been paid to the Swiss Government for ten years, and if they were maintained at the same rate the debt would not be repaid before the year 2000. At a time when all countries were mobilizing their resources to attain health for all by that year, the deviation of funds to the construction of more headquarters buildings was undesirable, and other solutions should be sought.

If a draft resolution was submitted for the Committee’s adoption, he reserved the right to speak again in order to put forward appropriate amendments.

Mr Boyer (United States of America) said that the proposal before the Committee was a very difficult one to analyse. Two questions arose: first, whether WHO actually needed the new office space, and, secondly, whether such space, if needed, could be financed with no financial impact on Member States. The document claimed that WHO did need the space and that there was no impact on the regular budget.

The proposal should be approached cautiously. He was delighted at the generosity of the Government of Switzerland in offering to extend the interest-free loan for a further seven years, but he was not persuaded that the project had no potential financial impact on Member States. For example, if there was a fall in the level of extrabudgetary programmes operated by WHO, both the need for new office space and the expected income from rental would be reduced. If that expected income was insufficient to meet all the costs listed in the document before the Committee, they would have to be borne by the regular budget.

He recognized that that was partly speculative reasoning, but the Secretariat document was also based partly on optimism and on the projection of uncertain space needs and financing. In its continuing search for ways to reduce costs in the United Nations system, his Government has voiced its opposition to the construction of new buildings. Its new administration was attempting to promote austerity both at home and internationally, and it would be incongruous for it to support the construction of a new annex building for WHO at the present stage. His delegation would therefore have to vote against the proposal.
Mr WIDDOWS (Australia) asked, first, whether the Director-General had any information as to the date of decentralization of the special programmes in human reproduction and in tropical diseases, bearing in mind that such decentralization would release more office space at headquarters.

Secondly, he asked whether more use could not be made of offices when staff were on leave or on mission.

His delegation considered that extrabudgetary resources should be used to fund programmes rather than accommodation. Such funds might eventually decrease, and their use for non-programme purposes would affect the rate of programme implementation.

Mr FURTH (Assistant Director-General), referring to the comments made by the USSR delegate, said that it was difficult for him to give a clearer explanation of the real and urgent need for office and storage space than was given in sections 3 and 4 of the Director-General's report. He could give assurances that no regular budgetary funds were to be used for the construction of the proposed building. What was being proposed was that certain regular budget provisions that were automatically included in each programme budget for the repayment of the Swiss loan during 1981 and the following six years should be used for the construction and maintenance of the proposed building, and that the Swiss loan should later be reimbursed from sources other than the regular budget. There would thus ultimately be no additional charge on the regular budget for the construction of the proposed building.

As could be seen from the table in paragraph 2.1 of the Director-General's report, there had indeed been a reduction in regular budget staff of 158 persons between December 1976 and October 1978, and the reduction of such staff at headquarters was still continuing. However, as the table in paragraph 2.1 indicated, there had been a substantial increase in staff financed from extrabudgetary sources (91 persons between December 1976 and October 1980) as well as an increase in short-term staff and consultants.

The last column of the table in paragraph 2.1 showed a total increase of 52 staff members and consultants. Why had there been such an increase? Resolution after resolution adopted at each Health Assembly had urgently requested the Director-General to initiate new programmes financed by extrabudgetary funds and to take vigorous measures to increase extrabudgetary support for certain programmes already financed from the regular budget. During the previous four Health Assemblies 24 resolutions had been adopted requesting the Director-General to collect funds from extrabudgetary sources. At the Thirty-third World Health Assembly five such resolutions had been adopted: resolution WHA33.33 on cooperation with newly independent and emerging States in Africa, resolution WHA33.25 on research development and coordination, resolution WHA33.31 on workers' health, resolution WHA33.27 on narcotic and psychotropic substances, and resolution WHA33.26 requesting the Director-General to seek extrabudgetary support for the tuberculosis control programme.

He thought that in that respect the Director-General had been rather successful, as the most recent Financial Report showed and as several delegates had observed. He could provide a list of all the extrabudgetary posts that had been established at headquarters since 1 January 1980 from which it would be seen that the establishment of such posts was necessary. For instance, the Director-General had established two posts for the prevention of blindness programme, another post in connexion with smoking and health, two posts for the diarrhoeal diseases control programme, two for the fluoridation and dental health programmes, two in the Expanded Programme on Immunization, and one in connexion with alcohol-related problems. All these programmes were priority programmes to which the Health Assembly had given a great deal of moral and financial support.

The delegate of the Soviet Union had implied that renting space outside WHO might be cheaper than constructing a building. The cheapest rent obtainable in Geneva would be from ILO, whose building was also the most convenient location, and in fact 15 offices had been rented from ILO since the beginning of March 1981. The whole Expanded Programme on Immunization had been moved there. The Director-General had an option to rent another 30 offices in ILO as from July 1981, and that option would have to be taken up pending completion of the proposed extension of the building if it was approved by the Health Assembly. However, ILO had emphasized that the rental arrangements could not continue beyond 1982 because it needed the space itself. Taking then the ILO rental as the cheapest in Geneva, the rental of the number of offices proposed in the Director-General's report would amount to over Sw.fr. 1 200 000 a year, which would exceed the costs of construction of the proposed extension in less than seven years.

He was not unduly worried about the possibility that WHO would not be able to use the additional space. An expansion of staff was not being counted on: the space was really needed
right now. As stated in paragraph 3.8 of the report, 82 offices were immediately needed to relieve the most serious overcrowding. He could assure the delegate of Australia that it was common practice to use headquarters offices when their habitual occupants were on leave or duty travel. There were no additional offices for consultants: they could only be shifted from one vacant office to another.

The United States delegate had suggested that if there were a drop in extrabudgetary funds, the costs of the proposed new building would have to be picked up by the regular budget. But even if there should be such a drop, WHO would have little difficulty in renting out the additional space. That had been the experience of other organizations in the United Nations system in Geneva, such as ILO and the United Nations, which had never had any difficulty in renting out additional space they had available from time to time.

The Australian delegate had also said that extrabudgetary funds should be used for programmes and not for office accommodation of staff, presumably including extrabudgetary staff. The Joint Inspection Unit and other organs of the United Nations had looked into this question on several occasions and had repeatedly expressed the opinion that to the greatest possible extent staff financed from extrabudgetary funds should have accommodation paid from programme support costs reimbursed by extrabudgetary funds so as not to burden the regular budget with these costs. The charging of "rent" for the accommodation of staff being financed from extrabudgetary funds would not result, except in the case of three special programmes, in additional support costs being reimbursed to WHO by those extrabudgetary funds. The Organization was already receiving 14%, and beginning in 1982 would receive 13%, of all extrabudgetary expenditures as programme support costs; and, beginning 1 January 1982, it would identify and set aside part of these programme support costs as being required to pay for the accommodation of extrabudgetary staff. There would thus be no additional charge to any programmes financed from extrabudgetary funds, except for the Special Programme for Research and Training in Tropical Diseases, the Special Programme of Research, Development and Research Training in Human Reproduction, and the Onchocerciasis Control Programme, which had special arrangements for the reimbursement of programme support costs. However, even if these three special programmes were now required to pay "rent" for their staff accommodated at headquarters, their programme support costs would still not exceed 13% or 14% of total programme expenditures.

The DIRECTOR-GENERAL, replying to the delegate of Australia on the decentralization of the Special Programmes for Research and Training in Tropical Diseases and in Human Reproduction, observed that both those programmes were without parallel in the history of international cooperation. No other programme had squarely set forth two objectives: the strengthening of research capability in the developing countries themselves, where the problems were found; and the acquisition of new and relevant knowledge as quickly as possible. Those twin objectives were not easy to reconcile in practice. The two programmes were subjected to more intensive evaluation for managerial effectiveness and efficiency than any other programme in the Organization’s history - and not only internally but by a series of external review mechanisms. He was himself concerned at the magnitude of investment in evaluation and reviews, but they were necessary to satisfy all the participants. The problem of how many staff to have and where they should be stationed had just been the subject of a major review in the Special Programme for Research and Training in Tropical Diseases.

Nothing was more wasteful than decentralization for its own sake, as political window-dressing. In every programme, a critical mass of managerial and scientific expertise was needed. The Special Programme for Research and Training in Tropical Diseases was being carried out effectively and efficiently because it was a WHO programme established by the World Health Assembly, and because WHO could also use in that connexion its traditional programmes such as those in malaria, other parasitic diseases and vector biology. It might be convenient to solve the headquarters accommodation problem by removing the two special programmes from the global level, but he was sure that they would not function as efficiently as at present if they were transferred to some institute elsewhere in the world. The matter was under constant study: if some parts of the programmes could be appropriately transferred, it would be done. If Member States wished to send some of their own managerial experts to study those two programmes, he thought that not only would they be satisfied with the continuous managerial evaluation in progress, but they could perhaps take back lessons for their own institutions.

Dr GALAHOV (Union of Soviet Socialist Republics) asked for clarification of a few details. He had not of course said that the construction of the proposed building was to be financed from the regular budget: that was clearly not the case. However, he pointed out the connexion between the construction of the building and the regular budget. The direct link
was the sum of Sw.fr. 1 325 000 which the Organization paid every year to the Swiss Government in reimbursement of its loan and which would be postponed for a seven-year period. The second link was perhaps theoretical. He, and also the United States delegate, had pointed out that extrabudgetary funds fluctuated. If the proportion of them used for rent decreased, the difference could only be made up from the regular budget.

He had not intended to suggest that the cost of constructing a new building would be more expensive than renting, but he had implied that a rent of Sw.fr. 2 400 000 would be paid not to WHO but to ILO, accommodation being provided for WHO staff.

He had two amendments to propose to the draft resolution in resolution EB67.R18. First, in operative paragraph 2(1) a date should be given for the reimbursement of the Swiss loan. Second, in operative paragraph 2(2) there should be a mention of the exact date from which rent would be paid.

Mr Furth had listed many new posts; he asked if it would be possible to have a copy of the list. Finally, when the interim financial report had been considered by the Committee, he had asked how much accommodation WHO had in reserve, what premises it rented out, and what premises it paid rent for itself. He had not asked for an immediate answer, saying that the matter would probably be taken up again when accommodation was discussed; but he would appreciate a reply now.

Mr FURTH (Assistant Director-General) said that the amendments proposed by the Soviet delegate presented no difficulties. Operative paragraph 2(1) could be amended to read: "deferral of reimbursement of the Swiss loan from the period 1981-1987 to the period 1988-1994". That would be a welcome precision. Operative paragraph 2(2) could read "the charging of rent to extrabudgetary funds as from 1 January 1982". Again, the precision would be welcome.

He could certainly make available a list of extrabudgetary posts created since 1 January 1980.

He had not quite understood the question as to how much WHO was paying in rent at the moment. Perhaps the Soviet delegate was referring to the rental paid to ILO for the 15 offices WHO was renting from that organization. Those charges were Sw.fr. 2535 per module per year for air-conditioned net usable office space.

Dr GALAHOV (Union of Soviet Socialist Republics) repeated his question.

Mr FURTH (Assistant Director-General) said that WHO received rent for staff housing at the Regional Office for Africa. Staff were accommodated on the premises of the Regional Office and paid rent to WHO for use of those premises. There were a few other duty stations in the field where staff were paying rent for housing to WHO. At headquarters rent was received primarily from the International Computing Centre. That centre was located on WHO's premises, although several United Nations organizations participated in it on an equal basis. The rent amounted to about Sw.fr. 350 000 for 1980. Occasionally WHO also rented out a meeting-room to other international organizations which needed space, at the normal interagency fee.

The CHAIRMAN asked if the Committee was prepared to approve the draft resolution contained in resolution EB67.R18, with the amendments proposed by the delegate of the Soviet Union.

Mr BOYER (United States of America) wished to be able to record his negative vote. He was not questioning the validity of the Special Programme for Research and Training in Tropical Diseases or the Expanded Programme on Immunization, nor was he doubting the judgement of the Director-General. The question was whether WHO would obtain, essentially free, a building costing Sw.fr. 9 million. He thought that ultimately it might not be free, and he asked for a vote to be taken on the matter.

The draft resolution proposed by the Executive Board in resolution EB67.R18, as amended by the delegate of the Soviet Union, was approved by 60 votes to 1, with 27 abstentions.1

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1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA34.10.
5. FIRST REPORT OF COMMITTEE B (Document A34/15)

The CHAIRMAN invited the Committee to consider its draft first report (document A34/15).

Dr RODRÍGUEZ (Argentina) said that his delegation wished to reserve its position with regard to the draft resolution on reimbursement of travel costs of representatives to regional committees set out on page 5 of the draft report. The Members whose contributions to the WHO regular budget were at the minimum rate in the scale of assessments included not only the least developed countries, which he agreed should be reimbursed, but also certain countries which might well pay their own travel costs and were not considered as developing countries. With that reservation, his delegation approved the draft report.

The report was adopted (see document WHA34/1981/REC/2).

6. STUDY OF THE ORGANIZATION'S STRUCTURES IN THE LIGHT OF ITS FUNCTIONS - IMPLEMENTATION OF RESOLUTION WHA33.17: Item 35 of the Agenda (Resolution WHA33.17; Document A34/15)

Dr ÁLVAREZ GUTÍERREZ (representative of the Executive Board), introducing the item, said that the Thirty-third World Health Assembly had adopted resolution WHA33.17 on the study of WHO's structures in the light of its functions, in paragraph 6(5) of which the Director-General was requested to monitor the implementation of the decisions in the resolution and to keep the regional committees, the Executive Board and the Health Assembly fully informed on progress. In June 1980, the Director-General had submitted a plan of action for the implementation of the resolution, which was to be found in document A34/15, Annex 1.

The plan of action had been brought to the attention of the regional committees at their 1980 sessions, and Annexes 2-6 of document A34/15 showed the resolutions and recommendations adopted thereon by the regional committees.

At its sixty-seventh session, in January 1981, the Executive Board had considered and commented favourably on the plan of action and the Director-General's report on progress in implementing resolution WHA33.17. It had drawn attention to the omission from the plan of action of any mention of paragraph 4(3) of the resolution. That omission had been rectified in section 21 of the revised version of the plan of action appearing as Annex 1 to document A34/15. With regard to the monitoring function mentioned in paragraph 4(4) of the resolution, it had been asked whether the regional committees could reply directly to communications from the Board or whether they must do so through the Health Assembly. The Director-General had explained that relations between the regional committees and the Executive Board were regulated by Article 50(g) of the Constitution, by virtue of which it was in order for the Board to deal directly with the regional committees and request information from the regional directors.

Another question had been raised concerning the meaning of the words "on matters of regional and global interest" in paragraph 3(1) of resolution WHA33.17. One member of the Board had expressed the fear that that provision might be abused and that questions of a political or commercial nature might be referred to the Board. However, the Director-General had indicated that it was in the interests of WHO as a whole that the Board should consult the regional committees on resolutions and decisions before submitting them to the Health Assembly. Finally, the Board had taken note of the Director-General's progress report, and had noted that a further report would be submitted to the Board's sixty-ninth session and to the Thirty-fifth World Health Assembly in 1982.

After the Board's consideration of the plan of action, an ad hoc working group had studied one of the elements of the plan, namely documentation for use by countries, as mentioned in section 31 of document A34/15, Annex 1. The main recommendations of that working group, which had been approved by the Director-General, appeared in Annex 7 of document A34/15.

At its sixty-sixth session, in May 1980, the Executive Board had set up a working group to study the functions and activities carried out by the Secretariat, in connexion with resolution WHA33.17, and particularly paragraph 6. The report of that working group would be submitted to the sixty-ninth session of the Board in January 1982.

With reference to operative paragraph 1(6) of resolution WHA33.17, the Board had considered at its sixty-seventh session a report by the Director-General on the establishment of a Health Resources Group, whose proposed functions were to rationalize the international
transfer of resources for primary health care in developing countries and to mobilize additional resources if possible. While acknowledging the importance of such action, the Board had expressed certain reservations concerning the Group's proposals for its mandate and legal status, and the use of the Primary Health Care Initiative Fund under the Group's control. At its sixty-eighth session, the Board would examine a new report by the Director-General on his subsequent consultations on the establishment of the Group.

Finally, it was clear from document A34/15 that the study of the Organization's structures in the light of its functions was being conducted with the utmost care, as recommended in resolution WHA31.27.

The CHAIRMAN reminded Members that the implementation of resolution WHA33.17 was a continuing process. The progress report submitted by the Director-General was designed to keep the Health Assembly informed not only of the action being taken to implement the resolution but of plans for such action. As already noted, a further report would be submitted to the Board's next session on the establishment of the Health Resources Group for Primary Health Care.

Mr VOHRA (India) stressed the importance of the item under consideration; it had first been introduced some two years previously with great excitement and enthusiasm, and he hoped that as time passed it would be kept under constant review, and not relegated to a secondary position.

The implementation of resolution WHA33.17 required considered thought on the type of contribution to be made by each country and the type of monitoring and evaluation to be used in assessing results. Without such careful thought, governments would continue to seek the Organization's help along traditional lines by requesting fellowships and equipment which might be outdated and irrelevant to present-day needs. To some extent that was continuing to happen, and he was not sure that restructuring was proceeding as the Director-General might have wished.

Resolution WHA33.17 also highlighted the need to intensify the role of the regional committees. It must be asked whether that was in fact being done and whether the issues discussed and the recommendations made by the regional committees were indeed more specific and more pertinent than they had been in the past. If events were to follow the correct course in the future, integrated and highly coordinated planning both at headquarters and at the regional offices was vitally important. It was clear that, unless the highest level of intersectoral coordination could be achieved, the goal of health for all by the year 2000 would remain a dream. A positive attempt must be made to ensure coordination among the various programmes at headquarters, including the special programmes, so as to avoid duplication and waste.

As had been indicated, one of the most important elements was the monitoring and evaluation of past activities to ensure that attention was not focused on those that were no longer relevant to current problems and priorities. These might include intercountry, interregional, and even some global programmes, although not the special programmes. In exercises carried out in the South-East Asia Region, it had been found that there was substantial scope for doing away with some of the continuing activities which had lost both relevance and credibility and had been supplanted by more directly useful programmes.

WHO might also consider whether the remaining period of the Sixth General Programme of Work could be reoriented to give it greater relevance to the problems, priorities and areas of need involved in the goal of health for all. Similarly, a completely new approach should be adopted in planning the Seventh General Programme of Work.

With regard to the Health Resources Group, his Government had so far been represented at only one meeting; he had had great hopes for the Group, but had since learned that some problems might be involved in setting it up. He stressed that whatever additional resources might be raised should be directed to the areas of most need, such as water supply and sanitation. Further in-depth studies were unnecessary since such deserving areas had already been listed and pages 1-3 of document A34/15 gave a broad indication of what was required. Whatever bodies might be set up to consider the relevant issues should spend most of their time in the regions, placing particular emphasis on studies in individual countries.

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

The meeting rose at 17h35.
SIXTH MEETING

Friday, 15 May 1981, at 9h30

Chairman: Dr Z. M. Dlamini (Swaziland)

TRANSFER OF THE REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN: Item 37 of the Agenda (Document WHA33/1980/REC/1, resolution WHA33.16 and Annex 2; Document A34/16) (continued from the fourth meeting, section 4)

The CHAIRMAN drew attention to the following draft resolution, sponsored by the delegations of Bahamas, Botswana, Canada, Central African Republic, Federal Republic of Germany, France, Guyana, Kenya, Nigeria, Norway, United Kingdom of Great Britain and Northern Ireland, United States of America, Zaire and Zambia:

The Thirty-fourth World Health Assembly,
Recalling resolution WHA33.16 deciding to submit to the International Court of Justice for its Advisory Opinion certain questions before taking any decision on a transfer of the Regional Office;
Having considered the Advisory Opinion on these questions given by the International Court of Justice;
Recalling further the study of the working group of the Executive Board concerning aspects of the question of a transfer of the Regional Office for the Eastern Mediterranean;
Noting the wishes of the majority of Member countries of the Eastern Mediterranean region to transfer the Regional Office from Alexandria;

1. THANKS the International Court of Justice for its advisory opinion on the questions submitted to the Court by the World Health Organization;

2. ACCEPTS the Advisory Opinion of the International Court of Justice of 20 December 1980 and recommends to all parties concerned to be guided by it:

3. REQUESTS the Director-General:

(a) to take necessary steps to initiate action as contained in sub-paragraph 2 (a) of paragraph 51 of the Advisory Opinion and report the result of his consultation to the sixty-ninth session of the Executive Board in January 1982 for consideration and recommendation to the Thirty-fifth World Health Assembly in May 1982;

(b) to continue to take whatever action he considers necessary to ensure the smooth operations of the technical, administrative and managerial programmes of the Regional Office for the Eastern Mediterranean Region during the period of consultation;

4. REQUESTS the Government of Egypt to hold consultations with the Director-General as mentioned above.

Dr AL SHABANDER (Iraq) associated himself with the many speakers who had stressed that, in order to meet the wishes of the overwhelming majority of the Member countries of the Eastern Mediterranean Region, it was essential to transfer the Regional Office from Alexandria. If the Regional Office remained inactive in its existing location, the Member countries of the Region would be prevented from enjoying the benefits of WHO and its services. It was to be regretted that, after a delay of two years, 14 countries not concerned with the Eastern Mediterranean Region should have submitted a draft resolution which was contrary to the wishes and interests of the States of the Region. The object of those countries was clearly to cause delays which would dilute the issue. Such attempts were being made at second or third hand and were designed to dissipate the rights of the countries of the Region.
The draft resolution, moreover, was in conflict with the Opinion of the International Court of Justice, which had referred explicitly to the need for the countries of the Region to assert their right to the location on which they insisted. He therefore hoped that the Health Assembly would adopt the alternative draft resolution submitted by 19 Member countries and put before the Committee at its fourth meeting.

Dr AL-AWADI (Kuwait) regretted that it had not so far been possible to negotiate a compromise on the issue. He therefore reiterated his delegation's complete support for the 19-country draft resolution, as amended by the delegation of Saudi Arabia, in the absence of compromise that draft resolution represented the only possible just solution.

In an effort to avoid further useless confrontation, his delegation had nevertheless continued its efforts to see whether the 14-country draft resolution could be amended in such a way that a compromise could still be reached. In that spirit he wished to introduce a number of amendments to that draft resolution. He proposed that the first preambular paragraph should be amended to read as follows:

"Recalling resolution EM/RC-SS2 A/R.1 of Sub-Committee 'A' of the Eastern Mediterranean Region and further recalling resolution WHA33.16 deciding to submit to the International Court of Justice for its Advisory Opinion certain questions before taking any decision on a transfer of the Regional Office;"

The fourth preambular paragraph should read as follows:

"Accepting the decision of the majority of Member countries of the Eastern Mediterranean Region to transfer the Regional Office from Alexandria;"

A new fifth preambular paragraph should be added as follows:

"Considering that every Organization has the right to choose the site of its Headquarters or of its Offices and to transfer them elsewhere;"

A new sixth preambular paragraph should be added as follows:

"Bearing in mind that the majority of the Member States of the Region have decided to cover, on a voluntary basis, the total costs resulting from the transfer of the Regional Office to Amman, together with the increase in the annual recurrent costs for five years;"

Operative paragraph 3(a) should read:

"(a) (i) to take action as contained in paragraph 51 of the Advisory Opinion and with the countries concerned;
(ii) to take the necessary steps to start the transfer of the Regional Office for the Eastern Mediterranean;
(iii) to inform the Regional Committee of the actions taken thereon;
(iv) to report to the sixty-ninth session of the Executive Board in January 1982 on the steps taken for its consideration in order to formulate its recommendations to the Thirty-fifth World Health Assembly in May 1982;"

Operative paragraph 3(b) should read:

"(b) to continue to take whatever action he considers necessary to ensure the smooth operations of the technical, administrative and managerial programmes of the Eastern Mediterranean Region;"

Lastly, operative paragraph 4 should be deleted.

The purpose of the proposed amendment to the first preambular paragraph was to draw attention to the origin of the problem by recalling the relevant resolutions. The amendment to the fourth preambular paragraph would make it clear that the Health Assembly at least accepted the wishes of the majority of Member countries of the Eastern Mediterranean Region to transfer the Regional Office from Alexandria. The proposed new fifth preambular paragraph would strengthen the text; an organization should clearly have an absolute right to choose the site of its headquarters or offices.

A number of delegations had drawn attention to the cost of the transfer. His delegation therefore proposed the addition of a new sixth preambular paragraph to cover that point. While some countries of the Region could clearly not contribute to the cost of the transfer, he was sure that the majority would be willing to do so on a voluntary basis.

Paragraphs 1 and 2 of the draft resolution were acceptable to his delegation but paragraph 3 stretched injustice to the limit. As it stood, paragraph 3 requested the Director-General to consult for a further year on modalities which could hinder progress for another 10 years. Consultations with Egypt were already in their third year and, in the meantime, the Regional Office was paralysed and would remain so if there was no change. The majority of the countries of the Region wanted the change. His delegation's amendments to paragraph 3 would authorize the Director-General to take the necessary steps to start the transfer of the Regional Office. Proposed paragraph 3(a)(iv) expressed his delegation's hope
that the sixty-ninth session of the Executive Board would be the last at which the matter would require to be considered. Proposed paragraph 3(b) stressed the need to continue the programmes for the Eastern Mediterranean while the Region itself remained paralysed. If those proposed amendments were adopted, paragraph 4 would not be necessary.

He expressed the hope that his delegation's amendments would be acceptable to the sponsors and to other delegations in a spirit of compromise.

Mr ZENKER (German Democratic Republic) considered that the Health Assembly would make a just decision if it respected the opinion of the majority of the Member countries of the Eastern Mediterranean and transferred the Regional Office from Alexandria. Such action would end the paralysis of the Regional Office, guarantee its normal operation, and improve international cooperation in health matters. Any alternative would have negative consequences.

His delegation therefore supported the transfer of the Regional Office for the Eastern Mediterranean from Alexandria.

Mr MUSTELAK (Poland) said that a number of the issues raised, such as the boycott, were debatable. His delegation could not agree with the way in which the question of setting a precedent was being dealt with, as it implied that governments were in the habit of taking irresponsible action.

Concerning the legal aspects, the Advisory Opinion of the International Court of Justice nowhere precluded the possibility of transferring the Regional Office. It was therefore important to be guided by facts, and no argument could change the very real fact that the Regional Office could not function against the will of the large majority of countries in the Region. The Health Assembly must provide adequate guidance to the Director-General by indicating that bringing about a transfer would ease the situation, make it possible to realize the fundamental and broader interests of the Organization, and allow the Region in question to proceed normally in implementing WHO's strategies.

Operative paragraphs 3(a) and 3(b) of the 14-country draft resolution would not be effective without such clear guidance, since delay would surely impair regional operations. Paragraph 3(b) was particularly misleading. In addition to technical, administrative and managerial programmes, WHO should be concerned above all with the health programmes in the Region.

The 19-country draft resolution provided an answer to the substantive question of a transfer without prejudice to the legal process. The amendments proposed by the delegate of Kuwait were intended to put the matter in its proper perspective and take into account all views expressed on the subject. His delegation would be guided by the interests of WHO and of the Eastern Mediterranean Region as expressed by a majority of countries from that Region.

Dr LUBANT (Jordan) reminded delegates, particularly in the light of the wording of the 14-country draft resolution, that it was a decision and not a wish that had been expressed in resolution EM/RC-SS2 A/R.1 of Sub-Committee A of the Regional Committee for the Eastern Mediterranean. Unfortunately, for purely political reasons, the Health Assembly had adopted resolution WHA33.16 and submitted the matter to the International Court of Justice. His country had contended and still contended that the matters raised therein were not relevant. Moreover, following the letter (reproduced in document WHA33/1980/REC/1, Annex 2, section 8) informing the Director-General that Members in the Region had decided to boycott the Regional Office in Alexandria, the Office had effectively been paralysed. He reminded delegates that in the previous year an estimated US$ 3 485 000 in running costs had been wasted and that to date the total cost to WHO stood at US$ 6 970 000, which was a high price to pay. To set the record straight, he pointed out that the percentage estimated for the increase in running costs if the Office was moved to Amman had been corrected downwards from 70% to 50% in document A33/19 Add.1 (see document WHA33/1980/REC/1, Annex 2, section 2). It would be interesting to know whether the US$ 3 485 000 included unforeseen or unmentioned expenses arising, for example, from time wasted by experts on travel and hotel accommodation. It was also relevant to ask whether telephone and telex communications were working effectively and whether an international airport existed in Alexandria, since without those means of communication no office could function adequately or efficiently.

The 14-country draft resolution once again opened the whole issue to question by intentionally disregarding the decision of the majority of the Members of the Region and by referring only to subparagraph 2(a) of paragraph 51 of the Advisory Opinion of the International Court of Justice. Both those points were unacceptable and must be rejected. He called on delegations to abide by resolution WHA33.16, by which it had specifically been decided to submit
the issue to the International Court of Justice, and to carry out their duty to take a decision now that the Advisory Opinion had been circulated. The logical and democratic way of reaching a decision was to act in conformity with Article 44(b) of the WHO Constitution and decide to move the Office from its current location. Anything short of that would mean that the Office would continue not to function.

In conclusion, he endorsed the remarks made by the delegate of Kuwait when introducing his amendments.

Dr LENghi (Libyan Arab Jamahiriya) said that he considered the 14-country draft resolution as a means of paralysing administration in the Region and preventing measures which should have been accepted in recognition of the demands of the overwhelming majority of Members in the Region. The draft resolution added nothing new and failed to serve the Region or offer an immediate solution to the existing problem. If it should be adopted as a result of a simple mathematical majority, a decision might not be taken for some five years, which would cause stagnation and have serious effects on the Region. As a Member of that Region, his country was particularly interested in the effectiveness and capacity of the Regional Office and attached great importance to its duties and functions for the benefit of the countries of the Region. In the light of the current situation his country was fully convinced of the need to transfer the Regional Office from Alexandria and therefore fully supported the amendments presented by the delegate of Kuwait. It was essential to respect the wishes of the ministers of health of the Eastern Mediterranean Region. He considered that any measures taken must be in conformity with the Advisory Opinion of the International Court of Justice and with paragraph 51 in its entirety. Moreover the necessary measures to proceed with the transfer of the Office must be taken without delay. The willingness of countries of the Region to assume all costs arising out of the transfer was in itself an expression of goodwill and further evidence of the repeated efforts to prevent any attempt to impede the work of the Organization, which would inevitably be adversely affected if the Regional Office were to remain in its present location.

Dr Falaki Moloma (Zaire) said that, if delegations were being called upon to choose between the different Arab countries in the problem dividing them, his delegation, no doubt like many others, would refrain. The Health Assembly was one of those rare forums where members spoke the same language, for illness had neither race nor frontier nor ideology, and health in the sense of total wellbeing provided peace for the individual, the family and society. Should not the Health Assembly therefore, at a time when mediatory missions for peace were increasing in the political arena, attempt through concrete action and open dialogue to attenuate the situation whereby one State was being rejected by its brother States on political grounds? In keeping with African wisdom, the Committee should encourage fraternal discussion, not division.

Disease knew no frontiers, and health policies did not always match national policies, which were limited by artificial borders and were subject to internal pressures applied by different interest groups. Health policies were on a higher plane and the Health Assembly's mission was universal, calling for objectivity, tolerance, and peace through frank discussion. The peoples represented at the Health Assembly had not asked their delegations to create division by being in sympathy with some countries or against others. The Committee had no right to support the rejection of one State by its brother States for transient, political or other, undisclosed motives.

Meanwhile, the Region had urgent health problems. The host country for the Regional Office had not refused entry to nationals of other countries in the Region nor had it refused to participate with representatives of those countries in meetings on health organized elsewhere. The problem was a political one which had to be solved as speedily as possible in the interests of the wellbeing of the peoples of the Region. Why and by what right should an Arab country be asked to agree to the transfer of the Regional Office to Amman when it was in conflict with another country in the Region as a result of a temporary majority? The countries concerned were being faced with a moral defeat at the risk of establishing a precedent for the other regions, where the same problems might exist, but the same unity in the background of the majority was lacking. Perhaps one day the Office would move from Amman, adding another blow to the moral rights and interests of WHO's host countries. Once the gangrene of perpetual moves set in, the Organization's offices would end up in outer space. Realism, objectivity and tolerance were essential if a balance was to be maintained and a solution reached which rose above mere feelings and focused on the effective running of the Regional Office for the good of the peoples of the Eastern Mediterranean.
Mr Vohra (India) said that he was aware of the deep concern felt by the Members of the Eastern Mediterranean Region and of their prolonged efforts to secure a consensus. Since the vast majority of those Members had resolved to transfer the Regional Office from Alexandria, their wishes, inasmuch as they were the countries directly involved, should be respected. His delegation therefore fully endorsed the amendments introduced by the delegate of Kuwait.

Mr EL REEDY (Egypt) said that, although it had not originally been his intention to speak, he wished to respond, in a spirit of dialogue between countries belonging to the Arab world, to certain points raised by the delegate of Kuwait. The latter had stated that the inclusion of the item before the Committee in the agenda of the World Health Assembly was the work of politicians. It was true that the issue should have been dealt with from the standpoint of the extensive interaction and communication which bound together the Arab countries and peoples and that cooperation in the field of health should not be allowed to become a political problem. Moreover, the matter must be settled as quickly as possible, as the lengthy discussion was wasting the time and efforts of delegates from all parts of the world. He therefore appealed to his Arab colleagues to join with him in resolving the issue without introducing emotional considerations.

The delegate of Kuwait had also observed that the recommendation of Sub-Committee A of the Regional Committee for the Eastern Mediterranean should be approved as representing the majority view. He did not wish to invoke legal arguments to show that, in such an important matter which was of concern to the Organization as a whole, that was not necessarily so. Speaking from a strictly democratic standpoint, he was sure that people in the street anywhere in the Arab world would disagree with the recommendation to transfer the Regional Office from Alexandria. Although Egypt had only one vote, it represented a third of the Arab world. Moreover, since Iran had made it known that it wished the Regional Office to be transferred not to Amman but to some other location, it could be concluded that at least half of the population of the Eastern Mediterranean Region opposed the transfer as recommended.

The delegate of Kuwait had further referred to the paralysis of the Regional Office, and yet the report of the Director-General for 1980 contained 12 paragraphs referring to its activities and meetings in various parts of the Region. The Regional Committee for the Eastern Mediterranean had been meeting outside Alexandria regularly for 30 years. It was clear, as the delegate from Peru had pointed out earlier, that it was precisely those who were complaining about the paralysis of regional activities that were boycotting its meetings. Egypt, on the other hand, was prepared to attend meetings of the Regional Office wherever they might be held.

Mrs Emmanuel (Nigeria) said that the alternative draft resolution sponsored by 14 countries had been described as anaemic and debilitated. If those words could mean compromise, fairness and rational action, then perhaps that was so. There was no doubt that all the delegations attending the World Health Assembly hoped that a peaceful and rational atmosphere would prevail so that they could work together towards a global improvement in the health status of mankind. Although politics could not be completely divorced from health, the sort of politics which had recently been permeating the Organization was likely to impede its progress and should therefore be transferred to the appropriate forum. Throughout the sequence of events which had led to the current proposal to transfer the Eastern Mediterranean Regional Office and, more recently, to the 14-country draft resolution in an effort to reconcile the somewhat inflexible and extreme positions adopted by the two parties concerned, the Health Assembly had acted promptly and in a rational, consistent and unbiased manner. The Advisory Opinion of the International Court of Justice, which was a carefully worded and commendable document that had been praised by both parties during the discussion, formed the basis of that draft resolution. If the Advisory Opinion was to be accepted, then logically that draft resolution must also be recommended to the Health Assembly for acceptance. The Nigerian delegation's own decision to co-sponsor the text was based on a desire to respect the technical nature of the Organization, a desire for justice and fair play, a desire for peace and understanding and a deep conviction that the overriding consideration of all delegations was the health of all mankind. It was for those reasons that she hoped that the members of the Committee would, in a spirit of compromise, agree to approve the alternative draft resolution by consensus.

Dr Mocumbi (Mozambique) said that his delegation was greatly concerned that the work of the Committee was being held up and urged that the matter under consideration be settled quickly. The most urgent task was to guarantee that the Eastern Mediterranean Regional Office could be made operational so that it could implement resolutions and decisions adopted at the regional and international levels. Since the Regional Office was clearly encountering difficulties in
its present location, the delegation of Mozambique felt that the recommendation of the countries involved to transfer its headquarters should be respected. Approval of the 14-country draft resolution as it stood, on the other hand, would mean that a final decision in the matter would have to be postponed to a later date and would fail to provide the Director-General with the means of ensuring that the Regional Office carried out its activities as the WHO Constitution required. In a spirit of compromise, however, his delegation was prepared to support it with the amendments submitted by the delegation of Kuwait.

Mr THABANE (Lesotho) said that the question before the Committee raised a deep political issue which must be treated on its merits. His delegation had waited before deciding to co-sponsor the 14-country draft resolution in the belief that there was still room for compromise and had been greatly relieved at the apparently unanimous decision to adjourn further debate until such a compromise could be reached. However, if no better solution could be found than that suggested in the amendments submitted by the Kuwaiti delegation, then his delegation had no alternative but to co-sponsor the draft resolution in its original form, which quite rightly continued to place the Organization's trust and confidence in the ability of the Director-General to resolve the issue satisfactorily. It would meanwhile keep an open mind on the subject and would willingly lend its support to any genuine effort to reach a compromise.

Dr THOMSON (Australia) said that the discussion concerned a delicate and important issue which could have far-reaching consequences for the Organization and its regions. There was a danger of an unfortunate precedent being set since what happened in one region might, for comparable reasons, happen in another region where financial arrangements of the kind currently being proposed might not be possible. The Health Assembly had been right to seek an Advisory Opinion from the International Court of Justice, which had delivered a clear and balanced Opinion that ought to be accepted as a guide, especially as there were rights and obligations on both sides of the regrettable division that was reflected in the debate. The draft resolution sponsored by 14 countries explicitly accepted the Advisory Opinion of the International Court of Justice as a guide and proposed a course of action that was firmly based on the first element of that opinion. It seemed to offer the best possible compromise around which a consensus might eventually be formed and therefore had the full support of the Australian delegation.

Mr ABBASSI TEHRANI (Iran), exercising his right of reply, drew attention to the Egyptian delegate's statement that no Arab asked about the transfer of the Regional Office would support the proposal. He suggested that the Egyptian delegation go to Iran, Cyprus and other non-Arab or even Arab countries, where they would no doubt find a positive response to the proposed transfer among people in the street. As Moslems, the Iranians had affinities with their Moslem brothers throughout the world but the Eastern Mediterranean Region was not composed solely of Arabs. He reminded the delegate of Egypt that Islam made no distinction between nations and condemned all forms of racism on grounds of colour or nationality.

Mr EL REEDY (Egypt) assured the delegate of Iran that at no point had he intended to suggest any division between Arab and non-Arab countries, when all were part of the Moslem nation and held the same values.

The meeting rose at 11h25.
1. TRANSFER OF THE REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN: Item 37 of the Agenda (Document WHA33/1980/REC/1, resolution WHA33.16 and Annex 2; Document A34/16) (continued)

Dr DE PAREDES (Guatemala) said that his country respected the wishes of the Member States of the Eastern Mediterranean Region, and was grateful to the International Court of Justice for the Advisory Opinion it had given on the matter. He fully agreed with the delegate of Kuwait that it was not for the politicians to decide on questions of the Organization's rights. However, he believed that it was undesirable to establish precedents which in the future might have repercussions on other regions.

His delegation supported the draft resolution sponsored by the 14 countries. In regard to the amendments proposed by the delegation of Kuwait, he proposed that they should be voted on along with the resolution, in accordance with Rule 67 of the Assembly's Rules of Procedure.

Dr LOEMBE (Congo) said the issue was one of the most sensitive and complex ones on the Health Assembly's agenda, involving as it did a multitude of political, economic, social and humanitarian considerations. The matter had been left to drag on for far too long, and the time had come to try to reach a decision if the whole proceedings of the Assembly were not to be paralysed. The problem was one that had baffled the best legal experts, and the distinguished representatives of the medical and political world who were present were far from unanimous on it. A number of recommendations and resolutions had been distributed which had not met with support on the part of the non-aligned and developing countries. The resolution of the 14 countries, recalling resolution WHA33.16 and the Advisory Opinion of the International Court of Justice, responded to the urgent need to resolve the problem in accordance with the wishes expressed by countries of the Region so that the Regional Office could resume its activities. However, the transfer of the Regional Office, although requested by the majority of Member States of the Region, was obstinately opposed by many countries other than Egypt. The refusal of Egypt to permit the transfer of the Alexandria Office had led to a paralysis of the Office's activities and consequently to an unhappy political climate and the jeopardizing of the spirit of solidarity which should normally exist among States of the same Region.

He was reassured by the fact that not all the activities of a regional office took place at its headquarters, and that regional committee meetings, and also seminars and workshops, could take place in different countries of a region. He therefore hoped that in time there would be an improvement in the situation, since time had often led to the solution of even more serious political problems.

While recognizing the complexity and seriousness of the issue, he appealed to those present not to give their support to action that was likely to be divisive, but rather to try and promote understanding and reconciliation, so that States could present a common front in the struggle against disease. It would be dangerous to create a precedent by agreeing to the transfer of the Regional Office; the draft resolution, under consideration, suitably amended, should permit an easing of the situation - at least for the present - for both sides alike. He urged that Members should devote all their efforts to the development of primary health care, in order to be ready to meet the challenge of the year 2000.

Mr AWAN (Pakistan) stressed that the meeting should not lose sight of the importance of respecting the wishes of the majority of Members in the Eastern Mediterranean Region. The majority had taken a clear stand on the issue, and the amendments proposed by the delegation of
Kuwait represented a balanced and reasonable approach. He would therefore vote in favour of those proposed amendments.

Dr AHMAD (Afghanistan) also supported those amendments.

Dr FERNANDES (Angola) said his delegation's guiding principle in the debate was the principle of democracy. The matter was one that had been at issue for many years, and a body had been set up to study the feasibility of a transfer. As he saw it, the very setting up of such a body implied approval of the transfer, since otherwise the study would not have been carried out. In addition, the opinion of the International Court of Justice had been sought. The fact that emerged from these investigations was that the Eastern Mediterranean Region preferred to carry out its work in a different way for the greater benefit of its peoples, and that most of the countries of that Region were in favour of the proposed transfer.

Since his delegation supported democracy it would vote in favour of the draft resolution of the 14 countries, as amended by the delegation of Kuwait.

Mr NAKAMURA (Japan) considered that the Assembly should abide by the Advisory Opinion given by the International Court of Justice. His delegation supported the Nigerian view that the draft resolution should be adopted by consensus.

Mrs PÁROVÁ (Czechoslovakia) said that if the majority of countries in the Eastern Mediterranean Region believed that the transfer of the Office would provide more effective working conditions and improve cooperation with other countries of the Region, their wishes should be respected. Her delegation would therefore be in favour of the Regional Office being transferred to some other country.

Mr BENAVIDES (Peru) said that the issue was essentially a political one, although it also had implications at other levels; that meant that it was not possible to consider it in a purely objective manner. Nevertheless, some progress had been made towards solving the problem, since now two possible versions of a solution had been put forward, whereas previously the Health Assembly was being asked to accept only one solution. Whereas it was perfectly legitimate for States to express their wishes and to exercise their rights by putting forward those wishes, as had been done by the delegations presenting amendments, that did not mean that those wishes had a universal validity.

He considered that the draft resolution of the 14 countries provided the wisest solution to the problem by placing it in a legal context, thus leaving less room for controversy. The disadvantage of that solution in the eyes of some would be that their wishes were not immediately gratified, whereas its disadvantage in the eyes of others (including his own delegation) would be that other equally valid interests might be affected. Basically, the choice was between a speedy solution and a more long-term one that would overcome the difficulty without detriment to the interests and dignity of all parties.

If the matter were to be put to the vote he believed that the resolution should be voted on as a whole rather than paragraph-by-paragraph, since all parts of the resolution were interrelated. In order to ensure that the stand taken on this highly political issue should not be taken as implying the adoption of particular positions on more important political issues, he proposed that voting should be by secret ballot.

Mr O'BRIEN (New Zealand) said that his delegation based its position on its conviction that political issues should not be allowed to dominate the concerns of specialist bodies such as WHO, and upon a belief in the broad overall role of the Organization. He shared the regret that had been expressed that Members of the Region had not themselves been able to resolve what had been described as an unfortunate family dispute. The good spirit shown in the debate led him to hope that a solution acceptable to all parties was not impossible, and he believed that the draft resolution of the 14 countries would provide a basis for such a solution. He supported the suggestion that it should be adopted by consensus.

Professor HALEEM (Bangladesh) said that, in his delegation's view, the issue under consider- ation was essentially a regional matter; it was therefore right that the wishes of the majority of countries in the Region should be met, bearing in mind however that the Organization's ability to function efficiently and effectively should not be hampered. In keeping with that principle, his delegation shared the feeling of the majority of delegations and supported the amendments submitted by the delegation of Kuwait, which met the requirements to which he had referred.
Dr Poudayl (Nepal) observed that, despite the brilliant speeches that had been made, there appeared to be little consensus. His delegation would therefore like the matter to be decided by secret ballot.

Dr Alderete Arias (Paraguay) said that, although the delicate issue under discussion was purely regional in character, it had worldwide implications; the attitude adopted by the Health Assembly might set a precedent for engaging in political arguments that had nothing to do with the aims and purposes of WHO. In order to bring to an end a discussion in which time that could have been devoted to more useful topics had been wasted, he supported the proposal for a secret ballot.

The Director-General recalled that he had been asked by a number of delegates to give an appraisal of the atmosphere in which the work of the Eastern Mediterranean Region had taken place during the period between the Thirty-third and Thirty-fourth World Health Assemblies.

In their teamwork, the Deputy Director-General and he himself had constantly been at the entire disposal of individual Member States, of groups of Member States, and of the Health Assembly as a whole in order to preserve two key aspects of the Organization: its universality and the optimum working atmosphere in which its constitutional mission could be fulfilled by all Member States, individually and collectively. If being at the disposal of Member States was called "playing politics", so be it. It was his interpretation of the Director-General's prerogative under the Constitution.

Turning to the substance of the matter, he recalled that, at the Thirty-third World Health Assembly, he had offered his good offices with a view to reducing the damage that might be caused to the Organization by the situation in the Eastern Mediterranean Region, to which damage repeated reference had been made during the discussion. Throughout the current year, the Regional Director and he himself had been in consultation to see what could be done to reduce that damage. He wished to refer to two aspects.

The first related to the functioning of the Region as foreseen in the Constitution. The efforts of the Regional Director and himself in that area, as far as the convening of the Regional Committee and the supervision of the Regional Office by the Regional Committee were concerned, had been unsuccessful.

Secondly, the Regional Director and he himself were prepared to go beyond the call of duty in order to satisfy the requirements of all Members of the Organization to the maximum extent possible within the constraints to which he had referred. He was grateful to those who had acknowledged that they had tried to do so; they had, in fact, tried very hard, for the sake of the peoples of the countries concerned, to organize a degree of cooperation.

In the spirit of health for all, he appealed to all delegations to do even more than their duty, in an endeavour to reach a consensus that would be to the benefit of all.

The meeting was suspended at 15h15 and resumed at 15h55.

The Chairman said that, in response to the Director-General's plea, a negotiating group composed of the delegations of Canada, Egypt, Kuwait, Nigeria and Saudi Arabia had held informal consultations during the break and had reached a consensus on a compromise. They proposed that the word "Noting", in the fourth preambular paragraph of the draft resolution of the 14 countries should be replaced by the word "Recognizing"; and that operative paragraph 3(a) should be amended to read:

"(a) to initiate action as contained in paragraph 51 of the Advisory Opinion and report the results to the sixty-ninth session of the Executive Board in January 1982 for consideration and recommendation to the Thirty-fifth World Health Assembly in May 1982;"

He appealed to the Committee to adopt the amendments in a spirit of brotherhood and cooperation, and to refrain from entering into further discussion on the item.

The amendments were adopted.

The draft resolution proposed by the 14 countries, as amended, was unanimously approved. 1

Mrs Brown (Bahamas) commended the efforts of the negotiating group and of all those who had worked so hard to bring about agreement. She earnestly hoped that the activities of the ensuing year would be conducted in a similar spirit of true brotherhood.

1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA34.11.
Mr EL REEDY (Egypt) expressed his deep appreciation and gratitude to the delegations from Africa, Europe and Latin America, and to the United States delegation and others, for their cooperation in reaching agreement on the draft resolution which had just been approved.

Dr AL-AWADI (Kuwait) thanked the Chairman for the efforts that he, personally, had put into the important move just made. The draft resolution was not what the countries of the Eastern Mediterranean Region would have wished, but since a consensus and a ground of cooperation and understanding had been reached, they hoped that it would facilitate the work of the Director-General in taking the right steps towards executing the operative provision of the Advisory Opinion of the International Court, so that greater justice might be done to the Region.

Mr BENAVIDES (Peru) expressed satisfaction at the fact that a group of delegates had succeeded in producing a negotiated text, which represented a small masterpiece of diplomacy. His delegation was gratified that the call for understanding and brotherhood had been heeded and that it had been possible to find a solution that safeguarded the dignity of all parties. Such a triumph of reason was a matter for rejoicing.

Dr GEZAIRY (Saudi Arabia) expressed appreciation to all those who had helped to reach agreement, and to all who had spoken in favour of the countries of the Eastern Mediterranean Region. In order to save time, those countries had departed considerably from their original proposal and had provided the Health Assembly with an opportunity to take the right decision at its next session. They expected to receive an explicit report from the Director-General and from the Executive Board, and he hoped that the Health Assembly would then be able to reach a satisfactory conclusion without delay.

2. STUDY OF THE ORGANIZATION'S STRUCTURES IN THE LIGHT OF ITS FUNCTIONS - IMPLEMENTATION OF RESOLUTION WHA33.17: Item 35 of the Agenda (Resolution WHA33.17; Document A34/15) (continued from the fifth meeting, section 6)

Dr BROYELLE (France) drew attention to the first paragraph on page 5 of Annex 1 to document A34/15, the second sentence of which read: "At the global level, the Health/2000 Resources Group will deal with the mobilization of external resources and the rationalization of their use." It was not correct in speaking of the Group to say that it would "deal with" the mobilization of resources and rationalization of their use, for that was in contradiction with the resolution adopted by the Thirty-third World Health Assembly and with the comments that had been made by the Executive Board. The Group had been accepted on an advisory basis and therefore did not itself have the function of mobilizing resources or rationalizing their use. Those were prerogatives of the Director-General. She thought that the drafting error should be amended, and noted that the question would again be examined at the forthcoming Executive Board.

Dr POUDAYL (Nepal) congratulated the Chairman on the most successful afternoon in the history of WHO, in which amicable agreement had been reached on a difficult issue. When individuals failed, a group could often solve such vital issues. That group dynamism had prevailed at Alma-Ata, where Member States had agreed to pursue the goal of health for all by the year 2000. He warned, however, against self-congratulation in what was a matter of historical necessity. In the present age of human emancipation no establishment could afford to ignore the basic needs of its members; history had repeatedly taught that lesson.

The present agenda item showed that another bold decision had been taken. It had been felt that WHO's structures were not adapted to meet the great challenge of health for all by the year 2000; hence a study had been made of these structures in the light of the Organization's functions. He congratulated the Secretariat on producing a document of some 40 pages in that connexion.

In the beginning, the study had generated considerable enthusiasm which seemed gradually to be fading, although he hoped he was wrong in that assumption. He himself considered the Organization's structural pyramid to be upside-down, with very little support at the country level where it was most needed. From the very beginning, Nepal had stressed the need to strengthen WHO at the country level. Moreover he was depressed to see that WHO was so slow in changing its structure. It discussed biennial Health Assemblies; it discussed regional committees that were not functional, but simply ritual. But it seemed to him that WHO was
busy counting the pence and forgetting the pound - which was the achievement of health for all by the year 2000. Nepal wished to see every aspect of WHO's activities geared towards that achievement.

Dr BRYANT (United States of America) said that the study of the Organization's structures in the light of its functions had provided Member countries, the regional committees, and the headquarters staff with extensive opportunities to review the Organization's purposes and the mechanisms whereby it pursued them. The study had been initiated before "health for all" became the priority programme of WHO, but that goal seemed to be the focus and referral point for the study. Indeed, the structures and the functions had both been seen to be necessarily oriented towards the achievement of health for all, thus providing a conceptual coherence that might not have emerged if that programme had not been in evidence.

In the Region of the Americas the study had led to a number of conclusions: (1) that a regional mechanism might be established for improving the flow of extrabudgetary resources available for priority programmes; (2) that Member governments should establish dynamic and evolving plans for achieving health for all that included appropriate indicators and quantitative objectives; (3) that emphasis should be given to the horizontal integration of the technical components of the Secretariat in order to ensure full coordination of the staff's capabilities; (4) that an attempt should be made to synchronize the planning cycles of the Region of the Americas with those of WHO; and (5) that support to country representatives should be increased and increasing responsibilities delegated to them, while at the same time improving communications and managerial support and providing more flexible administrative guidelines. His delegation looked forward to its Region's implementation of those decisions and recommendations.

There was one issue on which his Government particularly wished to record its views. Operative sub-paragraphs 1(6) and 3(6) of resolution WHA33.17 called in effect for the Organization, at global and regional levels, to maximize the use of all available resources for achieving health for all. The Directing Council of PAHO had decided to consider establishing a regional mechanism for improving the flow of extrabudgetary resources available for priority programmes. At global level, a proposal to establish a Health/2000 Resources Group had emerged from the study of WHO's structures. That proposal had been seriously questioned by the Executive Board at its sixty-seventh session (January 1981). He agreed that the establishment of such a new body must be examined very carefully in terms of mandate, potential overlap of responsibilities with the governing bodies of the Organization, and relationship to the role of the Director-General, but he believed it was very important that whatever resources were available should be effectively used. Effective mechanisms were therefore necessary at regional and global level to attract and channel extrabudgetary resources towards programmes related to the achievement of health for all. That was particularly important at a time of increasing constraints on the resources directly available to the Organization. He noted that the issue was on the agenda of the sixty-eighth session of the Executive Board, and he thought that the Health Assembly should encourage the Director-General to develop the Resources Group into an effective and acceptable mechanism for channelling further extrabudgetary resources towards the important purposes of the Organization.

Dr FERREIRA (Mozambique) congratulated the Director-General on the excellent report he had presented. It was in fact an operational plan of action, setting tasks, target dates and well-defined responsibilities which would greatly facilitate not only the carrying out but the monitoring of the action required for reformulating the Organization's structures. Her delegation was in general agreement with the report but she would comment on certain paragraphs.

The regular review of the Secretariat, referred to in sections 22 and 26, was of great importance to guarantee staff quality. People should not make themselves at home forever in the posts they occupied and those posts should not be held for life. People should, of course, do work for which they were qualified.

She also found extremely useful the measures advocated in section 28.3 on the staffing of the regional offices and headquarters. Those measures should lead to improvement in technical quality and in the staff of the regional offices. Her delegation hoped that they would lead to the creation in the regional offices of more homogeneous teams of staff to carry out the principles and policies of WHO as defined by the Member States in their governing bodies. Still with reference to section 28.3, she believed that Member States should be informed of the revision of the organizational structure of their respective regional offices. The opinion of Member States should be taken into account as and when the revision took place. She suggested that the subject be placed on the agenda of subsequent sessions of the regional committees.
With regard to section 31, on documentation for use by countries, she said that one of the first measures to be taken should be a more rapid distribution of the basic documentation for the Health Assembly so that Member States could prepare themselves in time and properly for their work.

Dr LITVINOV (Union of Soviet Socialist Republics) said that the proposed plan for implementing resolution WHA33.17 deserved serious study. Such a plan of action, specifying dates for completion and the people responsible, could be used as a model for implementing other WHO resolutions. Of course there were deficiencies in the report. On many points no target dates had been given for achieving certain tasks. Moreover the measures proposed under operative sub-paragraph 1(4) of the resolution to strengthen the unity of the Organization were not concrete enough: there should be a more carefully defined distribution of functions between the various levels of the Organization. The Health Assembly should give increased attention to activities at regional level. Not only the Executive Board but also the Health Assembly should hear from the Regional Directors what had been done to implement this or that resolution.

His delegation continued to believe that the activation of the regions would only be possible if the leadership role of headquarters was strengthened. The brunt of the responsibility, of course, rested with the Secretariat; it was therefore of importance to consider the measures for the review of the Secretariat’s work. In accordance with operative sub-paragraph 4(4) of resolution WHA33.17, a working group had been set up by the Executive Board to study the functions and activities of the Secretariat. Among the questions to be dealt with by that working group could be included the structure and functioning of headquarters and its subsections; the recruitment and utilization of staff, including consultants; and the work of the Secretariat in the collection and dissemination of information, the improvement of the network of collaborating centres, evaluation, etc. That analysis of the Secretariat’s work was so important that provision should be made for the results of the working group’s study to be submitted to the Health Assembly.

With regard to the Resources Group, he stressed that his delegation fully supported the Executive Board’s resolution on the subject, emphasizing however that no group could replace the Organization itself.

Dr NSOLO (Nigeria) thought that WHO should ask itself whether it was doing enough to support national strategies. That question had become pertinent because it was WHO that would be judged on the progress made by Member States in achieving health for all by the year 2000. Clearly, Member States were all at different stages of development and possessed varying levels of resources; it was consequently important to ensure that the gap between the well-to-do and the not so well-to-do was not widened. Inevitably, the rate of progress toward health for all by the year 2000 would differ from one country to another. WHO must therefore pay particular attention, at global and regional levels, to monitoring progress within each Member State. That would make it possible for the Organization to review its cooperation with Member States on a continuous basis so that its activities were, at all times, consistent with the spirit of resolution WHA33.17.

If results were really to be obtained at country level, there was no alternative but to strengthen the role of the WHO programme coordinators. Although WHO was about the most decentralized of the specialized agencies, it sometimes seemed that the process of decentralization stopped at the level of the regional office. A concerted effort was needed on the part of the Secretariat to see how further decentralization could take place, giving special attention to the role of WHO programme coordinators as the representatives of the Organization. Certain powers had to be delegated to enable them to perform efficiently and with a minimum of delay.

He understood that there were a number of constraints on the effort of the Organization to cooperate with the other specialized agencies of the United Nations system. One was the procedure for programme budget preparations, which varied from one organization to another. He wondered if anything could be done about that problem, which was proving an impediment to interagency cooperation, particularly at country level.

Mr NYGREN (Sweden) said that the Director-General’s interesting and valuable progress report showed the enormous effort which would be required to achieve the goal of health for all by the year 2000. Health had many facets and demanded action not only by WHO but by other United Nations bodies in the fields of economic and industrial development, housing, etc. He was glad to see the important role allocated to health in the New International Development Strategy. In that connexion, he stressed the importance of the contribution made
However, WHO must take the lead in all matters related to health, and coordination was therefore vital at regional, national and local levels. In principle, it was his delegation's view that health problems were best dealt with by those who lived with them and knew them best, and it was therefore necessary to strengthen regional action. He did not mean that the role of WHO headquarters should be reduced; on the contrary its coordinating efforts were increasingly important.

He mentioned the impact of voluntary funds on the planning of the regular budget programme. Voluntary contributions must be in line with and support the regular programme to obtain the best use of restricted resources. An effective evaluation system was very important in that connexion and must be an integral part of the programme itself. In a time of economic difficulty, everything possible must be done to make efficient use of all available resources.

Health for all by the year 2000 might call for a reorientation of activities and of resources both at headquarters and regional level. It was his hope that all personnel would work positively towards that end.

Dr SEBINA (Botswana) said that when the Director-General's study had been undertaken it had been considered the most wide-ranging managerial review ever embarked upon by the Organization. The Director-General's plan of action responded to the challenge of resolution WHA33.17 and covered widely separated responsibilities and activities. It would chart the path towards the goal of health for all. He welcomed the plan of action, and looked forward to the updated progress report to be submitted in 1982.

He drew attention to the need for studying the staffing structure of WHO programme coordinators' offices and reminded delegates that some programme coordinators covered more than one country. He welcomed the proposed Resources Group, designed to rationalize the transfer of resources for primary health care, and stressed the need for WHO to streamline its transfer mechanisms: the transfer of resources at the right time might make all the difference to the success or failure of a programme.

Dr BOOTH (Australia) said that the Director-General's plan of action was very general in nature and he looked forward to the progress report to be submitted to the Executive Board at its January session.

During discussions in the Western Pacific Regional Committee, the adoption by the Thirty-third World Health Assembly of the principle of health for all had been applauded. His Government believed that regional committees should play a more active part in the work of the Organization. It was glad to see that that was beginning to happen and it was for that reason that his delegation had supported the reimbursement of travel costs to representatives attending regional committee meetings.

He issued a plea for the early distribution of Health Assembly documents and for more rapid communications within WHO. It had been his recent experience that the length of time which documents and letters took to reach his own country left little time to organize programmes for visiting WHO groups. He suggested that some of the delays occurred when communications went not only through the regional office but also through the office of the programme coordinator. While all levels must be kept informed, that could be better done by copying correspondence to intermediate areas while ensuring that the original proceeded directly to the addressee.

His delegation agreed with the Indian delegation on the importance of the present agenda item and felt that certain aspects of the review should be settled as quickly as possible. His support for the holding of the Health Assembly only in alternate years was well known. Unless that important step was taken, he believed that the regional committees would be slow to assume the important role that belonged to them.

To conclude, he supported the Director-General's plan of action and looked forward to future progress reports.

Mr KAKOMA (Zambia) congratulated the Director-General on his plan of action, which was similar to the follow-up mechanism instituted by the Regional Director for Africa for his Regional Committee. Such a clear outline of follow-up machinery made the task of implementation easier. Operative paragraph 2 of resolution WHA33.17 was specifically addressed to Member States; he was therefore glad to inform the Committee that his country had embarked upon all the activities outlined in that paragraph.
Dr PLIANBANGCHANG (Thailand) said that his Government had been an active participant in the 1979 study of WHO’s organizational structure made in the South-East Asia Region, and had endorsed the recommendations of that study, particularly those concerning regional and country levels. Health for all could be achieved only through the efforts of countries themselves, and therefore it was the effectiveness of WHO support to countries’ endeavours that had the most meaning for their people.

In spite of its sincere intentions and dedicated efforts, the health leadership of his own country faced an almost overwhelming task while at the same time experiencing a severe shortage of manpower and technical resources. He therefore pressed for the strengthening of WHO collaboration at country level. Hence, in developing guidelines for the 1982-1983 programme budget, the Regional Committee’s working group had recommended the strengthening of the programme coordinator’s office in Thailand by the shifting of resources within the regular budget for the previous biennium.

The role and functions of WHO at country level must continue to evolve and develop in response to the intersectoral aspects of health for all and the reorientation and technical improvement of health systems and manpower that were required. Adequate resources and authority were needed in the programme coordinator’s office if that challenge was to be successfully met. WHO’s functions at national level required staff capable of involving themselves in multidisciplinary national health programme development, supporting the development of appropriate coordinating mechanisms, and processing and communicating relevant information for technical collaboration, cooperation and exchange. The number, composition and character of the support staff of the programme coordinator’s office should be determined by the size, intensity and complexity of the country’s needs and programmes; and the office should have the greatest possible freedom in coordinating WHO’s resources to support national policies, strategies, and plans of action. That flexibility might include authority to co-opt, on a short-term basis, WHO project staff within the country for priority national collaborative activities not within the scope of their terms of reference. The operational funds of the office should be increased and more flexibility should be permitted in their use, so that funds were available for informal types of educational, promotional or technical activity in support of country programmes. Some adjustments in regulations would be necessary if the desired flexibility were to be achieved.

In brief, in his country’s experience WHO programmes at national level should be expanded, strengthened and reoriented to focus more effectively on national programme priorities and needs. There also seemed to be a need for some administrative changes that were feasible in themselves but required global and regional cooperative action.

Professor HALEEM (Bangladesh) praised the Director-General’s action in inspiring the formulation of the health for all programme at the Alma-Ata Conference. The determination of the peoples of the world as a whole was the primary factor in the successful achievement of health for all.

Article 2 of WHO’s Constitution clearly indicated that it was WHO’s role to assist governments in extending their health services. But what, he asked, happened in poor countries? Health involved complete social wellbeing and not the mere absence of disease or deformity. If people did not have proper food, clothing and housing, they could not be healthy, and these were the basic problems to be tackled. Those who had must come forward to help those who had not.

In his own country certain basic health services had been developed at rural level but, although the number of hospital beds available was meagre by comparison with developed countries, at least 70% of those beds were vacant because of transport difficulties. Health services must be taken to the people, and specifically to the rural areas.

He also drew attention to the fact that the health for all programme paid little attention to maternal and child health and population control. His Government was endeavouring to reduce the growth rate of the population from 2.65% to 1.75% by 1990. However, the determination to do so was of little use unless the necessary resources were available. He appealed to WHO to lay more stress on population control.

He also emphasized the need for coordination, indicating that while the primary responsibility for programme implementation should be at regional level, headquarters should play a coordinating role at global level.

In conclusion, he recorded his Government’s appreciation of the Director-General’s dynamic leadership.
Mr ARSLAN (Mongolia) said that much work had been done on the implementation of resolution WHA33.17. Much work, too, had been done in the regions, especially in the South-East Asia Region, to define priority problems.

In that Region, stress had been laid on strengthening WHO's work at country level and on the WHO programme coordinators. Mongolia itself had a programme coordinator, and the Mongolian Government hoped that in the near future it would cooperate in the implementation and monitoring of national health programmes, a matter of particular importance for the attainment of health for all by the year 2000. He thought that WHO and the South-East Asia Regional Office in particular should make more use of such coordinators, who had an important role to play in cooperation between the Member States and WHO. The Mongolian Government would like the programme coordinator not merely to be a mediator but to be active in achieving common goals.

The plan of action in document A34/15, in its comment on operative sub-paragraph 1(2) of resolution WHA33.17, mentioned that the Organization's cooperative activities with other organizations in the United Nations system would be reviewed, particular attention being paid to the country level and a few countries being taken as case studies. The Mongolian delegation proposed that a study group of three members should make a list of countries for submission to regional committees and for discussion by them during the current year.

The DIRECTOR-GENERAL thanked the Indian delegate for emphasizing the importance of the issue under discussion. The Secretariat had been greatly encouraged by this attitude.

It had been made clear in the course of the afternoon's discussions, that once situations became clearly defined they could be managed, but that confusion, within WHO as elsewhere, could not be managed. The purpose of raising the question of function and structures, which had led to the formulation of resolution WHA33.17, was to find out where the problems lay. There must be many differences between the peoples, the governments and WHO itself, who formed the partners in the social contract for health for all. The more efforts made to identify those problems, the greater would be the success in improving the performance of all three partners.

Decentralization did not mean splitting up the Secretariat into smaller units, but decentralizing out to peoples and their governments, and supporting them in an activist role in their work for attaining health for all. The Secretariat must always be asking itself whether it did effectively support the peoples and their governments in their work. For this reason the plan of action had been devised, so that Member States could continue to check that they themselves in WHO and the Secretariat were performing their tasks properly. The whole purpose of the resolution, and of the plan of action for its implementation, had been to put an end to confusion. As the delegate of the Union of Soviet Socialist Republics had pointed out, an opportunity was offered to enter into a meaningful dialogue.

A number of delegates had emphasized the importance of WHO's role at country level. The expression "charity begins at home" meant for WHO that Member States should themselves have the will, courage and imagination to find out how they wanted to make use of WHO. Only a few countries had hitherto thought it worthwhile to ask themselves what they could expect from WHO in the attainment of health for all. He therefore asked all countries to give consideration to that question as part of their individual health for all programmes. Only on that condition could the Secretariat orient itself to support them as a partner rather than as just one of many international organizations. Countries must find in themselves the specific fields for WHO's unique mission. If they did find such fields, WHO itself would become a stronger and a better partner.

In order to avoid the reproach of being too abstract, he raised the question of what was meant by "government execution". He himself believed that the Organization should support Member States in carrying out their own health programmes. So far little had been done in this direction. The tendency was still to adopt a conventional project execution approach with supranational overtones. Everyone agreed that cooperation among all Member States, be they rich or poor, highly industrialized or not, was vital. That meant not entrusting WHO with the entire execution of intercountry projects, acting as it were by proxy - which was not in the spirit of cooperation among countries. The Secretariat must examine again and again whether it was truly playing an activist role as laid down in resolution WHA33.17. The top-to-bottom bottom-to-top dialogue must continue, and must become more meaningful than it had been hitherto.

He was grateful for all the constructive criticisms that had been made during the discussion: they showed that Member States thought it worthwhile to take WHO seriously.

The CHAIRMAN believed that the Committee could trust the Executive Board to continue monitoring the implementation of resolution WHA33.17 along the lines indicated.

The meeting rose at 17h25.
EIGHTH MEETING

Saturday, 16 May 1981, at 9h00

Chairman: Mr M. DE LA MATA (Spain)

1. REAL ESTATE FUND: Item 32 of the Agenda (Resolution EB65.R15, para. 3; Document EB67/1981/REC/1, resolution EB67.R20 and Annex 9) (continued from the fifth meeting, section 3)

The CHAIRMAN invited the Committee to consider the following draft resolution prepared by the Rapporteur:

The Thirty-fourth World Health Assembly,
Having considered resolution EB67.R20 and the report of the Director-General on the status of projects financed from the Real Estate Fund, the estimated requirements of the Fund for the period 1 June 1981 to 31 May 1982 and also information on the long-term requirements of the regional offices;
Recognizing that certain estimates in that report must remain provisional because of the fluctuation in exchange rates;
1. NOTES that at present there are no identifiable long-term requirements for financing the construction of accommodation at any of WHO’s regional offices from the Real Estate Fund;
2. REQUESTS the Director-General to keep the long-term accommodation requirements of the Organization at headquarters and in the regional offices under review and to report on the subject to the Executive Board whenever warranted;
3. AUTHORIZES the financing from the Real Estate Fund of the projects summarized in section 11 of the Director-General’s report and of the cost of construction of a small office building and staff housing in Malabo, Equatorial Guinea, at the following estimated costs:

<table>
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<tr>
<th>Project Description</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Conversion of staff housing at the Regional Office for Africa</td>
<td>£322,000</td>
</tr>
<tr>
<td>Repairs and alterations to the building and grounds of the Regional Office for Africa</td>
<td>£125,000</td>
</tr>
<tr>
<td>Contribution towards the construction of a building for the joint WHO/PAHO Publications and Documentation Service and the office of the PAHO representative for Area II in Mexico</td>
<td>£250,000</td>
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<tr>
<td>Construction of an extension to the Regional Office for South-East Asia, including a new air-conditioning plant and an electric substation</td>
<td>£675,000</td>
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<tr>
<td>Preliminary architectural study for an extension to the Regional Office for Europe</td>
<td>£66,000</td>
</tr>
<tr>
<td>Lift and toilet facilities for disabled persons in the Regional Office for Europe</td>
<td>£51,000</td>
</tr>
<tr>
<td>Repairs and alterations to the Regional Office for the Western Pacific</td>
<td>£275,000</td>
</tr>
<tr>
<td>Construction of a small office building and staff housing in Malabo, Equatorial Guinea</td>
<td>£480,000</td>
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The Committee also had before it a proposal by the delegation of the United States of America to amend that resolution by inserting a new paragraph 4, reading:

"4. REQUESTS the Director-General to minimize the financial impact on the Organization of the authorized construction in Malabo, Equatorial Guinea, by coordinating these office and staff housing needs with those of other bilateral and multilateral agencies providing or planning to provide assistance to Equatorial Guinea, in the interest of economy to all participating agencies, and to report to the Executive Board on the outcome of these efforts;"

The number of the following paragraph would then be amended from 4 to 5.

Mr BOYER (United States of America) suggested that the two words "bilateral and" should be deleted from the amendment proposed by his delegation. The purpose of the amendment was not to delay the project but to ensure that WHO adopted the most economic approach and, where possible, acted in coordination with other organizations in the United Nations system.

The amendment proposed by the United States delegation was adopted.

The draft resolution, as amended, was approved.¹

2. PERIODICITY AND DURATION OF HEALTH ASSEMBLIES: Item 36 of the Agenda (Resolution WHA33.19; Document EB67/1981/REC/1, decision EB67(6) and Annex 13; Document EB67/1981/REC/2, pages 284-295) (continued from the third meeting, section 3)

Dr RIDINGS (representative of the Executive Board), introducing the item, recalled that the Health Assembly had requested the Director-General to transmit to Member States the text of the proposed amendments to Articles 13, 14, 15 and 16 of the WHO Constitution. Two alternatives had been proposed for Article 13. Alternative "A" read: "The Health Assembly shall meet in regular session every two years." Alternative "B" read: "The Health Assembly shall meet in regular session at least once in every two years."

Drawing the attention of the Committee to the advantages and disadvantages of each alternative, he pointed out that alternative "A" offered the advantage that the principle that the Health Assembly should meet in regular session only once every two years would be clearly stated once and for all, thus eliminating the need for future debate on its periodicity. It would, however, require a transitional arrangement to ensure that, no matter in what future year the constitutional amendments came into force, (a) the Health Assembly would meet in regular session in odd-numbered years to review and approve the proposed programme budget, and (b) it would meet once more in an even-numbered year if it had already selected the country or region for its session in that year in accordance with Article 14 of the WHO Constitution. The advantage of alternative "B" was that it would be flexible and permit regular sessions of the Health Assembly to be held either annually or biennially and would not require a transitional arrangement. However, the Health Assembly would have to decide at each regular session in the odd-numbered year whether to hold the next regular session in the next even-numbered year - an issue which might give rise to lengthy debate and would require a vote.

It was estimated that the earliest date by which the constitutional amendments could come into force would be 1985, and it was unlikely that the first even-numbered year in which the Health Assembly would not meet would be earlier than 1988.

The Executive Board had agreed in principle with the various measures recommended in documents EB65/1980/REC/1, Annex 8, and EB67/1981/REC/1, Annex 13, should the principle of biennial Health Assemblies be adopted pursuant to resolution WHA33.19. On the understanding that specific decisions concerning those recommendations would be taken nearer the time the necessary constitutional amendments came into force, the Board, by its decision EB67(6), had transmitted the Director-General's report to the present Health Assembly for consideration,

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA34.12.
and drew attention to the views expressed by members of the Board, summarized in document EB67/1981/REC/2, pages 284-295.

He suggested that the Committee might wish first to take a decision on the question of periodicity and only then consider the five proposals to shorten the duration of future Health Assemblies. Those proposals were valid whether or not biennial Health Assemblies were introduced and they could be applied in odd-numbered or even-numbered years - or both - depending on the wishes of the Health Assembly. The five proposals were as follows:

(1) Two to three working days could be saved if the focus of the general discussion in plenary session was shifted to a limited number of oral reports on regional and global strategies for achieving health for all, supplemented by statements in writing by individual countries on national strategies and progress towards health, to be published in extenso in the verbatim records.

(2) Alternatively, the scheduling of one main committee to meet during the general discussion in plenary session could shorten the duration by one-and-a-half to two working days.

(3) If the Technical Discussions were not held during the Health Assembly in any particular year, the effect would be to reduce the overall duration by one-and-a-half days. The Health Assembly might decide to discontinue the Technical Discussions at future Health Assemblies or to hold them only at alternate Health Assemblies.

(4) Two or three working days could be saved if the Executive Board exercised restraint in preparing the provisional agenda of the Health Assembly, and if regional committees and the Board highlighted those issues that specifically required decision by the Health Assembly. The Health Assembly in turn might wish to exercise a more rigid measure of discipline over its own deliberations.

(5) In order to give effect to those measures it was recommended that the Executive Board should fix the closing date of the Health Assembly so as to reflect the estimated saving in time as a result of the introduction of procedures intended to reduce its duration.

If the current Health Assembly were to adopt a combination of the five proposals, it would be possible to reduce the duration of future Health Assemblies to as little as two weeks, starting with the Thirty-fifth World Health Assembly in 1982.

The CHAIRMAN drew the attention of the Committee to the two draft resolutions prepared by the Secretariat. The first of these reflected alternative "A", and read:

The Thirty-fourth World Health Assembly,
Recalling resolution WHA33.19, which recommended that the Thirty-fourth World Health Assembly consider amending the texts of Articles 13, 14, 15 and 16 of the Constitution in order to permit the change from annual to biennial Health Assemblies;
Having considered the reports, recommendations and views of the Executive Board, the Regional Committees and the Director-General on the periodicity of Health Assemblies, in the context of the study of WHO's structures in the light of its functions;
Noting the consequences of the introduction of biennial Health Assemblies for the work and functioning of all bodies of the Organization, as outlined by the Director-General in his report and reviewed by the Executive Board;
Appreciating the potential savings in time and cost as well as the opportunity for rationalizing the work and functioning of the Health Assembly and other bodies of the Organization afforded by biennial Health Assemblies;
Recognizing that the Health Assembly should meet in regular session every two years in an odd-numbered year, inter alia to review and approve the proposed programme budget for the financial period beginning in an even-numbered year pursuant to resolutions WHA28.69 and WHA30.20;
Agreeing in principle to the various measures recommended by the Director-General to facilitate the change in the periodicity of Health Assemblies, it being understood that specific decisions concerning these recommendations will be taken when, or shortly before, the amendments come into force;
Noting that the provision of Article 73 of the Constitution, which requires that the texts of proposed amendments to the Constitution shall be communicated to Members at least six months before consideration by the Health Assembly, has been duly complied with;
1. ADOPTS the amendments to the Constitution which are set forth in the Annex to this resolution and which shall form an integral part of this resolution, the texts in Arabic, Chinese, English, French, Russian and Spanish being equally authentic;

2. DECIDES that in order to give effect to this resolution:

(1) two copies of the resolution shall be authenticated by the signatures of the President of the Thirty-fourth 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, depository of the Constitution and one copy retained in the archives of the World Health Organization;

(2) notification of acceptance of these amendments by Members shall be effected by 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;

(3) the amendments shall come into force after acceptance by two-thirds of the Members in accordance with their respective constitutional processes, as provided for in Article 73 of the Constitution, and shall be implemented in such a manner as to ensure that the Health Assembly shall meet in regular session in all odd-numbered years, and to permit the Health Assembly to meet in one further regular session in an even-numbered year for which the Health Assembly may have already selected the country or region in accordance with Article 14 of the Constitution prior to the entry-into-force of the amendments.

ANNEX

Article 13

The Health Assembly shall meet in regular [annual] session every two years and in such special sessions as may be necessary. Special sessions shall be convened at the request of the Board or of a majority of the Members.

Article 14

The Health Assembly, at each [annual] regular session, shall select the country or region in which the next [annual] regular session shall be held, the Board subsequently fixing the place. The Board shall determine the place where a special session shall be held.

Article 15

The Board, after consultation with the Secretary-General of the United Nations, shall determine the date of each [annual] regular and special session.

Article 16

The Health Assembly shall elect its President and other officers at the beginning of each [annual] regular session. They shall hold office until their successors are elected.

The second draft resolution reflected alternative "B", and read:

The Thirty-fourth World Health Assembly,

Recalling resolution WHA33.19 which recommended that the Thirty-fourth World Health Assembly consider amending the texts of Articles 13, 14, 15 and 16 of the Constitution in order to permit the change from annual to biennial Health Assemblies;

Having considered the reports, recommendations and views of the Executive Board, the Regional Committees and the Director-General on the periodicity of Health Assemblies, in the context of the study of WHO's structures in the light of its functions;

Noting the consequences of the introduction of biennial Health Assemblies for the work and functioning of all bodies of the Organization, as outlined by the Director-General in his report and reviewed by the Executive Board;

Appreciating the potential savings in time and cost as well as the opportunity for rationalizing the work and functioning of the Health Assembly and other bodies of the Organization afforded by biennial Health Assemblies;
Recognizing that the Health Assembly should meet in regular session at least once in every two years in an odd-numbered year, inter alia to review and approve the proposed programme budget for the financial period beginning in an even-numbered year pursuant to resolutions WHA28.69 and WHA30.20;

Agreeing in principle to the various measures recommended by the Director-General to facilitate the change in the periodicity of Health Assemblies, it being understood that specific decisions concerning these recommendations will be taken when, or shortly before, the amendments come into force;

Noting that the provision of Article 73 of the Constitution which requires that the texts of proposed amendments to the Constitution shall be communicated to Members at least six months before consideration by the Health Assembly, has been duly complied with;

1. ADOPTS the amendments to the Constitution which are set forth in the Annex to this resolution and which shall form an integral part of this resolution, the texts in Arabic, Chinese, English, French, Russian and Spanish being equally authentic;

2. DECIDES that in order to give effect to this resolution:

(1) two copies of the resolution shall be authenticated by the signatures of the President of the Thirty-fourth 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;

(2) notification of acceptance of these amendments by Members shall be effected by 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;

(3) the amendments shall come into force after acceptance by two-thirds of the Members in accordance with their respective constitutional processes, as provided in Article 73 of the Constitution, and shall be implemented in such a manner as to ensure that the Health Assembly shall meet in regular session at least in all odd-numbered years.

ANNEX

Article 13

The Health Assembly shall meet in regular session at least once in every two years and in such special sessions as may be necessary. Special sessions shall be convened at the request of the Board or of a majority of the Members.

Article 14

The Health Assembly, at each regular session, shall select the country or region and determine the year in which the next regular session shall be held, the Board subsequently fixing the place. The Board shall determine the place where a special session shall be held.

Article 15

The Board, after consultation with the Secretary-General of the United Nations, shall determine the date of each regular and special session.

Article 16

The Health Assembly shall elect its President and other officers at the beginning of each regular session. They shall hold office until their successors are elected.

He drew attention to document A34/INF.DOC/7, which showed that, of 20 Member States that had replied to a letter on the subject from the Director-General, 9 had expressed a preference for alternative "A" and 4 for alternative "B", while 7 had favoured continuing annual Health Assemblies.

Lastly, he drew attention to a third draft resolution, proposed by the delegations of Algeria, Bahrain, Bangladesh, Cuba, Democratic Yemen, Djibouti, Ethiopia, German Democratic Republic, Hungary, India, Indonesia, Iraq, Jordan, Kuwait, Lebanon, Lesotho, Libyan Arab
The Thirty-fourth World Health Assembly,
Recalling resolution WHA12.38, which affirms that "notwithstanding any savings that might accrue it would not be opportune, at a time when the Organization is expanding and its activities developing, to reduce the number of occasions upon which the World Health Assembly would have the opportunity to direct and control such expansion and activities";
Having considered the views expressed by the regional committees, the discussions at the sixty-seventh session of the Executive Board, and the Director-General's report on the periodicity and duration of Health Assemblies;
Recalling that studies in regard to the restructuring of the Organization in the light of its functions are ongoing, but remembering the recommendation in resolution WHA33.17 to increase the Health Assembly monitoring and control functions with to the work of the Organization;
Keeping in mind, at all times, the collective commitment of all countries to achieve the goal of health for all by the year 2000 and the consequential necessity of further strengthening the role of the Assembly as the highest forum of the Organization;
Taking into account the positive experience of the long-time practice of annual Assemblies and realizing that any change in the current system and changeover from annual to biennial Assemblies will have adverse implications for the attainment of regional and global commitments, besides reflecting upon effective fulfilment of the constitutional functions of the Assembly;
1. BELIEVES that changes in the duration of and arrangement of work in the Assemblies can be considered only after experimental verification of their effectiveness;
2. RESOLVES to retain the practice of annual Assemblies.

He suggested that the Committee should consider first the periodicity of future Health Assemblies and subsequently their duration. He also suggested that the first two resolutions (i.e., those reflecting alternatives "A" and "B" respectively) should be taken up immediately on conclusion of the debate on periodicity, since they dealt with that aspect only; whereas the third draft resolution should be considered after discussion of the question of duration also, since it dealt with both aspects.

It was so agreed.

Dr VENEDIKTOV (Union of Soviet Socialist Republics), supporting the third draft resolution, said that three arguments had been put forward in favour of holding biennial Health Assemblies, none of which stood up to criticism, particularly following the adoption of the strategy of health for all by the year 2000, and at a time when attention should be actively concentrated on primary health care and the organization of health services. The first argument linked the periodicity of Health Assemblies with the two-year programme budget cycle; he recalled however that when the two-year cycle had been introduced, the same delegations who were currently using that argument had stated that a two-year cycle would not entail holding Health Assemblies biennially. The second argument was that the Health Assembly wasted too much time on so-called "political" discussions; but health could not be divorced from the social, economic and political context, and it was difficult to determine where politics began in such issues, for example, as the transfer of a regional office, the situation of the populations in certain territories, and even the question of breast-feeding. The third argument was related to the saving of funds, and in this connexion it was no accident that there had also been a proposal for various types of outside resource groups that would have a voice in health development activities, outside the framework of the Executive Board and the Assembly. The suggestion had been rightfully rejected at the January meeting of the Board.

Arguments in favour of an annual Health Assembly included the fact that over a hundred ministers or directors-general of health participated in the Health Assembly each year, and the bilateral or multilateral contacts that were made there were of great value in the development of technical cooperation among developing and other countries and in the strengthening international understanding in the field of health. Moreover, biennial Assemblies would mean less control over the Organization's activities and a deterioration in the work of the regional committees (particularly as it had already been seen that there were situations when a
regional committee could not meet). The Health Assembly could not pass on to the Executive Board certain constitutional and other matters without having considered their substance.

It was significant that, according to A34/INF.DOC./7, only 20 Member States had sent in comments in response to the Director-General's inquiry, and only nine of them were in favour of alternative "A".

In conclusion, his delegation believed that it was essential to continue to hold the Assembly annually and was opposed in that connexion to any change in the WHO Constitution, although it believed that it was possible to improve and rationalize existing procedures. Some of the suggestions put forward might be put into practice on an experimental basis.

Dr QUAMINA (Trinidad and Tobago) reiterated her delegation's support for biennial Health Assemblies. Alternative "A" seemed to be the most reasonable proposal and she hoped that it would have the support of most delegations.

Concerning the text of the first draft resolution, reflecting alternative "A", she suggested the inclusion of the word "once" before "every two years" in the fifth preambular paragraph and in the proposed Article 13 in the annex.

Concerning the third draft resolution (submitted by a large group of countries), she drew attention to operative paragraph 1 which referred to "experimental verification" of changes in the effectiveness of changes in periodicity. If there had been no experimentation, how could the sponsors of that resolution draw the conclusion, (fifth preambular paragraph) that "biennial Assemblies will have adverse implications ..."? On the contrary, her delegation believed that a change from annual to biennial Health Assemblies could prove to be a positive experience, as some other organizations, e.g., FAO and UNESCO, had already found.

Dr FERREIRA (Mozambique) said that, in the view of her delegation, Health Assemblies should be held annually in order to be able to assess the progress made in the implementation of the Organization's global strategy and to take the policy decisions that were required. Increasing the interval between Health Assemblies would add to the workload of the Executive Board, which would also be progressively turned into a deliberative organ. Given the fact that the Board was not fully representative of the various WHO regions and the developing countries, it would be unfortunate if its powers were enhanced at the expense of the Health Assembly. Moreover, it was doubtful whether the holding of biennial Assemblies would produce any real saving, since the sessions would no doubt have to be lengthened accordingly, as would those of the Executive Board and the regional committees. Even if some economy of time and money proved to be possible, the moment was ill chosen to reduce the frequency of Health Assemblies when WHO had just collectively undertaken to implement national, regional and global strategies for attaining health for all by the year 2000. On the contrary, the participation of Member States in the life of the Organization needed to be stepped up.

She supported the measures advocated by the Director-General with a view to rationalizing the work of an annual World Health Assembly, and specifically those involving a better organization of the timetable for the main committees and the plenary meetings as outlined in paragraphs 66-67 of his report (document EB87/1981/REC/1, Annex 13). The time devoted to the annual Health Assembly was not wasted since it enabled delegates to meet, discuss and exchange experiences with their counterparts in other countries and to follow closely the development of the health situation in the world. That form of collaboration was one of the fundamental raisons d'être of WHO. Mozambique accordingly wished to be added to the list of co-sponsors of the draft resolution favouring annual Health Assemblies.

Dr STOKE (New Zealand) observed that three major issues were involved in the present discussion; (1) the effective work of WHO; (2) the time needed to prepare for and attend the Health Assembly; and (3) the financial effects of a change in policy. The decision of the New Zealand delegation to support the draft resolution advocating biennial Assemblies (alternative "A") was based on the fact that the work of the regional committees would thereby assume greater importance; there would be an increased opportunity for ministers to participate in regional meetings and to ensure more efficient regional liaison; technical cooperation and the provision of WHO advice would be improved; there would be adequate time to implement the decisions taken by the Health Assembly; more authority would be delegated to the Executive Board, whose work would thereby be made more effective; smaller countries would be able to participate in Health Assemblies without disrupting the implementation of their domestic health programmes; there would also be less disruption in the work of the Secretariat and a corresponding increase in its efficiency; and, lastly, there would be an annual saving of more than US$ 2 million each year, which could be used to promote health programmes.
Mr. HUSSAIN (Maldives) emphasized that the Thirty-fourth World Health Assembly was embarking upon an important global march, namely, the attainment of health for all by the year 2000. It was essential that developments should be thoroughly discussed each year so that each country could make such adjustments to its health policies as might be called for in the light of the political and health situation in the world. The suggestion had been made that great reliance could be placed on regional committees, yet how could that be possible if some of those committees did not even meet once a year?

The health situation must be looked at globally and not just at national level. Annual Health Assemblies were ideally suited to an exchange of experience and the discussion of important topics among those responsible for health planning. Health was not a topic that could be taken in isolation: the modern world was such that man was called upon to change more rapidly than he could hope to do on his own. It would be a mistake to change a practice that had existed since the inception of WHO at a time when the Organization was embarking upon a more ambitious project than it had ever contemplated in the past. He therefore urged his colleagues to support the draft resolution advocating the maintenance of annual Health Assemblies.

Mr. VOHRA (India) observed that the discussions that had taken place at the previous Health Assembly and at the Executive Board were apparently not being kept in view in the present debate. The entire question of annual or biennial Assemblies was bound up with the role and functions of the various organs of WHO. Until the relative role of each had been made quite clear, the debate would remain academic. For the time being, therefore, the Organization must be guided by past wisdom. Bearing in mind that WHO was more directly and intimately concerned with people all over the world than any other United Nations body, there must be no confusion as to its specific vocation. In the context of a budget amounting to nearly US$ 540 million, a saving of two or three million dollars (about 0.31% of the total) was not very significant. That was not to suggest that money should be thrown away unthinkingly but, inasmuch as the Organization was constitutionally expected to play a catalytic role, such a small economy should not be allowed to be a determining factor.

A year before, the Director-General had been pressed to take action and seek the necessary financial assistance to help in establishing the New International Economic Order, in collaboration with the other United Nations organizations. How would that be possible, and how could the attention of the economic bodies be drawn to world health requirements if the Health Assembly did not meet every year? Given the goal of health for all by the year 2000 and the corresponding need for technical cooperation and the transfer of skills, resources and technology, it was difficult to see how the attainment of the Organization's collective objectives could be secured by such infrequent meetings. It was significant that only two of the regional committees had endorsed the proposal for biennial Assemblies. It seemed to be generally agreed that, if such a proposal were adopted, the role of the Executive Board would have to be enhanced and its meetings held more frequently or over longer periods. Yet the Board was a small body that could not represent all the Member States and, if it were to take all important decisions that arose between biennial Assemblies, it would very likely fail to reflect the spirit, sentiments and aspirations of the vast majority of States that were not represented.

It had been calculated that a more rational organization of work could bring a saving of six to eight-and-a-half days of meetings. A number of countries - including India - had accordingly submitted a draft resolution advocating the maintenance of annual Health Assemblies in the belief that there was still great scope for improving arrangements for carrying on the business of WHO. Reference had been made to the way the agenda could be formulated, documentation prepared and various issues raised for consideration by the Health Assembly and also to the potential role of the Joint Inspection Unit. All these matters were also intimately connected with the study on the structure of WHO that was still under way. The Joint Inspection Unit, in any case, was not competent to decide which WHO organ was best equipped to deal with individual issues. Until such time as a decision had been reached as to how the Organization could be made to function more efficiently, therefore, there was no reason for the Health Assembly not to continue to meet every year.

Dr. LEBENTRAU (German Democratic Republic) said that his delegation continued to advocate the holding of annual Health Assemblies, pending the organizational restructuring of WHO. Annual comprehensive discussions among Member States would be needed in the coming years, which would be of the utmost importance for the attainment of WHO's global target. For that reason, his delegation supported the draft resolution calling for the maintenance of the current practice.
Dr Poudayl (Nepal) said that, despite the eloquent speeches and intensive lobbying, the actual benefit to be gained from Health Assemblies by small developing countries was very limited. A great deal of organizational restructuring was required and that could surely not be achieved by reducing the frequency of meetings. It was essential that the Member States should meet and discuss regularly and often if they were to attain the goal of health for all by the year 2000. Because of its unbalanced representation, the Executive Board could not be a satisfactory substitute for the annual Health Assembly. He endorsed the views expressed by the delegate of Maldives and urged his colleagues to reconsider the matter, giving some thought to the requirements of small developing countries such as Nepal.

Dr Marques de Lima (Sao Tome and Principe) said that the goal of health for all by the year 2000 made it essential that WHO's work should be followed closely by Member States. His delegation was therefore in favour of holding annual Health Assemblies and would support the draft resolution that called for the maintenance of that practice.

Dr Harris (United Kingdom of Great Britain and Northern Ireland) said that his delegation fully endorsed the views expressed by the delegates of New Zealand and of Trinidad and Tobago. Of the two proposals put forward by the Secretariat, alternative "A" was the correct solution.

Mr Perera (Sri Lanka) said that the question of whether the World Health Assembly should be held annually or biennially was independent of the trend towards a gradual strengthening of the regional committees, which had been going on for years. The initial task must be to develop the regional committees effectively and only then to examine whether or not the frequency of Health Assemblies could safely be reduced. In an organization such as WHO it was difficult to assess the potential financial savings that could be obtained from holding less frequent meetings, and it was in any case impossible to weigh the desirability of a possible economy of 3 million dollars against the benefit to Member States of annual Health Assemblies. His delegation therefore supported the draft resolution advocating the maintenance of the present system.

Mr Musielak (Poland) said that, after careful study of all the documents and arguments advanced during the Thirty-third World Health Assembly, his delegation felt obliged to maintain its opinion that the adoption of a biennial system might affect irreparably the substantial progress being made in the formulation of health strategies, the evaluation of their impact, and the planning of the necessary technical cooperation. The fundamental issue was the role of the Health Assembly in implementing global health strategies, and there it seemed that the benefits to be derived from annual Assemblies far outweighed the doubtful savings that a biennial system might bring. Such savings could in any case be achieved by improving arrangements at the yearly sessions. Moreover, WHO could hardly inform the United Nations, which had adopted a resolution specifically referring to WHO's strategies, that one of the first decisions of the Health Assembly thereafter had been to go on leave for two years. The Polish delegation therefore supported the draft resolution that advocated retaining the existing system.

Miss Betton (Jamaica) supported the draft resolution that reflected alternative "A". Her delegation's preference for that alternative was influenced by the ongoing study of the Organization's structure in the light of its functions. She was confident that the adoption of a system of biennial Assemblies would improve the efficiency of the Organization: it would not only be time-saving and money-saving, but would also help to promote the process of decentralization and the strengthening of the regional committees. Her delegation endorsed the views expressed by the delegates of New Zealand and of Trinidad and Tobago.

Dr Houénassou-Houangbé (Togo) said there was always a fear of change, particularly when a certain system had become habitual. Many eminent people had even thought the Organization foolish to launch campaigns for primary health care and for attaining health for all by the year 2000. WHO's work at regional level needed to be strengthened. In any event there was nothing to be lost and everything to be gained by the change. It was possible that a saving of US$ 2 million every two years was relatively insignificant in a budget of $540 million - but that saving would be enough to supply drinking-water to 10 000 people in a country of the developing world.
It was claimed that annual Assemblies were essential if the objectives of primary health care and health for all were to be attained. That argument however implied that most of the work towards achieving those objectives had to be carried out at headquarters; in fact all that work should be done by the countries themselves. It was also argued that since WHO was concerned with the health of the whole world it was essential for Member States to meet yearly, but he did not think WHO's role as catalyst and coordinator need necessarily depend on annual meetings of the Assembly at headquarters. There was no risk that if alternative "A" were adopted, the planning of the strategy for attaining health for all by the year 2000 would suffer, since the biennial system would only come into operation after 1985, and by that year planning of the strategy should be completed. If after 1985 other problems should arise it would always be possible to convene a special session. He therefore supported the draft resolution which reflected alternative "A".

Dr BOOTH (Australia) also favoured that alternative. The solution put forward in the draft resolution to retain annual Assemblies would condemn the Secretariat to a continuing burden of work, and would absorb funds which could better be spent on the implementation of programmes. It would also hinder the development of greater regional responsibility, which was a desirable trend.

A further objection to the draft resolution advocating the continuation of annual Health Assemblies was that, since it covered both duration and periodicity, its adoption might preclude further discussion on the matter of duration; he would appreciate legal advice on that point. He would also like some further explanation of how the effectiveness of Assemblies, referred to in operative paragraph 1 of that resolution, was in fact to be verified; he feared that such verification would involve interminable debates on matters of procedure. If there was to be a review of the Organization's structure, bold decisions on the part of the Assembly would be needed.

Dr PLIANBANGCHANG (Thailand) said the Health Assembly was an important forum for the discussion and joint solution of technical health problems. The exchange of technical experience and know-how at global level was undoubtedly of the greatest benefit to the developing countries, particularly in the context of their commitment to attain the goal of health for all by the year 2000. He therefore reaffirmed his delegation's support for the system of annual Health Assemblies, and would vote for the draft resolution in that sense.

Professor VON MANGER-KOENIG (Federal Republic of Germany) pointed out that biennial sessions would mean that one important function of the Health Assembly, namely to determine the policies of the Organization, could be exercised only every two years, despite the recognized fact that a common international policy was vital for WHO's technical work. Biennial sessions would also mean that another important task of the Assembly, namely to review and approve the reports of the Executive Board and of the Director-General and to instruct the Board, could be performed only every two years. A third disadvantage would be that any resolutions and recommendations with important health implications adopted either by the United Nations or the organizations in its system could be discussed and approved by the Health Assembly only with a year's delay. It had been argued that, since regional committees met annually, there was no need for the Health Assembly to do the same; that argument was unconvincing, because the topics to be discussed by the Assembly concerned more than one region.

He urged that annual Assemblies should be retained, as a way of maintaining the constant and intensive care on the part of its Members that the Organization needed if it was to survive. His delegation supported the draft resolution advocating such retention.

(Discussion resumed in section 4 below.)

3. SECOND REPORT OF COMMITTEE B (Document A34/36)

The CHAIRMAN invited the Committee to adopt its draft second report, contained in document A34/36.

Dr ASHLEY (Jamaica), Rapporteur, read out the report.

Dr HASSOUN (Iraq), speaking in his capacity as delegate of Iraq and not as Vice-Chairman of the Committee, expressed his delegation's reservations on the resolution regarding the transfer of the Regional Office for the Eastern Mediterranean. He was convinced that that resolution did not meet the needs and concerns of the majority of Member countries in the Region.
The CHAIRMAN said that the reservations expressed by the delegation of Iraq would be reflected in the summary record of the meeting.

The report was adopted (see document WHA34/1981/REC/2).


Mr BENAVIDES (Peru) said that international organizations such as WHO were the depositaries of the hopes and aspirations of developing countries in their struggle against the chief obstacles to their development - disease, hunger, and poverty. WHO played a crucial part in the efforts of the international community to overcome problems affecting millions of people throughout the world, problems which were the common concern of all. The role played by the Organization ought therefore to be strengthened and stimulated at all levels, and its main organ, the Health Assembly, should not be condemned to lengthy periods of inactivity. The Assembly had the task not only of adopting the budget but also of framing guidelines for policy and of evaluating work achieved, thus determining how WHO carried out the role entrusted to it by the international community. If Members were to be seriously committed to attaining health for all by the year 2000, it was surely preferable for them to meet as frequently as possible within the period that had been set for reaching that goal. The goal would not thereby be automatically attained, but at least the Assembly would have had twice as many opportunities to review its course of action and to decide whether changes were needed. The subject of world health, and how each country could best contribute towards it, was important and interesting enough to justify meeting to discuss it at least once a year. He saw no point in altering the workings of a complex piece of administrative machinery purely for the sake of a change that had not been shown to have any convincing advantages. The effectiveness of WHO's work should take precedence over financial considerations.

It had been argued that one of the advantages of a biennial system would be that it would enable small countries to participate more fully in Health Assemblies. He could not accept that argument. When the subject of travel expenses for representatives at regional committees had recently been discussed, it had been generally agreed that the Organization should contribute by paying those expenses. Now, on the contrary, it was being argued that, to save expense, it was better not to have any meeting at all. He rejected that reasoning also. Another justification that had been put forward for the change to the biennial system had been that the savings made would be sufficient to build a hospital in some Third World country. That argument was not relevant, since it was well known that the money saved would not in fact go towards such a hospital but would be returned to Member countries themselves in the form of reductions in annual contributions. It was dangerous to make economies the overriding objective.

Mr MAGNUSSON (Sweden), reiterating the view expressed by his delegation at the Thirty-third World Health Assembly that there should be no change in the periodicity of Assemblies which was not accompanied by profound structural reform, proposed the following amendments to the draft resolution advocating the retention of annual Assemblies:

1. to add, between the first and second preambular paragraphs, a new paragraph reading: "Having in mind the need to preserve and strengthen the democratic participation of all Member States in the work of WHO..."

2. to replace the present third preambular paragraph by the following text:
"Recognizing that the implementation of the plan of action consequent upon the study of the structure of the Organization in the light of its functions is still incomplete and therefore does not yet provide adequate documentation on which to base a definitive decision as regards the periodicity of Health Assemblies;"

3. in the present fifth preambular paragraph, to add after the words "changeover from annual to biennial Assemblies": "without accompanying consequential arrangements as regards the composition and the size of the Executive Board and in the role and function of all bodies in the Organization..."

4. to add the following new paragraph after operative paragraph 1: "CONSIDERS that changes in the periodicity of Health Assemblies should only take place in connexion
with other structural reforms, such as changes in the composition and size of the Executive Board and changes in the role and function of all bodies of the Organization;"

(5) in the present operative paragraph 2, to add the words "for the time being" after "annual Assemblies".

Dr BROYELLE (France) noted that the various proposals concerning the periodicity of the Health Assemblies all enjoyed a measure of support; in particular, the draft resolution which would retain annual Assemblies had been sponsored by 34 Member countries. Any change in the periodicity of Assemblies would involve advantages, such as economies of time and money, but also disadvantages. The latter included the possible implications of structural change, in particular an enhanced role for the Executive Board and the weakening of the Health Assembly, which was the only body representing all Member countries. Her delegation fully appreciated the imperative that all countries must be permitted to express their views adequately. If the Health Assembly was weakened further, the growing trend towards the development of parallel structures, such as advisory groups with powers that tended to replace those of constitutional bodies, would receive further impetus.

Her delegation had at first, on grounds of economy, leaned towards the proposals that favoured biennial Health Assemblies. It would however go along with the proposal to maintain the status quo, provided that efforts were made to effect rationalization and economies by, for example, reducing the duration of Assemblies.

Miss GARRIDO-RUIZ (Mexico) considered that the Health Assembly should continue to meet annually.

Professor HALEEM (Bangladesh) asked whether the proposed amendments to Articles 13, 14, 15 and 16 of the Constitution had been submitted within the time-limit stipulated by Article 73 of the Constitution.

Mr VIGNES (Legal Adviser) said that, at the request of the Thirty-third World Health Assembly, the Director-General had on 24 July 1980 addressed a circular letter to all Member States pursuant to Article 73 of the Constitution which required that the text of proposed amendments to the Constitution must be communicated by the Director-General to Members at least six months in advance of their consideration by the World Health Assembly. That letter had contained the text of the proposed constitutional amendments which were before the Committee. Constitutionally, the rules had been scrupulously observed by the Director-General.

Mr LO (Senegal) expressed concern at the arguments that had been put forward regarding economies of time and money. Delegates attended the Health Assembly in the interests of the health of their peoples, and all the Assembly's working time should therefore be devoted to the issue of health improvement. If countries could solve all their health problems by themselves there would be no need for international cooperation. WHO's raison d'être lay in the fact that it was an organ for coordination and cooperation and provided an opportunity for delegations to meet, exchange views and participate in the common struggle for the welfare of mankind. He associated himself with those delegations which had emphasized that no opportunity for meeting each other should be lost at a time when developments in the health field were so rapid. The goal of health for all by the year 2000 would not be attained if meetings took place only at two-year intervals. Under the current system of annual meetings, almost three weeks were required to deal with the workload. What would be the position if the Assembly were to meet every second year, bearing in mind the many issues which it must decide and which the Executive Board could never decide on its behalf. If the Health Assembly did not meet for two years, there was a risk that special sessions, which should be convened only in exceptional circumstances, would gradually become the rule. Moreover, the irregular periodicity of special sessions might well prove to be an obstacle to a fully representative attendance.

The money that countries would save if they did not send delegates to health-related meetings would be unlikely to benefit the health sector and would most probably be used by governments to send delegates to other, possibly political, meetings. Furthermore, if ministers of health were to admit an implicit lack of interest in health matters by deciding to meet only once every two years, their efforts to persuade their own governments to devote greater resources to health would be undermined.
The problem could be solved by other means, such as rationalization of present procedures without prejudice to the principle of annual meetings. His delegation therefore unreservedly supported the draft resolution which would retain the practice of annual Assemblies.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) proposed, under Rule 63 of the Rules of Procedure, that the debate on the part of the item dealing with periodicity should be declared closed and a vote taken on it; following which the Committee should go on to discuss the duration of Health Assemblies.

Following a procedural discussion, in which Dr BROYELLE (France), Dr VENEDIKTOV (Union of Soviet Socialist Republics), Mr BOYER (United States of America) and Mr VIGNES (Legal Adviser) took part, Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) withdrew his proposal.

Mr VOHRA (India) said that the legal position had been rightly brought out. There were three proposals before the Committee: two circulated earlier by the Secretariat, and the draft resolution sponsored by 34 countries and supported by others. There were also proposed amendments to the last-mentioned resolution by the delegate of Sweden. Perhaps if there was no delegate who still wished to press the earlier alternatives, that resolution could be given final shape in consultations at the end of the present meeting or early the next morning. Otherwise it would be necessary to continue the debate.

Dr QUAMINA (Trinidad and Tobago) asked to have the amendments proposed by the delegate of Sweden in writing.

Mr MBOUMBA (Gabon) said that his delegation's position was based on its conviction of the need for decentralizing the Organization and transferring its main activities to the regions. He observed that a number of steps had already been taken by the Organization, all tending towards the hoped-for decentralization, which was considered as guaranteeing the future effectiveness of the Organization's programme. Other measures incumbent upon the Health Assembly would of course have to be taken, and that was why he supported the principle of biennial Assemblies as contained in the draft resolution reflecting alternative "A".

Dr XU Shouren (China) said that his delegation supported the draft resolution reflecting alternative "A", which had been supported by New Zealand, Trinidad and Tobago, and others. Those delegations had stated what would be the advantages of a meeting every two years. The Chinese delegation had already voiced its opinion at the Thirty-third World Health Assembly, explaining why it was in favour of biennial meetings; he did not intend to repeat the argument.

Mr BERWAERTS (Belgium) said that his delegation was in favour of keeping the system of annual meetings unchanged. He felt that changing to a biennial system would lead to profound changes in the institutional balance of the Organization, particularly with regard to the functions and responsibilities of the Executive Board. Biennial meetings would be acceptable only if the membership of the Executive Board were increased to 48. It would also be necessary to redefine the responsibilities of the members of the Executive Board so that they might indeed effectively represent the governments of sovereign States.

Dr SAMBO (Angola) was convinced that the Committee had a clear idea of the part played by the Health Assembly in an evolving world, and he would therefore not repeat the various arguments in support of annual sessions. To change the periodicity of the Health Assembly would, in his view, diminish its powers and the opportunities to make its voice heard. For that reason his delegation preferred to maintain the system of annual Assemblies and wished to join the co-sponsors of the draft resolution advocating that line.

Mr JAAFAR (Kuwait) said that his delegation would also support that draft resolution because even now, when the Health Assembly met every year, the developing countries still did not fully enjoy their rights. He wondered, then, what the situation would be if the Health Assembly met only every two years. Further, the primary objective of the annual sessions was to take advantage of the considerable health experience of the developed countries for the benefit of the developing countries. The exchange of experience and opinion made for improved health services in all countries. Since that was indeed the Organization's prime objective, why should the chances of attaining it be diminished by meeting biennially rather than annually?
He noted a lack of clarity in the Arabic translation of operative paragraph 1 of the draft resolution and hoped that it would be corrected.

Mr SOÓS (Hungary) said that his delegation had always supported the maintenance of the status quo, and was one of the co-sponsors of the draft resolution to ensure such maintenance. If there were delegations hesitating over which side to take, he appealed to them to support that draft resolution.

Dr CISSE (Niger) said that the debate could no doubt be continued for a year without reconciling the two positions. It had become a kind of polemic, to the advantage neither of the Health Assembly itself nor of Member States. His country, however, wished to make its contribution to the discussion by raising issues that were controversial but nonetheless real. His delegation had already made clear the previous year that it was in favour of biennial Assemblies; it had defended that position consistently; and rather than change its views it would appeal to its opponents to understand them. Those who wished to change the present periodicity of Health Assemblies did not hold their views lightly. It had been said that the maintenance of annual Health Assemblies would ensure a better monitoring of the implementation of Assembly decisions. But every delegate present could cite from experience at least one example of distortion between the decision taken and its implementation in his or her own country. He quoted as examples the 1974 decision that cholera vaccination would no longer be necessary for travellers; and the resolutions voted by the Health Assembly against the racist system in South Africa and against Israel? No, there was not better monitoring. There was often discussion in great depth on certain subjects, but when delegates reached home, their country reassumed its full sovereignty, often as if that sovereignty were incompatible with the resolutions of WHO.

It had been said that WHO was an organization within the United Nations system whose activities were in no way comparable to those of other organizations. Yet few of the delegates present could have arrived at the Health Assembly by plane without the intervention of the World Meteorological Organization. WMO met in general assembly every four or five years, with meetings of commissions in the intervals to resolve urgent problems. Similarly, without the International Telecommunications Union the Health Assembly would have to be continued for the 365 days of the year, since long-distance communication would be impossible.

It had been said that a yearly exchange of views made it possible to settle a number of questions. That might be so. But when one listened to the speeches made by ministers or their representatives in plenary meetings, and to the statements made by colleagues from neighbouring countries with whose internal situation one was familiar, one realized that the actual state of affairs was really quite different. The sole advantage of annual Health Assemblies was that they provided an opportunity for bilateral discussions with representatives of friendly countries on projects of mutual interest - but such exchanges had nothing to do with the Health Assembly. Indeed, so far as medical practice was concerned, there were other meetings which were of much more value than the Health Assembly.

The tragic fact was that countries were divided between developed and underdeveloped, North and South, and their priorities were quite different. In Niger, the matters of most interest were the campaign against malaria, the literacy campaign, and the campaign against starvation; whereas in other countries the priorities might be road-traffic accidents, obesity, or geriatrics. In years to come those latter subjects might be of interest to his country also, but for the time being all that mattered was to have enough to eat and a supply of clean drinking-water. Solutions to such problems were indeed sought by the Organization - but not at the level of the Health Assembly. If governments did not have confidence in the Director-General and his staff, they should seek to change them until they were satisfied.

It had been said that even if the principle of biennial periodicity was adopted it could not be implemented until 1988. However, that was no argument against it at a time when the Organization was considering a programme which extended to the year 2000.

Mention had been made of the developing countries. Whether developed or underdeveloped, each country attempted to defend its own interests. Those interests might be divergent; they might even be diametrically opposed; in the political sphere, unfortunately, such opposition might lead to war. But doctors did not in general wish matters to degenerate to such a stage of confrontation. Whether from developed or developing countries, doctors were primarily health technicians, and they often found on their return home that reality as seen from their office was not quite what it had appeared at the Health Assembly.

The representatives of the developing countries were best placed to know their countries' own interests, but there should be no attempt to suggest that Health Assembly delegates as a
whole were speaking only in the interests of the developing countries. The state of under-development was maintained by countries which had neither the interest nor the desire to see the underdeveloped countries progress. The people of Niger had proclaimed their desire to work towards development, but there were still states that were doing what they could in every field, including that of health, to ensure that their position remained intolerable.

It had been suggested that the time and money which would be saved by holding Assemblies biennially would be negligible. It might be negligible to some speakers but certainly not to him: the cost of the air tickets alone for his delegation to attend the Health Assembly was equivalent to the annual salaries of at least ten state-registered nurses. He was therefore strongly in favour of reducing costs. Moreover, so far as time was concerned, each member of his delegation was responsible for a department in the Ministry of Health and there was inevitably a tremendous backlog of work on their return after three weeks in Geneva.

In conclusion, he urged the Committee to spend no more time in discussing the item but to consider only the best interests and the health of their populations when expressing themselves for or against the proposal.

Mr ABBASSI TEHRANI (Iran) said that his delegation was in favour of the principle of biennial Health Assemblies. He agreed with the statement made by various other delegates that it was not possible for some countries to attend a three-week Assembly every year because of financial constraints. What might be acceptable to rich countries was not so to the countries of the Third World. So far as Iran was concerned, and in accordance with the injunctions of Islam, his delegation believed that it had no right to spend money that belonged to the whole nation. It was therefore preferable to change to a system of biennial Health Assemblies, which would cause no problems and would save funds. His delegation supported the draft resolution reflecting alternative "A".

Mrs LEFEBVRE (Canada) associated herself with those who had spoken in favour of biennial Health Assemblies. Her Government had expressed itself in favour of alternative "A" in reply to the Director-General's letter of 24 July 1980. She therefore supported the draft resolution incorporating that alternative.

Dr OLDFIELD (Gambia) said that his country's delegation to Health Assemblies was always small. He enjoyed coming to Geneva and would be glad to do so as often as possible in order to have a fruitful exchange of views with his colleagues. However, such visits involved considerable sacrifice in terms both of finance and manpower, and he did not think that any policy question was of such urgency that it was necessary to hold an Assembly every year. Attention should be focused on the regional level, where matters of common interest to the region were discussed for implementation at country level. He favoured greater decentralization in discussions and supported the draft resolution reflecting alternative "A".

The meeting rose at 13h00.
PERIODICITY AND DURATION OF HEALTH ASSEMBLIES: Item 36 of the Agenda (Resolution WHA33.19; Document EB67/1981/1, decision EB67(6) and Annex 13; Document EB67/1981/REC/2, pages 284-295) (continued)

The CHAIRMAN reminded the Committee that at its eighth meeting it had decided to consider the two topics of periodicity and duration separately, and to complete its consideration of periodicity and consider the two draft resolutions submitted by the Secretariat reflecting alternatives "A" and "B" before taking up the question of duration and the third draft resolution submitted by a number of delegations.

Dr VENEDIKTOV (Union of Soviet Socialist Republics), speaking on a point of order, said that he did not consider the proposed order of consideration of the draft resolutions, as outlined by the Chairman, quite correct. There was only one agenda item before the Committee, namely periodicity and duration of Health Assemblies. Hence, in accordance with the Rules of Procedure, the Committee should consider first the Swedish amendments to the draft resolution submitted by a number of delegations, and then the draft resolution itself; there would be no need to vote on the two draft resolutions submitted by the Secretariat if the other draft resolution was approved.

Dr BROYELLE (France) agreed with that view.

Mr BOYER (United States of America) considered the Chairman's proposal correct. The Committee had so far discussed only the periodicity of Health Assemblies. It could not consider the draft resolution proposed by a number of delegations until it had discussed the question of duration.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) pointed out that the two draft resolutions submitted by the Secretariat were submitted under the heading "Periodicity and duration of Health Assemblies".

Dr BOOTH (Australia) understood that the Chairman had ruled, and the Committee had agreed, that it should consider the first draft resolution prepared by the Secretariat reflecting alternative "A", the second draft resolution prepared by the Secretariat reflecting alternative "B", and the third draft resolution submitted by a number of delegations, in that order.

Mr VIGNES (Legal Adviser) said that the situation was somewhat complicated but, if he remembered correctly, the Committee, at its previous meeting, had decided to consider the item in two parts: first, periodicity, and then duration. It was difficult to discuss duration without knowing what decision had been reached regarding periodicity. For example, if the Health Assembly were to meet biennially, it might be decided that it should hold longer sessions, or that one of the main Committees might meet at the same time as a plenary meeting, which was not the case at present. If it were to meet annually, it might be decided that the Technical Discussions should be held only every two years, i.e., every second Assembly, whereas if it met biennially, the decision would say that the Technical Discussions should be held during each Assembly. The Committee's decision to discuss the item in two parts therefore appeared logical and coherent. It did, however, raise the problem of when to consider the
draft resolution submitted by a number of delegations. That problem might be solved by dividing the draft resolution into two parts, one dealing with periodicity and the other with duration.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) pointed out that the Legal Adviser had not indicated in what order the draft resolutions should be put to the vote. The Committee's decision to divide discussion of the topic into two parts did not necessarily affect the order of voting. Moreover, when, at the Committee's eighth meeting, the United Kingdom delegate had moved closure of the debate on periodicity, the Legal Adviser's opinion had been that periodicity and duration constituted a single item and that it was not possible to move closure of the debate on part of an item.

In his view, therefore, since the two parts of the discussion formed a single item, the draft resolution furthest from the original should be put to the vote first.

Dr BROYELLE (France) said it appeared logical that the Legal Adviser's opinion expressed in connexion with the motion for closure of the debate on periodicity also meant that the draft resolutions submitted related to the item as a whole.

Dr ALUOCH (Kenya) said that he was becoming increasingly confused. He asked whether, if the third draft resolution submitted by a number of delegations was adopted, it would be necessary to put the other two draft resolutions to the vote.

Mr VIGNES (Legal Adviser) repeated that the Committee had decided, for practical reasons, to hold its debate in two parts. Legally, there was no objection to taking a vote on a draft resolution at the end of the first part of a debate, if the second part of the debate did not deal with the subject of the draft resolution. There was therefore no contradiction between the opinion he had given at the Committee's previous meeting and that which he was now expressing.

He suggested to the USSR delegate that it would be difficult to put to the vote a draft resolution dealing with two topics at the same time as draft resolutions dealing only with one topic. The solution would appear to be either to vote on all three draft resolutions at the end of the debate, which would have the disadvantage that it would not be known what the Committee's view was on periodicity, or to divide into two parts the third draft resolution submitted by a number of delegations and to vote first on the three draft resolutions dealing with periodicity. In both those cases, the third draft resolution would have to be voted on first, as it was furthest removed from the earliest draft resolution.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) did not think that the Legal Adviser had fully clarified the matter. The agenda item as it stood dealt with both periodicity and duration of Health Assemblies. It had been on the agenda of the Thirty-third World Health Assembly in the same form and no delegation had proposed that it be subdivided, but now the Legal Adviser was proposing exactly that. If delegates agreed that the first and second draft resolutions should be withdrawn and that the third draft resolution - with possible additional amendments - should be put to the vote, he would be quite happy. He pointed out that the principle of reducing the duration of the Health Assembly in even years had already been decided, in resolution WHA33.19, and he suggested that the Board be asked to make concrete proposals on ways and means to the Thirty-fifth World Health Assembly.

The DIRECTOR-GENERAL said that to avoid any misunderstanding he wished at the outset to emphasize that the Secretariat did not propose draft resolutions. The two draft resolutions in question had been prepared by the Secretariat on the Committee's instructions at its third meeting.

As he saw it, the position was that the Committee had decided, for the sake of clarity, to discuss the item in two parts and no objection had been made to that procedure. The question now was how to proceed so that the draft resolutions, including those prepared by the Secretariat on the Committee's instructions, could be put to the vote in the correct order. The best solution might be, as suggested by the Legal Adviser, to divide into two the third draft resolution proposed by a number of delegations, and to vote on all the draft resolutions dealing with periodicity before considering the question of duration. On the other hand, members might prefer to vote on all the draft resolutions at the end of the debate on the entire item, but in that case it would seem necessary to have an indicative show of hands at the end of the discussion on periodicity in order to know the Committee's feelings.
Dr VENEDIKTOV (Union of Soviet Socialist Republics) agreed in part with the Director-General. He was pleased to hear that the Secretariat had not proposed the draft resolutions, but had prepared them in response to the request of the previous Health Assembly and of the Chairman. The topics before the Committee came under a single agenda item. What was proposed was in a sense that the vote on the third draft resolution should be split, and voting proceed paragraph by paragraph. He was not certain what was meant by "an indicative show of hands". Did it mean that the other two draft resolutions would be taken out of order or had the Committee still to vote on them? If it meant that only other issues could then be discussed, without a return to periodicity, then his delegation could accept it in this sense. If, however, after an indicative show of hands the whole procedure must be repeated, then it would be better to vote at once.

The DIRECTOR-GENERAL explained that by "an indicative show of hands" he meant that the Committee would show its choice of annual or biennial Health Assemblies when the discussion on periodicity had come to an end. After the question of duration had also been discussed, the Committee would then have all resolutions tabled and would vote upon them in the order already indicated. The Committee would thus first continue its discussions on periodicity, then proceed to discussions on duration, as the USSR delegate had requested, but the two discussions would be kept separate, with an indicative show of hands between the two. At the end of both discussions there would be a vote on the Swedish amendments to the draft resolution proposed by a number of delegations, and then on the draft resolution itself, with or without amendments; after those had been accepted or rejected, the Committee would pass to the two other draft resolutions if and as necessary.

Professor VANNUGLI (Italy) pointed out that the question before the Committee was extremely simple: whether to have annual or biennial Health Assemblies. The legal and procedural aspects were both subtle and interesting, but time and pressure of other work forbade consideration of them. His delegation was willing to accept any solution that would curtail discussion. The Director-General's suggestions were simple and practical. Procedural questions should be postponed temporarily. An indicative vote on periodicity would assist the Committee to pass to the issue of duration. The delegates' opinions should first be ascertained and legal complexities left aside.

Professor HALEEM (Bangladesh) said that his delegation, which was a co-sponsor of the third draft resolution, was concerned with the regular periodicity of the Health Assembly, and was dubious of the feasibility of discussing the holding of special sessions. He noted that the duration issue remained separate. The duration of Health Assemblies was not a constitutional matter; it could conceivably be fixed by the Secretariat, and not necessarily by the Assembly. He therefore urged that the third draft resolution should be approved.

Dr BOOTH (Australia) agreed with the Director-General that a vote on periodicity should be taken before that on duration. The issue now was the order in which the various proposals were to be taken. He suggested that a vote might be taken to decide whether the draft resolutions should be taken in reverse order, beginning with the third, or whether they should be taken in the numerical order, starting with the two alternative draft resolutions.

Professor AUJALEU (France) thanked the Director-General for his efforts to break the deadlock. However, the matter was serious and it would be undesirable for the outcome to be open to question on procedural grounds. An indicative vote would only create confusion since the final vote, if the results differed, might well be contested. Accordingly, he favoured the Legal Advisor's suggestion, i.e., that the paragraph referring to duration in the third draft resolution be set aside; that the amendments to that draft resolution (excluding those on duration) be considered; and that a vote then be taken on all the draft resolutions relating to periodicity. Thereafter, the issue of duration, including the paragraph of the third draft resolution still pending, could be discussed.

The CHAIRMAN asked if that proposal was acceptable to the USSR delegate. If not, shortage of time might oblige the Committee to vote on the procedural issue.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) was not clear what the French delegate's intentions were as to the issue of duration. The Director-General had proposed an indicative show of hands, after which the discussion would continue. Now the French delegation proposed a vote
on the third draft resolution, except for one paragraph which was to be voted on subsequently. Since the Committee was discussing an item which was a glaring example of the way the Health Assembly systematically wasted time year after year, he wished to know the views of other delegations concerning the issue of duration. The third draft resolution contained nothing very specific about duration, and the previous Health Assembly had already decided to curtail sessions in even years.

Professor AUJALEU (France) explained that the first operative paragraph of the third draft resolution, relating to duration, would be set aside temporarily, together with any amendments to it, until the end of the discussion on that topic, which would follow the voting on all proposals dealing with periodicity.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) concurred.

Mr BOYER (United States of America) said that if the reference to duration in the third draft resolution were set aside, what remained was three proposals on periodicity. His delegation considered that voting on them should proceed in the following order: first, the draft resolution reflecting alternative "A"; second, the draft resolution reflecting alternative "B"; and third, the draft resolution submitted by a number of delegations. That proposal was made in the light of Rule 68 of the Rules of Procedure, according to which: "If two or more proposals are moved, the Health Assembly shall first vote on the proposal deemed by the President to be furthest removed in substance from the proposal first presented, and then on the proposal next removed therefrom, and so on, until all the proposals have been put to the vote". The wording of that Rule was not very clear; it was necessary to know which proposal had been moved first. The first proposal was the draft resolution submitted by the Soviet Union and other delegations; the USSR delegate had stated that no delegation had introduced the two draft resolutions reflecting alternatives "A" and "B", and the Director-General had explained that they had been prepared by the Secretariat for information. The first of those two drafts had been moved only at the present meeting, when endorsed by the Trinidad and Tobago delegate. The draft resolution submitted by a number of delegations had therefore been introduced first, and must be voted on last. The order of voting must be the draft resolution reflecting alternative "A", the draft resolution reflecting alternative "B", and finally, if necessary, the third draft resolution.

The CHAIRMAN ruled that the order of voting would be that he had referred to earlier and as outlined by the delegate of France.

He invited the Committee to resume its discussion on the periodicity of Health Assemblies.

Dr BRITO GOMES (Cape Verde) stated that, since a global strategy for the attainment of health for all by the year 2000 had to be defined, his delegation favoured annual Health Assemblies. They were of great importance for the newer developing countries which were acquiring their first experience of planning because they provided an opportunity for the exchange of experience in all health fields.

Mr NAKAMURA (Japan) said that his delegation favoured biennial Assemblies. He agreed with many of the points made by the New Zealand delegate. When the decision was finally taken, WHO, as a United Nations specialized agency, should bear in mind that most of the other specialized agencies already held their general assembly biennially, in line with their biennial budgetary system. He saw no reason why WHO should hold Assemblies every year after adopting and introducing a biennial budgetary system. He therefore supported the introduction of a biennial system of meetings and the proposed amendments to Articles 13, 14, 15 and 16 of the WHO Constitution, as set out in the draft resolution reflecting alternative "A".

Mr SEEWOONARAIN (Mauritius) pointed out that if there were biennial Assemblies, there would be more decentralization and thus more and longer meetings at regional level. There would thus be an increase in expenditure of time and money. He felt that the contacts in Geneva with ministers of health from other countries, with the Director-General, and with WHO's specialists, gave greater opportunity for discussion of problems. This had a speeding-up effect on the solution of problems and the execution of projects. His delegation therefore supported the principle of annual Assemblies.

Mrs EMMANUEL (Nigeria) repeated her delegation's support for biennial Assemblies. It was pertinent here to refer to the recent study of the structures of WHO in the light of its
functions. The purpose of the study was to encourage self-reliance and to achieve effectiveness in planning, execution and evaluation, so as to ensure the maximum impact at the country level. If these goals were to be achieved, more power and authority must be given to the WHO country representatives. Decentralization to country level also implied that the Health Assembly must delegate greater powers to the Executive Board, which should be restructured if necessary. No doubt, for example, the African and other Regions would have views on adequate representation on the Board. The opportunity had now come to restructure the Board to equip it better to discharge the additional duties which a decision to hold biennial meetings would place upon it. Her delegation therefore strongly supported the proposal in the draft resolution reflecting alternative "A".

Mr Teka (Ethiopia) said that his country was a co-sponsor of the third draft resolution and supported the principle of annual Assemblies. One issue to be clarified, however, before the issue of periodicity was decided was the role of the Executive Board. As constituted at present, the Board did not represent countries or regions. If it was decided to hold biennial Assemblies, then regional committee decisions must wait at least two years before discussion in the Health Assembly. That meant in practical terms that they would be decided on by the Board. Therefore, unless and until the Board was restructured so that it could deal effectively with matters arising from individual countries and the regions, periodicity could not be discussed. Duration was of minor importance - an issue which could be settled at any time. The determination of periodicity, however, entailed constitutional changes.

Dr Adibo (Ghana) had two observations to make in support of biennial Assemblies. His delegation saw the issue as an exercise in the devolution of functions and responsibilities to the lower levels of WHO, which after 34 years of existence needed certain changes. That was a challenge to the partners in the contract for health mentioned by the Director-General, the challenge of health for all by the year 2000.

It was estimated that from four to six weeks of preparation were needed before a World Health Assembly or a regional committee session, and about the same amount of time for discussions afterwards so that resolutions could be translated into action. The Health Assembly took place in May, the regional committee sessions in September. That meant, in practical terms, that the period from March to September was occupied with these two meetings. There were thus only six months available for action on what was achieved at the meetings. That was neither practicable nor realistic. More time was needed to work out strategies and implement plans for the future Health Assembly. If those were granted, more countries would come to Geneva to discuss their experiences, successes, difficulties or even failures, instead of using the first 10 days of each Assembly to make declarations of intent.

Sending a delegation to Geneva for three weeks demanded sacrifices. Other national commitments and obligations must be honoured, and the cost of them all, in terms of precious foreign exchange, was very great. Foreign exchange was needed for the development of the national infrastructure and for meeting the target of health for all by the year 2000. His delegation found acceptable the proposals for the smooth functioning of the Secretariat during intervals between biennial Assemblies. By tradition, the Director-General attended regional committee sessions. He would continue to do so if the Health Assembly became biennial, in order to tell the regions what was happening at headquarters. For those and other reasons his delegation supported the draft resolution reflecting alternative "A".

Dr Nkondi (Zaire) said that the problem of periodicity was extremely complex and not new. Member States had different geographical, socioeconomic, cultural, and psychological backgrounds; it was not surprising therefore that their views on periodicity should differ. Some were long-standing Members of WHO, while others were comparative newcomers. The importance attached to the draft resolution submitted by a number of delegations would therefore be different in each case. The list of delegates for the current Health Assembly indicated that 149 Member States were represented, with delegations of from one to 29 members. His delegation had made it clear during the Thirty-third World Health Assembly that it was in favour of yearly Assemblies. Views which had been valid at that time were still valid. Articles 60 and 73 of the WHO Constitution and Rule 72 of the Rules of Procedure provided that decisions of the Health Assembly on important questions should be made by a two-thirds majority of the Members present and voting, and that those questions should include amendments to the Constitution. Article 60(c) of the Constitution and Rule 85 of the Rules of Procedure embodied similar provisions with respect to committees and sub-committees. In view of the different views that had been expressed, it was unlikely that a two-thirds majority
could be achieved at present. Furthermore, Article 73 of the Constitution provided that "amendments shall come into force for all Members when adopted by a two-thirds vote of the Health Assembly and accepted by two-thirds of the Members in accordance with their respective constitutional processes".

The amendments to Articles 24 and 25 of the Constitution concerning the membership of the Executive Board, as adopted in resolution WHA29.38, were not yet in force; they dealt only with an increase in the number of members of the Executive Board from 30 to 31. A month earlier, a letter received from WHO, asking for Zaire’s position on resolution WHA29.38, had disclosed that only 51 out of 156 Member States had accepted the amendments up to that time. The two-thirds majority, therefore, still lay in the future. Neither the amendment to Article 7 of the Constitution adopted in 1965 in resolution WHA18.48, nor the amendment to Article 74 adopted in 1978 in resolution WHA31.18, was yet in force.

The Director-General’s report referring to the replies from Member States on the question of periodicity noted that only 20 out of 156 States had answered; 13 had declared for biennial, and seven for annual Assemblies. Those figures did not permit any general conclusions to be drawn. It was therefore unlikely that Committee B, and subsequently the plenary Assembly, would be in a position to attain a two-thirds majority vote. Even if such a majority vote were to be obtained, the Committee could scarcely expect two-thirds of the Member States to accept, within a reasonable period of time, the amendments to the Constitution which such a majority vote would render necessary.

During the Thirty-third World Health Assembly, in May 1980, his delegation had pointed out that the periodicity of the Health Assembly was an integral part of the study on WHO's structures in the light of its functions. His delegation believed also that the problem was not yet ripe for solution and that the Health Assembly was not yet in a position to reach a decision to amend the Constitution. For these reasons, he suggested that the problem be dealt with as part of the reorganization of WHO in the light of its functions and therefore that the problem be further studied. Member States should show mutual understanding and recognize that circumstances, and therefore opinions, must differ. Bearing in mind, however, the fundamental aim of WHO, namely to raise standards of health as much as possible for all peoples, the Health Assembly should adopt the solution which would best enable the Organization to achieve its goal.

Mr BOYER (United States of America) believed that the arguments for biennial Assemblies were stronger; on the ground of cost, both to WHO and to Member States; on the ground of time lost by the Secretariat in preparing for meetings and of money spent on documentation; and on the ground of time lost by delegates in attending meetings. The basic reason, that a new biennial budgetary system made annual adoption of the budget, and thus an annual meeting, unnecessary, had scarcely been mentioned. A further reason was that other specialized agencies had shown that annual meetings were unnecessary.

He had been impressed by the views of the Swedish and other delegations which, with regard to WHO's structures, had indicated that changes in the periodicity of Assemblies could not be made until adjustments had taken place in the operations of the Executive Board, the regional committees and other WHO bodies. Some such adjustments might also be needed elsewhere. He felt, however, that the argument proved the reverse. What was necessary was not that the Committee should do nothing, but that it should act at once. There could be no incentive to change the functions of the Executive Board or the regional committees until the decision had been taken to have biennial Assemblies. The Board had pointed out that, even if the principle of biennial Assemblies was adopted at once, such Assemblies could not become part of WHO practice until 1988. If the Committee decided today to have biennial Assemblies it had seven years at its disposal—enough time to make corresponding adjustments in other WHO functions.

The Committee could not remain inactive simply because the task was complicated. It was important to decide immediately to adopt constitutional amendments. The vote of all supporters of a biennial Assembly was needed. He believed that it was possible to obtain a two-thirds majority, both in the Committee and in plenary session. Those who were still in doubt should vote for biennial Assemblies rather than abstain. Two regional committees, those for the Americas and the Western Pacific, had adopted resolutions in favour of biennial Assemblies, and he hoped that Members from those regions would vote correspondingly.

Since only periodicity was at issue, and not duration, he asked for a vote firstly on the draft resolution reflecting alternative "A". Those who desired biennial Assemblies should vote for that draft resolution. If the draft resolution should be rejected, they should vote in favour of the draft resolution reflecting alternative "B". If neither draft resolution was approved, the issue would be settled and no further resolution would be required.
Dr ALUOCH (Kenya), repeating the position of his delegation, believed that the issues were well summarized in the Director-General's report (document EB67/1981/REC/1, Annex 13). After considering the arguments once more, he still felt that they supported biennial Assemblies, and his delegation accepted them. In terms of time and money saved, biennial Assemblies could be important to smaller countries with limited staff and limited ability to attend meetings. Such staff might not be willing to spend so long away from their home base, thus delaying the implementation of their own health programmes. He therefore supported the draft resolution reflecting alternative "A" and the proposal for biennial Assemblies.

Mr KAKOMA (Zambia) also believed that biennial Assemblies were desirable.

Dr AL-SARRAG (Sudan) welcomed the clarifications given by the Director-General and the Legal Adviser. He re-emphasized the importance of the subject, particularly in the light of the restructuring of the Organization. If decentralization was to be achieved, thereby increasing the responsibilities of the regional committees and of the Executive Board, great efforts would be required of the international community, particularly during the early years of implementation of the strategy.

As a co-sponsor of the third draft resolution, his delegation welcomed the Swedish amendments. The French delegation had simplified matters by making a clear distinction between periodicity and duration of Health Assemblies and by proposing that a vote be taken on the third draft resolution with the exclusion of operative paragraph 1. His delegation agreed that a vote should first be taken on periodicity before the question of duration was discussed. He appealed to all delegations to vote in favour of retaining the practice of annual Health Assemblies, pending the further consideration of WHO's structures in the light of its functions. The Executive Board and the regional committees could continue as at present until the time came for changing to biennial Health Assemblies.

Mr SAWI (Sierra Leone) supported the draft resolution reflecting alternative "A", in view of the advantages of biennial Health Assemblies.

Mr VOHRA (India) said that, from the discussion at the preceding meeting, his delegation had been under the impression that it would be unnecessary to vote on any point. Now, however, there appeared to be an obligation to vote on all the issues. The third draft resolution had originally been tabled by 12 countries from various regions, and the delegations of 23 other countries had subsequently co-sponsored it. While agreeing in principle with the draft resolution, the Nordic group had submitted some amendments. At the preceding meeting, the sponsors had felt that it would be possible to get together with other delegations with a view to reaching a satisfactory solution, but they had had no opportunity to do so and the situation now appeared to have become unnecessarily contentious. In the circumstances, the Committee should proceed to a vote.

Dr OUOBA (Upper Volta) observed that the question under consideration had given rise to a lengthy discussion at the Thirty-second and Thirty-third World Health Assemblies. Having listened to all the arguments advanced by various speakers, his delegation supported the idea of holding biennial Health Assemblies in the interest of greater efficiency and improved implementation of Health Assembly decisions. It attached particular importance to regional committees and other regional meetings, which would benefit from the proposal.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) said that the United States representative must be well aware of the Rules of Procedure, although he persisted in raising points concerning the order of voting.

He shared the desire of certain delegations, to do what was best for the Organization; he understood that they wished to change its manner of functioning since they were not satisfied that it had so far done all it could either at headquarters or in the regions, and he respected that position.

He also sympathized with the view that the regional committees and the Executive Board should be strengthened and that the Organization should be decentralized, provided such decentralization did not impair its unity or flexibility. WHO was a world health army, and any army struggling against famine, disease and poverty and for social justice drew strength from unity. A disunited army was doomed to defeat. The paramount requirement was to improve the operation of the Health Assembly, as the major instrument for action. If the documentation
was not entirely satisfactory, or if time was being wasted, steps should be taken to improve the functioning of the machinery. His delegation was convinced, however, that a move to biennial Assemblies at the present stage would be harmful. It would therefore vote in favour of the third draft resolution, which should be decided by a simple majority.

Dr Chew Chin HIN (Singapore) shared the views expressed by the delegate of Sierra Leone as to the benefits to be derived from biennial Health Assemblies. He urged the Swedish delegate to withdraw his amendments.

Mr NYGREN (Sweden) said that, in his delegation's view, the various aspects of the entire problem of structure, of which periodicity was but one, should be dealt with concurrently. That was extremely important for his delegation, which maintained its amendments.

Mr VIGNES (Legal Adviser) said he had six observations to make on the point raised by the United States delegate, who had suggested that, since the draft resolutions reflecting alternatives "A" and "B" had been transmitted according to him, after the submission of the draft resolution by a number of delegations, they should be voted on first, in accordance with Rule 68 of the Rules of Procedure.

First, it was by an express request of the Health Assembly, in resolution WHA33.19, that the Director-General had been asked to prepare the proposed texts of amendments to the Constitution.

Secondly, the text of the amendments which were now before the Committee as draft resolutions reflecting alternatives "A" and "B" had been transmitted by circular letter to Member States on 24 July 1980 in accordance with Article 73 of the Constitution.

Thirdly, at the Committee's third meeting, on 12 May, the Chairman had suggested that the Secretariat be asked to prepare draft resolutions in connexion with agenda item 36, one relating to alternative "A" and the second to alternative "B" of the proposed constitutional amendments, and that suggestion had been accepted.

Fourthly, at the Committee's request, the Secretariat had circulated those texts in two documents dated 14 May 1981.

Fifthly, the draft resolution submitted by a number of delegations had been circulated in a document dated 15 May 1981.

Lastly, if one were to accept the United States suggestion to the effect that the amendments to the Constitution contained in the two draft resolutions reflecting alternatives "A" and "B" had been submitted after the draft resolution proposed by a number of delegations, those amendments could be considered as inadmissible, since it could be argued that they had not been submitted six months in advance of the Health Assembly, in accordance with Article 73 of the Constitution.

The Committee should accordingly vote first on the amendments to the draft resolution submitted by a number of delegations, and then on the draft resolution itself; only if that vote was negative would the Committee then vote on the draft resolutions reflecting alternatives "A" and "B".

Mr BOYER (United States of America) said that the Legal Adviser appeared to be suggesting that the Committee should vote first on a draft resolution that advocated doing nothing, and that if that negative draft resolution was adopted there would be no need to vote on the two draft resolutions that advocated positive action. Logic required that the opposite course should be followed.

The CHAIRMAN suggested that the Committee should proceed to vote in the manner outlined by the Legal Adviser.

Mr BOYER (United States of America) said that, in his view, such a course was not logical. He therefore requested that a vote should be taken as to the order in which the draft resolutions should be voted on.

Dr SEBINA (Botswana) said that the Committee should follow the Rules of Procedure and vote first on the proposal furthest removed from the original proposal.

Dr ABDULHADI (Libyan Arab Jamahiriya) said that the Legal Adviser's advice should be followed.
Professor AUJALEU (France) pointed out that it was the Chairman's prerogative to give a ruling as to the order of voting.

The CHAIRMAN said that, in a spirit of democracy, he recognized the United States proposal that the Committee should take a vote on the order of voting.

Mr VIGNES (Legal Adviser) agreed with the French representative that it was the Chairman's prerogative to indicate his preference as to the order of voting. Any delegate could then appeal against the Chairman's ruling, as the United States delegate had done, and the appeal should then be put to the vote immediately, in accordance with Rule 58 of the Rules of Procedure.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) said that the Committee could not depart from the Rules of Procedure but could only interpret them. If it was sufficiently clear which proposal was the one furthest removed from the proposal first presented and the proposal next removed therefrom, voting should proceed on that basis.

He recalled that, during the discussion at the Thirty-third World Health Assembly on the proposal to transfer the Regional Office for the Eastern Mediterranean, the United States delegate had sponsored a proposal in favour of maintaining the status quo. A vote had been taken on the latter proposal first, in accordance with the Rules of Procedure. He failed to understand why the United States delegate should be opposed to the similar application of the Rules of Procedure in the present case. The Legal Adviser had clearly indicated the course that should be followed.

The CHAIRMAN said that he would follow that course and would first put to the vote the draft resolution submitted by a number of delegations.

Mr FIGUEIREDO MACHADO (Brazil), speaking on a point of order, said that the draft resolution was related to a proposal requiring amendment of the Constitution, and would therefore require a two-thirds majority vote.

Mr VIGNES (Legal Adviser) said that the usual majority was a simple majority. Matters requiring a two-thirds majority were exceptional matters specifically provided for in the Constitution and the Rules of Procedure. The draft resolution submitted by a number of delegations involved no amendment to the Constitution and only required a simple majority.

Mr BOYER (United States of America) supported the Brazilian delegate's suggestion, which was in accordance with Rules 72 and 73 of the Rules of Procedure.

Professor HALEEM (Bangladesh), speaking on a point of order, said that it was clear from Rule 72 of the Rules of Procedure that decisions on important matters should be taken by a two-thirds majority.

Mr VIGNES (Legal Adviser) pointed out that the Brazilian delegate had not made his suggestion on the ground that the draft resolution dealt with an important matter, but on the ground that it related to questions concerning amendments to the Constitution. The advice he had given was that the draft resolution did not relate to any of the cases to which specific reference was made in the Rules of Procedure. If it were to be decided that it was an important question, then a two-thirds majority would be required for the vote on the draft resolution; whether the question was important or not should be decided by a simple majority vote, in accordance with Rule 73.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) said that the Legal Adviser's point was well-founded. Any matter could theoretically be declared important for the purposes of a two-thirds majority vote, but such voting had so far been used only for genuinely important matters. Even such politically important matters as the admission of new Members had always been decided by simple majority. Resolution WHA33.19 on periodicity and duration of the Health Assembly had itself been adopted by simple majority and there had been no request for a two-thirds majority vote. The Committee should respect its Rules of Procedure and make consistent use of them. The situation was clear. Any confusion was deliberate and unnecessary.
Mr FIGUEIREDO MACHADO (Brazil) said that the Legal Adviser had misunderstood his point. The matter was an important one because there was an amendment to the Constitution which would not be considered if the draft resolution proposed by several delegations was adopted.

Mr NAKAMURA (Japan), speaking on a point of order, said that he understood that the draft resolutions reflecting alternatives "A" and "B" required a two-thirds majority vote because they would involve amendment of the Constitution. Since all the draft resolutions related to periodicity, the one submitted by a number of delegations should also be considered as an important question requiring a two-thirds majority vote.

Dr FERNANDES (Angola) said that the only important issue was the question of the amendment to the Constitution dealt with in the two draft resolutions relating to alternatives "A" and "B". The draft resolution tabled by a number of delegations had no implications for the Constitution, and there was no need to seek important issues other than those referred to in Rule 72 of the Rules of Procedure.

The DIRECTOR-GENERAL thought that it would be helpful to recall what the Legal Adviser had said and to clarify the situation as it stood at present. At first there had been a question whether or not the order of voting on the draft resolutions as decided by the Chairman was being challenged. It had appeared that there was no challenge. Then the delegate of Brazil had drawn certain inferences making it appear that the draft resolution submitted by a number of delegations would also require a decision by a two-thirds majority, with or without amendments. The Legal Adviser had made it clear that if, as the United States delegate had maintained, the delegate of Brazil was making a formal proposal, the Committee would have to follow Rule 73 of the Rules of Procedure and decide by a simple majority that the question referred to in that draft resolution and the amendments thereto was of such exceptional importance that it required a decision by a two-thirds majority. If the Committee should establish that it was such an exceptionally important question, the Committee would then proceed to decide it by a two-thirds majority.

The CHAIRMAN asked the Committee to vote by show of hands on the proposal to consider the draft resolution submitted by a number of delegations, with its amendments, of such importance that it required a decision by a two-thirds majority.

The proposal was rejected by 70 votes to 42, with 8 abstentions.

The CHAIRMAN said that, in the light of the vote just completed, only a simple majority would be needed for a decision on the amendments proposed by the Swedish delegation to the draft resolution submitted by a number of delegations. The amendments would have to be voted on as a whole. He asked the co-sponsors of the draft resolution whether the amendments were acceptable.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) said that he could not speak on behalf of all the co-sponsors, but, as far as the spirit of the amendments was concerned, he agreed in principle. He was not altogether in agreement with the wording of the proposed text to replace the third preambular paragraph regarding the need for further documentation before taking a definitive decision; perhaps the Swedish delegation might consider removing that wording. He was, however, in favour of the amendments in principle.

Mr VOHRA (India) said that he spoke on behalf of the other co-sponsors and thought they would agree with him. As the delegate of the USSR had suggested, they had doubts on some of the wording, but they entirely agreed in principle with the amendments proposed by the Swedish delegation.

Dr ACOSTA (Philippines), speaking on a point of order, said that since the draft resolution submitted by a number of delegations did not imply any changes in the Constitution it needed only a simple majority decision. However, the Swedish delegation's amendments implied certain changes in the Constitution which required a two-thirds vote, since they envisaged changes in the Executive Board, its role and its function.

The CHAIRMAN pointed out that the question had already been voted on.

Mr NYGREN (Sweden) confirmed that his delegation's amendments did not propose any changes in the Constitution. With regard to the comments made by the Soviet delegate, he was prepared
to delete the second part of the proposed text to replace the third preambular paragraph, which would end after the word "incomplete".

The CHAIRMAN asked the Committee to vote by show of hands on the proposed amendments.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) asked whether, since the Swedish delegate had amended the proposed text to replace the third preambular paragraph, the Committee was voting on the amendments as amended.

The CHAIRMAN confirmed that that was the case.

The amendments, as amended, were adopted by 70 votes to 35, with 15 abstentions.

The CHAIRMAN invited the Committee to vote on the draft resolution submitted by a number of delegations, as amended, without operative paragraph 1 which referred to the duration of Health Assemblies.

The draft resolution, as amended and without operative paragraph 1, was approved by 69 votes to 45, with 4 abstentions.¹

The CHAIRMAN said that in view of the motion just carried it now appeared unnecessary to vote on the remaining two draft resolutions.

He invited the Committee to take up the issue of the duration of Health Assemblies. The Executive Board representative had summarized the five proposals made by the Director-General to the Board for shortening the duration of future Health Assemblies. Those proposals could be found in paragraph 85 of the Director-General's report to the Board, on page 214 of document EB67/1981/REC/1. Before considering each of the five proposals, he invited members of the Committee to express their general views on the subject.

Dr VANNUGLI (Italy) recalled that in May 1959 there had already been discussions on whether and how to shorten the length of Health Assemblies. At that time, the Twelfth World Health Assembly had requested the Board, in resolution WHA12.38, to consider in what ways and to what extent it could shorten the sessions of the Health Assembly. Time has passed and the matter was still being discussed. The only result so far had been to extend the length of the debates. He had concluded that there were only two ways to reduce the duration of Health Assemblies. One would be to dispense with the general debate; the other, to dispense with the Technical Discussions. Neither way was popular, and he saw no great chance for the adoption of either. He wished, therefore, to hear his colleagues' opinions.

Professor HALEEM (Bangladesh) observed that, as far as he understood it, the Constitution made no provision for the Health Assembly to fix the duration of its annual sessions. He therefore thought that it should be left to the Director-General and the Secretariat to fix the duration, depending on the volume of work on the agenda.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) suggested that, in those years when the programme budget was not being considered, the Director-General, with the advice of the Executive Board, should restrict Health Assemblies to not more than two weeks' duration, and that it should be left to the Director-General and the Secretariat, with the advice of the Board, to decide how best to achieve that aim.

Mr VOHRA (India) said that there seemed to be three main possibilities of saving time. The first possibility concerned the week or more spent in general discussions (items 9 and 10 on the agenda of the current Health Assembly), when ministers came and expressed views on the Organization's past performance and the promise for the future. Perhaps it could be agreed by consensus that every year, depending on the number of countries in each region, a selected number of ministers could speak for a limited time on matters relating not to individual countries but to the region. By rotation, of course, a representative of every country would get the chance to speak. That device would not only focus sharper collective attention on common regional programmes but also save much time. Perhaps it could be decided by consensus as well that, apart from the first speaker at the first meeting, none of the delegates speaking at any stage would offer congratulations to office-bearers. Ten days after the election of an office-bearer he was still being congratulated. Such congratulations became redundant.

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA34.28.
The second possibility was the Technical Discussions. It had to be decided whether the kind of discussions which had been held were really useful or just a ritual that should be dropped. The subjects selected for discussion were invariably of the highest importance, but when the discussions on matters of global concern were broken up into five or six groups, the tendency in each group was to discuss what had or had not been achieved in each delegate's respective country. That was understandable, but the net result was not really commensurate with the time spent. He thought that the same technical subjects should be discussed in each of the regional committees, which could send their reports to the Secretariat. The Secretariat could then circulate them to all delegations arriving at the Health Assembly. If more discussion was needed on one or more issues it could take place in one of the committees, but should not go on for one-and-a-half to two days.

The third possibility was to hold committee meetings while plenary meetings were in progress. Clearly, however, that would not do, especially for countries that sent one- or two-man delegations, and in view of the fact that it was being considered whether to reduce the time spent on plenary meetings by shortening the general discussion.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) repeated that his delegation was in no way opposed to saving the Health Assembly's time so as to enhance its effectiveness. On the contrary, it wanted to use the time to the best advantage to improve the agenda, the documentation, the timetable, the procedure and so on. The time appeared to be coming to consider reducing the duration of one of the Health Assemblies in the very near future, as resolution WHA33.19 made clear, though he wondered exactly how that would be done. In his view the Executive Board should be asked to consider ways in which time could be saved. Dr Ridings had referred to some proposals that might reduce the use of time. Some of those proposals seemed acceptable, others rather dubious, for example, calling for discussion only on certain items. He hardly thought it would be possible to cut back on the general discussions: delegations and ministers had very interesting statements to make. Regarding the Indian delegate's suggestion that speakers should speak only about what was of common interest to the region, that was for the regions to decide. It might be possible for one committee to meet at the same time as a plenary meeting, for certain items. The Technical Discussions were very important and should be kept, because they were the forum for preliminary discussions of a number of important and complex issues oriented towards the future. In any case, it might be useful for regions to choose some topic for technical discussions taking account of each region's characteristics, and perhaps in that way the general discussion could be limited and made more to the point.

It was also proposed to reduce the number of items on the agenda. He had also proposed a limit on administrative matters, but according to the Constitution many of them could not be dispensed with. At the present Health Assembly, at which the budget was considered, there were few programme matters: however, the next Health Assembly would be examining the biennial report of the Director-General and he was sure programme matters would come up. Perhaps the Board, in preparing the Health Assembly's agenda, could see what should be retained and what dispensed with. The proposal that the Board should fix the closing date of the Health Assembly was premature and hardly acceptable; the Assembly should plan its own work. The Board already provided a provisional agenda, which gave the Health Assembly an ample basis for decision.

Thus, there were a number of proposals that merited consideration for improving the way the Health Assembly functioned and it was important to keep in mind the idea of an experimental approach. Some of the proposals could be tried out, and if they were effective they could be kept; any measure that proved unproductive could be abandoned. In January 1979 the Board had taken the view that experimentation with the work of the Health Assembly had to involve logic and consistency; in resolution EB63.R33 it had considered that "the method of work of the Health Assembly need not be reviewed every year and that it would be desirable to have such a review undertaken only in the light of experience gained over a period of several years". All possible ways of reducing the duration of Health Assemblies should be sought, but without going from one extreme to another, and nothing should detract from the quality or integrity of the Assembly's work. Thus the paragraph set aside from the draft resolution should be rephrased in that light and the Executive Board should be requested to make relevant proposals.

The CHAIRMAN said that the proposals set out in the Director-General's report (document EB67/1981/REC/1, Annex 13) would be considered item by item at a later stage and asked the delegates to prepare their interventions accordingly.

The meeting rose at 12h30.
TENTH MEETING

Monday, 18 May 1981, at 14h30

Chairman: Dr Z. M. DLAMINI (Swaziland)

1. PERIODICITY AND DURATION OF HEALTH ASSEMBLIES: Item 36 of the Agenda
   (Resolution WHA33.19; Document EB67/1981/REC/1, decision EB67(6) and Annex 13;

   Dr ABDULHADI (Libyan Arab Jamahiriya) said that the duration of Health Assemblies would
   inevitably depend on the agenda that was adopted. The Assembly had already attempted to
   improve its method of work in the past but it should still be possible to save time,
   particularly on recurring items. Arrangements could perhaps be made to have delegates
   take turns from one year to the next in addressing the Assembly. Moreover, some statements
   might be omitted from the actual discussions and published separately in booklet form. That
   was a matter for regional committees and for the heads of delegations. It should also be
   possible to save one-and-a-half days if the Technical Discussions were held only every two
   years. However, so long as the principle of annual Assemblies was maintained, the current
   duration of the session should be retained until such time as the Executive Board was able
   to make new proposals.

   Professor AUJALEU (France) said that, since past discussions and proposals on the subject
   had so far had no effect, the only way to reduce the duration of Health Assemblies was to
   decide once and for all that, in years when there was no budgetary discussion, the Assembly
   should last no more than two weeks. Once that was established, the Assembly would then
   have to arrange its schedule in such a way that it completed its agenda within the time
   allotted.

   Dr VENEDIKTOV (Union of Soviet Socialist Republics) supported the proposal put forward
   by the delegate of France. The suggestion that the Health Assembly last two weeks in years
   when there was no budgetary discussion was already contained in resolution WHA33.19. He
   therefore proposed that the Committee adopt a draft text asking the Executive Board to
   prepare proposals regarding changes in the duration of the Health Assembly and arrangements
   for its work, bearing in mind resolution WHA33.19 and the views expressed by delegates, and
   to submit those proposals to the Assembly for experimental verification and final approval. 
   Experimental verification was particularly important because of all the possibilities that
   existed; if the proposals did not meet the Assembly's views, the Board might be asked to
   continue making suggestions until a satisfactory formula was found.

   The CHAIRMAN asked the Committee whether it wished to request the Rapporteur to prepare
   a draft text along the lines indicated, for consideration at a later meeting.

   It was so agreed.
   (For continuation, see summary record of the thirteenth meeting, section 2.)

2. AMENDMENT OF THE INTERNATIONAL HEALTH REGULATIONS (1969): Item 38 of the Agenda
   (Resolution WHA33.4; Document EB67/1981/REC/1, resolution EB67.R13 and Annex 4)

   Dr MORK (representative of the Executive Board) said that, following the eradication of
   smallpox, it had been suggested that the International Health Regulations be amended to
   reflect the changed epidemiological situation of that disease. The Director-General had

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accordingly contacted all members of the WHO Expert Advisory Panel on International Surveillance of Communicable Diseases, and complete agreement had been reached on the deletion of all references to smallpox from the Regulations.

The proposed deletion, which had been brought to the attention of all Member governments in September 1980, had been submitted to the sixty-seventh session of the Executive Board. The latter had drawn attention to the fact that international certificates of vaccination against smallpox were still asked for in certain cases; Member States should therefore be requested once again to ensure that the practice at all points-of-entry to a given country, and at its embassies, consulates and missions abroad, reflected the declared policy not to require smallpox vaccination certificates from any traveller. Resolution EB67.R13 contained a draft resolution recommended for adoption by the Health Assembly which would fully clarify the situation.

Mr VOHRA (India) recalled that, in the discussion on resolution WHA33.4, some concern had been expressed regarding the recommendation to reduce the number of laboratories holding stocks of variola virus to four and the danger that still existed from human monkeypox and other orthopox viruses. Since the need for constant surveillance had been emphasized, he asked what safeguards had been introduced.

As to the proposal to delete Article 18 from the International Health Regulations, one possible consequence of such action might be to cause unnecessary inconvenience to in-transit airline passengers who had passed through yellow fever endemic areas and who would therefore have to be placed in quarantine.

Dr ALLOUC (Kenya) said that his country no longer required travellers to carry international certificates of vaccination against smallpox and accordingly supported adoption of the draft resolution in resolution EB67.R13. He welcomed the additions to the WHO booklet on vaccination certificates in its new format, particularly the section on the health risks to which travellers might be subject.

Dr VARGAS (Nicaragua) said that his country was complying with the resolutions adopted at the Thirty-third World Health Assembly in respect of certificates of vaccination against smallpox. He fully supported the draft resolution before the Committee.

Mr GILBERT (United Kingdom of Great Britain and Northern Ireland) said that his delegation fully supported the deletion of references to smallpox in the International Health Regulations and its inclusion among the diseases under international surveillance. Some embassies and officials at entry-points, however, were still advising travellers to carry smallpox vaccination certificates. He therefore requested that a further appeal be made to Member States to review their instructions to their overseas posts and ports of entry to ensure that such certificates were no longer asked for.

Dr CARTER (Epidemiological Surveillance of Communicable Diseases), replying to the delegate of India, said that, since the requirement for health administrations to send information to WHO about airports with direct transit areas had been removed from the International Health Regulations with the deletion of Article 21, the requirement in Article 18 that health administrations designate airports that possessed direct transit areas was an editorial anomaly that should be corrected. There was naturally no objection to any health administration designating such an airport, but there were no longer any grounds for requiring such designation. In the instance of an arriving traveller who had passed through a yellow fever endemic area, WHO could be contacted in order to determine rapidly whether the country concerned had designated an airport as having a direct transit area, and whether there were sound epidemiological grounds for considering there to be transmission of yellow fever.

Dr GROMYKO (Smallpox Eradication), also replying to the delegate of India, recalled that, thanks to collaboration between WHO and national health authorities, the number of laboratories retaining variola virus stocks had been reduced from 76 in 1976 to five in 1981 to date. Periodic visits were being made to ensure that the virus was kept under good safety conditions.

As far as monkeypox surveillance was concerned, it was being maintained in countries where the disease had been reported in West and Central Africa. Special surveillance was being carried out in Ivory Coast, Sierra Leone and Zaire and would shortly be extended to Congo. In those countries, existing health institutions were conducting surveillance to
detect potential outbreaks of suspected monkeypox, and serological surveys were also being carried out to obtain more information on the natural history of human monkeypox.

The draft resolution proposed by the Executive Board in resolution EB67.R13 was approved.

3. ORGANIZATIONAL STUDIES BY THE EXECUTIVE BOARD: Item 39 of the Agenda


Dr BARAKAMFITEYE (representative of the Executive Board) recalled that in 1978 the Thirty-first World Health Assembly had requested the Executive Board to undertake an organizational study on the role of WHO in training in public health and health programme management, including the use of country health programming. The report of its working group on that study (document EB67/1981/REC/1, Annex 5) had been submitted to the sixteenth session of the Executive Board. It defined the scope and framework of the study, discussed the quantity of management training resources currently available and their relevance to national needs, and proposed national strategies for management training; it also defined the role of WHO in management training.

In discussing the report the Board had focused on Part IV, concerning national strategies for management training. It had stressed that there could be no clear dividing-line between short-term and long-term strategies, since any measures taken now must necessarily take into account the formulation and implementation of strategies to cover the next 20 years. That meant that efforts should be made immediately, not only to provide appropriate management training for existing personnel but also to start reviewing the content and methods of education programmes for various health occupations, including those carried out by schools of public health, so as to ensure that competence in management became an integral part of the health worker’s skills. Steps should also be taken to systematize and institutionalize continuing education as a means of improving the managerial performance of all health workers.

The Board had urged Member States, as the first step in the development of national strategies for management training, to make an inventory of their resources (e.g., institutions, programmes and personnel) and then to begin organizing those resources, either as part of a health development network or (in the case of the African Region) for management development.

The Board had endorsed the emphasis laid in the report on the importance of management training for all categories of health workers at all levels of administration. It had drawn attention to the need for training managers in such sectors as housing, basic sanitation, and education. It had been pointed out that health management worked in parallel with the management of other community services, and that managers in both cases should work as a team to promote development as a whole. It had noted that national efforts to decentralize management applied to all sectors, including the health sector, which was by no means independent of other social services.

Since management training was one of the elements of the global strategy for attaining health for all by the year 2000, the Board had felt that the conduct of the study might have been easier if it had been carried out after that strategy had been formulated. However, it considered that the conclusions and recommendations for management training were in line with that global strategy, particularly in regard to the managerial process for national health development, and the need to bring training institutions into line with reforms in the health system. The study outlined the supporting role of WHO in that respect.

Although the Board had felt that more practical guidance might have been included on management training methods, it recognized that the study had never been intended as a substitute for individual country studies of problems, needs and resources.

The Board had adopted a resolution (EB67.R14) inviting the World Health Assembly to examine the report on the study, and to consider for adoption a draft resolution calling for specific action to implement its recommendations.

1 Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA34.13.
Dr VENEDIKTOV (Union of Soviet Socialist Republics) said the study had been a difficult one because of the complex nature of its subject. He suggested that the report might, after appropriate amendment by the Secretariat, be published more widely, since it could be useful to many countries in solving their problems in health programme management training. He fully supported the draft resolution.

Mr VOHRA (India) said that training should not be viewed in isolation, but as related both to the global strategy for the attainment of health for all, and to the restructuring of the Organization. Training could not be conceived as unrelated to the structure of the system that delivered health care, and there was therefore urgent need for every Member State to look at its own health system to see how far it was capable of delivering the kind of care needed. The staff employed at various levels in primary health care must have sufficient background and orientation to be able to provide the required services. In primary health care the crux of the matter where training was concerned was that decisions must be taken at local level, whereas in most countries the decision-making machinery was situated at central or national level. If decision-making was to be relevant, if technologies were to be appropriate, and if the programmes devised were to be viable both in financial and in technical terms, then the training must be conceived in a local rather than in a national context. He did not think it would be sufficient for the Health Assembly merely to express satisfaction with the Board’s study; it should keep it as a focus of discussion when dealing with other items on its agenda.

He fully endorsed the Board’s conclusion that many countries did not have an adequate realization of their own potential where training was concerned; they should accordingly appraise the status of their resources before establishing a mechanism for providing that training. The concept of a health development or management development network was vital. Both at country level and at regional level such networks could play an important role not only in training national personnel but in helping other countries in similar circumstances with their own training problems. The strategy would require a basic review of the content and orientation of medical education, not only at graduate level but, more important, at lower levels. Unless the entire approach in training was focused on achieving the goal of primary health care, all efforts at improvement would be ineffective.

Miss BELMONT (United States of America) also emphasized that appropriate training at all levels of management was essential in the implementation at national level of strategies for health for all. The training of managers of hospitals and other health facilities might require reorientation to enable those managers to recognize their role in supporting, rather than competing with, primary health care. Similarly, personnel with management capabilities were needed for primary health care itself, whether at the periphery, where the care was actually being delivered, or at the centre.

In training managers concerned with primary health care the needs of the entire population should be taken into account, not only the needs of those seeking care in health facilities. If it was not possible to serve all the population, then priorities should be set for deciding which elements should receive the most urgent attention. Since resources for health care would often be extremely scarce, managers should be prepared to take crucial decisions on the allocation of those resources. Finally, the use of indicators, notably of health status and health services, would need to become part of management’s decision-making process. She concurred in the study’s findings that in health management the link between research and training was important, and that a basic background in health services research would help in carrying out long-term activities.

Dr XU Shouren (China) said health management was an essential aspect of primary health care and was an important link in a whole chain of objectives that were to be attained in the context of health for all by the year 2000. Experience in China had shown that, where there was equivalent equipment for the delivery of health care, differences in the effectiveness of delivery were due to a more or a less efficient management. The strengthening of the training of management staff was particularly important at peripheral level. Where circumstances did not permit training to be carried out on a normal basis, special short-term training courses could be organized.

His delegation supported the proposals made in the Board’s resolution, and hoped that, both at headquarters and in the regional committees, there could be a continued exchange of experience on health management training so that it could be improved and made more systematic.
Dr ALUOCH (Kenya) said that in his country a programme of training in health management had been in operation since 1975, focusing mainly on the development of management capabilities for rural health units. He supported the concept of promoting and strengthening health management development in the African Region through the establishment of a regional network of institutions, which would develop national health management capabilities with a view to attaining the goal of health for all by the year 2000.

His country had in the past participated in WHO-sponsored workshops on country health programming and he looked forward to working closely with the Organization on the new training effort. Kenya was willing to collaborate in that effort and would offer facilities for use by WHO for training courses as from 1982.

Dr BROYELLE (France) said the title of the organizational study did not accurately reflect its content, since it referred to the role of WHO in "training in public health and health programme management", whereas the study in fact dealt only with training in health programme management. So as not to imply that the study also covered public health, she proposed that the words "public health and" should be deleted.

She agreed with the stress laid in the study on the need to adapt training to priorities, and on the need for flexibility, since priorities were often changed. It was important to bear in mind that training must be provided for all categories of personnel, and not merely for certain privileged managerial categories. An integrated management structure would be easier to achieve if managers were not systematically separated from technicians and health workers at other levels. She would like that point to be given more emphasis in the draft resolution before the Committee and therefore proposed that, at the beginning of operative paragraph 3, the words "management and related training" should be replaced by: "management and management training for different categories of personnel".

Mr SÓOS (Hungary) said that in his country training in public health was carried out at various levels. The Health College provided a three-year course to train public health epidemiological inspectors, the curriculum for which included natural sciences, sociology, hygiene of human settlements, occupational safety, nutrition, social medicine and health management, legal and administrative aspects, and protection of children and young people. Staff of a higher category working in the field of public health possessed medical diplomas and could specialize after four years of postgraduate training.

Each year a certain number of doctors specializing in hygiene were given a two-year training course after graduation. A large percentage of health administrators had also trained as doctors, though they did not specialize in hygiene. Doctors could choose to specialize in social medicine and could follow a four-year postgraduate course which would include spells of work as district or industrial physicians. Programmes of continuing education included emphasis on managerial and administrative skills.

A reform of medical training, with the assistance of WHO, was under way in Hungary, its aim being to provide high-level management and leadership skills. It was also planned to train lawyers, economists or engineers to take up work involving health administration, planning and organization.

Professor HALEEM (Bangladesh) stressed that a large proportion of health workers involved in the health for all endeavour would be basic-level workers at the periphery, who had little or no opportunity for training at regional or global level. He urged that WHO should formulate policies for training such workers as a matter of priority. WHO should also assist in standardizing management programmes, for example by advising Member countries as to where certain ministries, or divisions within ministries, could be amalgamated. It could also help in standardizing health education as between Member countries. He felt that such education should be concentrated at the lowest, or field, level.

Dr SEBINA (Botswana) emphasized the reference in operative paragraph 3 of the draft resolution to the need for Member States to include as components of their strategies for attaining health for all "strategies for strengthening management and related training and for developing suitable career structures for those trained". Member countries were trying to assemble as many resources as possible to attain their health objectives, but the management of such resources, whether human, financial or material, had hitherto been neglected. The study was therefore most welcome. Without good management, resources, be they substantial or limited, would be dissipated, and proper resource management was required at all levels of the health
system. He supported the view expressed in the study regarding the significant role which postbasic, basic and continuing programmes of education and training could play in developing management capabilities.

Suitable career structures for those trained in health programmes were essential. If Member countries accepted the draft resolution and the concept of country programming, they should also create the environment in which a proper career structure could be developed, so as to attract candidates for training.

Dr LO (Senegal) said that the report had pinpointed the need for countries to make an inventory of management mechanisms with a view to ascertaining how training for management could be improved on the basis of existing resources and constraints. The working group on technical cooperation among developing countries (TCDC) for subregion 1 of the African Region, which had met in March 1981, had discussed health management and its related mechanisms. It had concluded that: in view of constraints within health systems, the importance of management must be stressed; management systems should be integrated with the national development effort; many related sectors had quite different managerial systems; the management of health systems differed from one country to another and, as a result, terminologies differed. The lack of coordination among the various development sectors led to sectors with a health component tending to set up projects without consulting health departments, thus creating confusion. The lack of realism in setting up what were often complex management systems had also been stressed. But fundamental improvement was only possible if objectives were clearly defined on the basis of available ways and means. In that connexion, the working group had discussed the Region’s available resources, including its technological resources and the need for standardizing and simplifying mechanisms, so that technical resources could be compared. Forms of technology must be selected which could be introduced whatever the level of development of a particular country. As to the administrative resources available for health management, the working group had considered it essential to establish a health management system whose interdependent components could be geared to local, intermediate and central levels. Particular stress had been laid on the local level and on the need for exchange of personnel at that level as part of technical cooperation among developing countries. As regards financial resources it had been felt essential to move towards an optimization of local resources and to gain the participation of the local population in a self-financing system involving self-management, possibly also co-management and international cooperation.

As regards staff, the working group had emphasized the need for training responsible managers at all levels in the primary health care approach. In that connexion it had cited the example of certain English-speaking countries of the Region.

TCDC should be encouraged through appropriate legislation. The working group had also discussed the question of regional and national health development centres and whether responsibility for such centres should lie with the university or the public health administration. The Technical Discussions at the present Assembly had demonstrated the importance of universities in that respect, but universities were traditionalist. The working group had felt that health development networks should be placed at the level of the health administration rather than under the wing of the university, although the latter should participate fully in the work of the regional or national centres. In any form of training, account should be taken of needs and constraints before a training programme was actually established.

Dr BARAKAMPITIYE (representative of the Executive Board) said that delegates clearly agreed with the Executive Board as regards the fundamental importance of management in health development projects. The comments made would serve as guidelines to the Board in monitoring the progress achieved in implementing the study.

He agreed with the delegate of India that the management component could not be viewed in isolation. All delegations had insisted on its importance, as was also shown by the discussion on the 1982-1983 programme budget in Committee A. The delegate of China had made an interesting comparison when he had said that, when resources and equipment were equal, the difference in performance hinged on management. In developing countries, where resources and equipment were scarce, management had to reach an even higher standard.

In reply to the delegate of France, he said that the Board, in paragraph 4 of the report, had tried to identify the various elements constituting the title of the study. The study had been carried out on the basis of the title chosen by the Health Assembly; if the Health Assembly wished to change the title, it could of course do so.
Dr BROYELLE (France) repeated her proposed amendment to operative paragraph 3 of the draft resolution.

The draft resolution proposed by the Executive Board in resolution EB67.R14, as amended by the delegate of France, was approved.  

Future organizational studies: Item 39.2 of the Agenda (Decisions EB65(11) and EB67(11))

Dr MORK (representative of the Executive Board) recalled that in January 1980 the Board had decided to assess its previous organizational studies and their impact on the policies and activities of WHO. The working group it established had met in January 1981 and had defined its objective, namely: the preparation of a set of recommendations that would permit the Board to express its views to the Health Assembly on the desirable frequency of organizational studies, criteria for selection of subjects, and methodology of future studies. The working group had agreed on the methodology to be followed in carrying out its assessment and had decided to concentrate on a sample of eight previous organizational studies. The group would meet immediately following the Board's sixty-eighth session (May 1981) and again in October-November, reporting to the Board at its sixty-ninth session (January 1982).

In its decision EB67(11), the Executive Board had decided not to select a subject for a future organizational study pending its review of the findings of the working group.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) thought that the Committee should express agreement with the conclusions of the Executive Board and ask the working group to continue and accelerate its study. The background to the question was connected with the rationalization of the work of the Health Assembly and the Executive Board, some members of the Board (citing reasons of economy) having expressed doubts as to whether organizational studies were really necessary.

The Board's organizational studies were prepared in great depth: working groups often went out into the field to investigate on the spot. In his opinion those studies had contributed to the effectiveness of the work both of the Board and of the Health Assembly. A number of the organizational studies had enabled the Health Assembly to reach important decisions which were now part of the history of WHO. Cases in point were the organizational study on methods of promoting the development of basic health services; and that on the role of WHO expert advisory panels and committees and of collaborating centres.

He was convinced of the significance of the organizational studies and proposed that the Board should continue its study of their utility, concentrating its attention not on the question of what or what not to study, but on the best methods of investigating the matters that would be referred to the Board and subsequently submitted to the Health Assembly.

Dr MORK (representative of the Executive Board) said that the comments of the delegate of the Soviet Union would be borne in mind at the next meeting of the working group.

The Executive Board's report was noted.


Dr RIDINGS (representative of the Executive Board), introducing the item, said that the major issue considered by the Executive Board was that of the desirable ranges in number of posts on the basis of which it could be determined whether, in terms of geographical distribution, a Member State was adequately represented, under-represented or over-represented. The Board had intended to examine that concept and the criteria for establishing such desirable ranges at its sixty-fifth session (January 1980). However, in view of a similar re-examination requested by the United Nations General Assembly in December 1979, it had decided to postpone the matter until its sixty-seventh session. That decision had been confirmed by the Thirty-third World Health Assembly in resolution WHA33.30.

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA34.14.
Following its consideration of the Director-General's report on the decisions taken by the United Nations General Assembly regarding desirable ranges (resolution 35/210), the Board had examined his proposals for modifying the current method of calculating desirable ranges in WHO by adapting the new United Nations formula to the circumstances of WHO. It recommended that the Health Assembly should adopt those proposals.

In essence, the proposals gave increased weight to the membership factor, i.e., the allocation of an equal number of posts to each Member State in calculating its desirable range. They gave reduced weight to the contribution factor, i.e., the number of posts allocated on the basis of the size of each Member's assessed contribution to the regular budget. The effect of the proposals would be to increase the desirable ranges of the lower contributors and to decrease them in the case of Members making an assessed contribution over 0.60%.

The Executive Board had also noted the progress made between June 1978 and October 1980 in improving the geographical representativeness of WHO's staff as measured by the existing desirable ranges. Notwithstanding some progress, however, there continued to be an imbalance in the geographical distribution of the professional and higher grades of the Organization. The Board therefore recommended that the Health Assembly should establish a target of 40% in the appointment of nationals of unrepresented and under-represented countries for all vacancies arising in posts subject to geographical distribution during the period 1981-1982.

The Executive Board was concerned that the proportion of women in the professional and higher grades had not increased. It therefore recommended that the Health Assembly should request the Director-General not only to continue but to intensify his efforts to appoint more women to the staff of WHO while at the same time reviewing what the reasons might be for the apparently insufficient availability of women candidates.

Noting that the United Nations General Assembly had asked both the International Civil Service Commission and the Joint Inspection Unit to study the related matters of career development and the duration of appointments of staff, the Executive Board recommended that, pending the outcome of those studies, the Health Assembly should confirm the current policy limiting the award of permanent or career-service appointments to the minimum required by WHO's programme.

The Board intended to report further to the Health Assembly on the duration of staff appointments after it had reviewed that matter, probably at its sixty-ninth session. Finally, noting that the resolution of the United Nations General Assembly on personnel matters had dealt with certain procedural aspects in the United Nations related to the recruitment of staff, it recommended that the Health Assembly should request the Director-General to keep in mind the evolving practices of the United Nations and to continue his efforts to improve the recruitment process in WHO. The Board recommended that the Thirty-fourth World Health Assembly adopt a draft resolution on the subject, the text of which was contained in resolution EB67.R25.

Dr VENEDIKTOV (Union of Soviet Socialist Republics), noting that the attitude taken by the United Nations General Assembly towards this subject was indicative of the importance that other international agencies attached to the issue of the recruitment of international staff, said that, although progress had been made, it was too slow, and the situation in WHO remained unsatisfactory. There was still an imbalance as regards both the distribution of posts and their levels.

Of the 156 Member States, 48, including the Soviet Union, were either unrepresented or under-represented, whereas 38 were over-represented. The Organization was clearly not taking adequate steps to recruit specialists from under-represented countries.

In its resolution 35/210, the United Nations General Assembly had proposed a new series of desirable ranges for geographical representation, and the Executive Board had recommended their extension to WHO. The Director-General and Regional Directors should take additional measures to overcome the existing imbalance.

The draft resolution before the Committee failed to mention a number of points, of which, in the opinion of his delegation, the following were particularly important:

1. WHO must elaborate and approve a procedure, similar to that adopted in United Nations General Assembly resolution 35/210, for recruitment to posts subject to geographical distribution.

2. Plans should be drawn up annually for the recruitment of international staff, taking into particular account that part of the General Assembly resolution calling for the appointment of qualified candidates primarily from unrepresented and under-represented countries and from among women.
(3) Not enough timely information was provided to Member States concerning the transfer of staff between headquarters and regional offices or field projects, or concerning vacant posts financed by extrabudgetary funds.

(4) Most of the experts engaged by WHO had not been appointed on the recommendation of their own government, an aspect of recruitment that needed review if WHO was to attract better qualified staff and ensure their subsequent reintegration into their own national health systems.

(5) WHO and Member States should devote greater attention to establishing optimal terms of appointment for international staff. His delegation believed that a five- or seven-year period would be the best option to ensure a suitable length of appointment. It should be combined with the rotation of staff members, which would assure both stability and flexibility. There might, of course, be exceptions in the case of particularly highly qualified experts in specific fields.

His delegation was for the time being limiting its proposals to only one amendment, which would expand operative paragraph 8 of the draft resolution to make reference to matters of procedure for recruitment of international staff to posts subject to geographical distribution, to annual planning for such recruitment, and to the timely provision of information to Member States on posts within WHO, both at headquarters and regional offices. The proposed amendment would be made available in writing as soon as possible for consideration by the Health Assembly.

In addition, he had a number of further observations, which, if supported by other delegations, might also be submitted at a later stage as proposed amendments to the draft resolution. First, greater attention should be given to the training for WHO posts of experts in developing and other countries that were unrepresented because of lack of qualified personnel. He proposed that the Director-General should formulate a plan of action to help developing countries to prepare experts for posts in the Organization on the basis of recommendations by ministries of health. In that way a greater number of qualified experts would be available to WHO and subsequently, with the added experience acquired within the Organization, to their countries of origin. Secondly, his delegation was particularly interested in having available an analysis of regional participation in staff recruitment; that analysis should indicate the effects of WHO’s policy of regionalization on the geographical distribution of posts. Thirdly, it was very important to consider the recruitment of short-term consultants, which his delegation felt was not always on the basis of fair geographical distribution. Criteria similar to those established for appointment to expert committees and expert panels should be applied.

Mr ZENKER (German Democratic Republic) said that, like the Soviet delegate, he found the progress towards remedying unequal geographical distribution too slow. Whilst appreciating the Director-General’s efforts in recent years to change the situation, he none the less must point out that the representation of the socialist and developing countries remained insufficient. A suitable geographical distribution of international staff was important if the tasks of the Organization were to be accomplished, and it was therefore urgent to continue and intensify efforts to eliminate the existing inequality. WHO should adopt as speedily as possible the United Nations recruitment principles that would enable candidates from socialist and developing countries to be given greater consideration. His country would make every effort to present highly qualified candidates for Secretariat posts.

He supported the proposals made by the delegate of the USSR.

Dr JIMÉNEZ DE BETHANCOURT (Panama) said that the recruitment of international staff was of particular concern to her country since it considered that the developing countries, of which Panama was one, were not being taken into sufficient consideration. Equality of opportunity in the scientific and technical fields must apply to the developing as well as the developed countries. Her delegation supported the draft resolution proposed by the Executive Board and endorsed the position of the Soviet Union. It suggested, however, that the amendment should not be included in operative paragraph 8 of the draft resolution, but should take the form of a separate paragraph 9, in which emphasis would be placed on the timely notification of vacant posts to Member States in order to give technicians in developing countries a better chance of being recruited.

The question of employment of women in WHO was also of particular concern. In today’s world women were playing an important role, and professional women should therefore have every opportunity to be represented in WHO’s Secretariat.
Her delegation would give its full support to a review by the Director-General of the situation in the regions, particularly the Latin American area, in respect both to professional men and women in general and the participation of women in particular.

Dr HIDDLESTONE (New Zealand) said that the draft resolution was of considerable importance to Member States, the Organization as a whole, and the Director-General as chief administrator of the Organization. It could not be considered as a simple administrative or organizational arrangement and delegates should not be beguiled too readily into believing that existing practices elsewhere were necessarily ideal in the case of WHO. Although he had no doubt that all delegations wished to see a fair geographical balance, in a specialized technical agency such as WHO, individual expertise was often crucial and had to be given serious weighting in staff selection and appointment. He cautioned against too readily accepting the proposed addition to operative paragraph 8 of the draft resolution, since he believed that, if the United Nations General Assembly principles were carried too far, they might constrain the constitutional freedom of the Director-General and the Regional Directors in relation to recruitment. The composition of WHO was significantly different from that of the United Nations itself; for example, in WHO 92% of all professional posts were subject to geographical distribution as compared with only 42% in the United Nations; recruitment authority in the United Nations was almost entirely centralized in New York whereas in WHO it was largely decentralized; most WHO staff entered the service of the Organization at a later age than was general in the United Nations; and the posts to which they were recruited were more individual and less interchangeable than in the United Nations.

The suggestion by the delegate of the Soviet Union concerning the training of potential future staff, especially candidates from developing countries, was worthy of serious consideration by the Secretariat. However, he entered a note of caution in the matter of short-term consultancy posts; they differed considerably from membership of the expert advisory panels, which often carried more long-term responsibility to the Organization. In the case of short-term consultants there was usually a need for immediate, specific expertise which only certain individuals had - although it was certainly desirable to take into account geographical considerations wherever possible.

In conclusion, he urged support for the Panamanian delegate’s plea for increased recruitment of women to the Organization. The number of women entering the health professions was increasing throughout the world, and that increase should be reflected to a greater degree in WHO.

Professor HALEEM (Bangladesh) referred to Article 9 of the WHO Constitution, which defined the three organs of WHO. In the case of the Health Assembly, Article 11 of the Constitution established the representation of Member States by delegations chosen from among the persons most qualified by their technical competence in the field of health. (He had already requested information at the eleventh plenary meeting on the extent to which Article 11 was being observed.) A similar reference to technical competence applied in the designation of Members to serve on the Executive Board. If countries could provide delegates to the Health Assembly and members for the Board, then as far as appointment of staff to the third organ - the Secretariat - was concerned, they could also provide candidates. Nationals of developed countries had greater opportunities for education and development than those of developing countries; that factor was equally relevant when considering the composition of the Health Assembly, the Executive Board, and the Secretariat. It would therefore be unjust to stipulate equal standards for recruitment of Secretariat staff, unless there was equal opportunity for developing ability. If there was a real desire to have staff from developing countries, the same principle must be accepted in relation to the Secretariat as in relation to the other two organs of WHO. If paragraphs (a) and (b) of Article 9 could be violated, then delegates had no right to legislate for paragraph (c), which related to the Secretariat. Only when he received an answer to his question concerning observance of Article 11 would it be possible for him to express further views on the item under consideration.

Mr VOHRA (India) noted that WHO was becoming increasingly differentiated from other organizations as a result of its present and future commitments. But it was the acceptability of a proposed consultant or expert to a receiving country that was a matter of concern to his Government. Since decentralization was under consideration in other areas, there was also a case in the present instance for greater powers to be given to Regional Directors to employ appropriately qualified staff who were acceptable to receiving countries and conversant with the problems of the region.
He shared the view of the Soviet delegation that it was necessary (a) to have a definite approach and programme for establishing a quota for those countries currently under-represented or under-represented so as to achieve equitable representation at headquarters and regional level as speedily as possible, and (b) to have an adequately representative Secretariat to ensure that information on the views and policies of the different Member States was readily available and that senior officials continued to be in touch with the real problems of the regions. He urged that, while in general the Organization should remain within the parameters established by the United Nations General Assembly, there should be no precipitate action to adopt patent formulas unacceptable in the field and likely to encounter practical difficulties in application.

Lastly, the process of recruitment to posts on the basis of specific criteria sometimes led to the appointment of experts who, although eminent in their field, were not acceptable to the receiving countries or lacked knowledge of the local situation in the areas in which they had been selected to serve. He suggested that there should be greater flexibility both at regional and headquarters level as regards the appointment of suitably qualified staff; and that priority consideration should be given to the appointment of staff from countries in the region that were unrepresented. It was becoming increasingly necessary to employ greater numbers of staff who could offer appropriate technology and advice and who would be selected from the region in question.

Dr SEBINA (Botswana) agreed that equitable recruitment of international staff was difficult to achieve. If one examined the list of countries that were over- and under-represented, it would be seen that the problem was not related to underdevelopment. He agreed that it was desirable for the Organization to follow the United Nations formula, but it would not be easy to adapt that formula to the situation in WHO. As regards the representation of women, he welcomed the suggestion in the draft resolution that the Director-General should analyse the reasons why women were not being recruited to, or did not apply for, vacant posts.

Returning to the specific proposals, he thought that significant progress had been made towards equitable recruitment, but he agreed with the delegate of the USSR that it was not enough. He did not think that annual reviews would produce the desired result and suggested that the relevant information should be transmitted to the Executive Board, which could then report to the Health Assembly every two years. The proposal made by the delegate of the USSR concerning rotation and transfer of staff to the regions was interesting, but it was important that transfers should occur in both directions.

The delegate of India had said that there was a need to recruit regional staff on a regional basis; while welcoming that idea, he pointed out that it was important to have a mixture of staff in all regions.

The suggestion of the delegate of the USSR that WHO should assist developing countries by training suitable staff was worthy of consideration. The question of candidates being recommended by Member States was however delicate. The Director-General and the Regional Directors had to fill vacancies on the basis of competence and expertise. The question of candidates being recommended by Member States was however delicate. The Director-General and the Regional Directors had to fill vacancies on the basis of competence and expertise. It was well known that some countries did not always recommend people solely on the basis of their competence. As regards the duration of staff appointments, he found the proposal made by the delegate of the USSR attractive; whether the limit should be five, seven, 10, or 15 years would be subject to discussion.

He supported the draft resolution and suggested that the Director-General should be encouraged to adopt the United Nations procedures, bearing in mind the unique character of WHO.

Dr BROYELLE (France) said that her delegation also regretted that geographical representation and the proportion of women recruited were not ideal. But what improvement should the Health Assembly expect? Improvement in the information that countries received might be helpful and, as regards women, changes in the methods of selection. However, one must be realistic: nothing could be done unless good candidates were put forward. The recruitment policy that the Director-General must follow had been established, but he should be given sufficient latitude to ensure good management.

She wondered whether the United Nations procedures were suitable for application in WHO in view of the special qualifications the Organization required. She would also like the opinion of the Secretariat on the proposal for annual work plans.

Mr BOYER (United States of America) said that his delegation supported the Executive Board’s proposed resolution. Its presentation and tone were just right, and it was also
reasonable. In his view there was no need for any amendment. The amendment proposed by the delegate of the USSR would tie the hands of the Secretariat and its tone seemed to indicate a lack of confidence in the Director-General. Everybody agreed that it was regrettable that 41 countries were not represented on the staff, and also that there were not enough women candidates. In all other categories, WHO performed better than other United Nations organizations. The document before the Committee showed that ten of the targets had been met in the last two years. Among the underrepresented States, three had moved out of that category, and among the under-represented States, two had moved out of the category; five countries had moved into the category of adequately represented states.

As regards the nine East European socialist countries, the document showed that four were adequately represented and two were over-represented; thus the representation of six out of the nine fell within the desirable ranges. He could see no evidence of discrimination against the USSR. Other countries - including China, Federal Republic of Germany, Japan, Netherlands, United States of America, and Venezuela - were also under-represented. Of the 38 over-represented countries, 33 were developing countries.

He did not think that an annual action plan was needed. The Executive Board's recommendations were rational and provided for reasonable measures. The amendment proposed by the delegation of the USSR was unnecessary.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) said it was a matter of extreme importance. All speakers had noted that progress had not been satisfactory so far. He did not agree that the Director-General would be hampered in his action by being asked to follow the United Nations procedures. No one had ever insisted that all the international organizations should apply exactly the same rules as the United Nations; each organization had its own particular requirements. The decisions of the United Nations General Assembly were those of the highest international political and administrative forum, but did not tie the hands of the Director-General in everything he did.

In relation to the points made by the delegate of New Zealand - that WHO's posts were more individualized and were filled by slightly older persons than in other United Nations organizations - he wondered why that should be so. It should be possible to recruit younger people, train them, and even study United Nations practices in this respect. He was gratified that many speakers had supported his proposal for training suitable candidates from the under-represented developing countries.

Understandably there should be greater recruitment of women, and the Director-General should continue to study the matter. He could not understand, however, why there were objections to geographical criteria being applied to short-term consultants. While not advocating strict geographical quotas, he thought that some consideration should be given to the question of why qualified consultants seemed always to be found in the same group of countries.

Responding to the point made by the delegate of India, he said that over-representation took many forms: there were examples of under-represented countries that had staff members in very high posts in the Organization, officials who had been in charge of WHO's programmes for many years; and there were over-represented countries whose nationals were working in field projects.

He agreed with the delegate of Botswana that it would be unwise to limit WHO staff in the regions to nationals of the region in question, since that would preclude a desirable rotation of experts.

The delegate of the United States had said that he did not see any evidence of discrimination against the USSR. However, despite the fact that the Government of the Soviet Union had regularly recommended its most qualified people to the Secretariat, for the last 15-20 years only half of their so-called quota had been filled. This could be regarded as political discrimination on the part of a non-political, technical organization, even if the Director-General was not to be blamed for it.

The question of governments recommending candidates for appointment was also related to their obligation to facilitate the reintegration of international staff members on completion of their employment by WHO. Delegates were well aware that there were now many long-serving staff who relied entirely on the United Nations or WHO for their employment. In advocating that governments recommend candidates, he had in mind a two-way process by which former staff members of WHO could go back to work in their national health administrations.

His delegation had full confidence in the Director-General and his Secretariat, but facts were facts. The present situation in geographical recruitment of staff was unacceptable and he was confident that the Director-General would wish to see it improved as soon as possible.
The Soviet delegation's amendments were aimed to ensure, not that WHO should follow United Nations practices to the letter, but that it should follow them in so far as they were compatible with WHO's constitutional obligations, that there should be annual or biennial action plans for recruitment, and that Member States should be aware of the position and be informed of transfers of staff, etc. As for the suggestion that the matter should not be considered every year, he failed to see the logic in recognizing that a matter was vitally important and then refraining from discussing it.

Professor VANNUGLI (Italy) agreed that the matter was important but questioned whether yet more recommendations were needed. Resolution WHA33.30 of the Thirty-third World Health Assembly had requested the Executive Board to report on the matter. The present Health Assembly was not required to take a particular stand, it could merely note the report.

Operative paragraph 3 of resolution WHA33.30 reaffirmed "the principle of recruiting on as wide a geographical basis as possible, with due regard to quality, efficiency, and integrity ...". There was no such clause in the draft resolution now before the Committee, which merely emphasized reference to United Nations methods of calculating desirable ranges. It must be remembered however that WHO dealt with more complex technical problems than the United Nations. He considered that it must be left to the Director-General to appoint the best man or woman for the job. The preparation each year of work plans, with new lists of details, would jeopardize good recruitment practices and not aid them.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) agreed with the delegate of Italy that WHO needed highly qualified technical specialists. He was prepared to consider any amendment on that point.

Mr GILBERT (United Kingdom of Great Britain and Northern Ireland) said that Article 35 of the Constitution made it quite clear that "the paramount consideration in the employment of the staff shall be to assure that the efficiency, integrity and internationally representative character of the Secretariat shall be maintained at the highest level". The geographical basis for recruiting staff was referred to only in the following sentence of that Article.

He did not think that any amendment to the draft resolution was required.

Dr RIDINGS (representative of the Executive Board) recognized the need to take into consideration many factors, including the qualifications and suitability of the applicant and the demands of equitable geographical representation. The question was whether WHO should follow United Nations procedures or should adapt them to the special requirements of WHO. The note of caution sounded by the delegates of Botswana, France, India, New Zealand, and others had found similar expression at the Executive Board. The present draft resolution was the compromise that had been reached by the Board following an impassioned debate. The proposal for WHO to train staff from developing countries would certainly be well received by the Board.

He would leave the Secretariat to comment on the proposal for an annual work plan of recruitment.

Mr FURTH (Assistant Director-General) said that he would deal first with the points concerning the United Nations recruitment procedures and the proposal put forward by the delegate of the USSR for an annual work plan of recruitment. He was glad that all delegates agreed that some progress had been made as regards equitable geographical distribution of staff, although further progress in this matter was required. The Director-General agreed with that point of view. He also agreed with the need for caution that had been expressed - that WHO should not follow slavishly the United Nations procedures. Those procedures applied to quite different situations and problems. As had been stated by one of the speakers, in the United Nations, geographical distribution was applied to only 42% of the professional staff. From a report of the Secretary-General to the Fifth Committee of the General Assembly (document A/C.5/35/36, of 27 October 1980), it appeared that the staffs of the United Nations Development Programme, the United Nations High Commissioner for Refugees, the United Nations Children's Fund, the United Nations Institute for Training and Research, the United Nations Relief and Works Agency for Palestine Refugees in the Near East, the International Trade
Centre UNCTAD/GATT (ITC), and several other United Nations entities did not occupy "posts subject to geographical distribution". In addition, the Secretary-General stated that more than 2000 personnel who advised governments on the implementation of technical cooperation projects were also excluded from the group of posts subject to geographical distribution, because their appointments were normally subject to the approval of the recipient government.

If that United Nations principle were to be applied to WHO, the Director-General would not have to apply the geographical distribution rules to field project staff. He did not, however, propose to make that exception. He referred to the United Nations principles merely in order to indicate that in some respects the WHO rules were already far stricter and more comprehensive that the United Nations on geographical distribution of staff. In WHO, about 92% of all professional and higher graded staff were subject to geographical distribution; linguistic staff were the only exception.

In the United Nations, the posts that were subject to geographical distribution and for which the Secretary-General had been asked to develop an annual work plan of recruitment were largely "generalist" posts (for example, economists, political officers, and administrative officers), and it was relatively easy to make those appointments from among the staff of foreign services and diplomatic missions. In WHO, appointments were made on a much more individual basis. However in 1980, 76% of all WHO selections and appointments for posts subject to geographical distribution had been for project staff, who had to be acceptable to the governments concerned; in the United Nations, none of those staff would have been subject to geographical distribution. Furthermore, in the United Nations the posts covered by the proposed recruitment procedures were all under the direct appointment authority of the substantive departments and the Office of Personnel Services. In WHO the recruitment of staff for the regional offices was a matter for agreement between the Director-General and the Regional Director, as stipulated in Article 53 of the Constitution.

Thus, the situations in the United Nations and WHO were totally different for several reasons. In WHO, technical appointments normally required special qualifications and most of them were at the level of P4 or P5, whereas in the United Nations the posts subject to geographical distribution were largely generalist posts and almost half of them were in the grades P1 - P3. The appointment authorities were different in the two organizations and the proportions of posts in established offices and technical cooperation posts were different. In the United Nations, there was the possibility of forecasting staff requirements, whereas in WHO (but never in the United Nations) a large number of posts subject to geographical distribution were dependent on individual government requests to establish, continue, or disestablish project posts. In respect of geographical distribution, the United Nations was mainly concerned with permanent staff at its headquarters in New York and in its other established offices.

Concerning the recruitment procedures outlined in the Annex to General Assembly resolution 35/210, some of these already applied in WHO and were contained in the Staff Regulations adopted by the Health Assembly and in the Staff Rules formulated by the Director-General and endorsed by the Executive Board. Some of the "procedures" in question were essentially management directives to the Secretary-General. Under the WHO Constitution, the Director-General was the authority for recruitment to WHO and the chief technical and administrative officer of the Organization, and implementation of policies should be entrusted to him.

Another point made by the delegate of the USSR had been the possibility of training persons from developing countries for WHO posts and subsequently for service in their own countries. The question would be considered by the Director-General, the Deputy Director-General, the Regional Directors and the Assistant Directors-General at a forthcoming meeting of the Global Programme Committee.

As regards rotation of staff and terms of appointment, these subjects could be considered under the plan of work for the study of the Organization's structure in the light of its functions. Any proposals emerging from the study would be reported to the Executive Board and the Health Assembly.

In reply to the delegate of Panama, he pointed out that notices of vacancies in established offices were transmitted to Member States. For project staff, different methods of recruitment were used, e.g., direct approaches to governments and institutes, or search in the recruitment roster which comprised over 13 000 applicants.

In reply to the USSR delegate's suggestion that short-term consultants' posts should also be subject to geographical distribution, he pointed out that, to his knowledge, this was not the case in the rest of the United Nations system. If the Director-General were to be
constrained in this way his task would be made more difficult. Nor did he think that the developing countries would feel this to be in their best interests.

The problem of reintegration of WHO staff into the national services had already been considered by the Executive Board and the Health Assembly several times and resolutions had been adopted by the Board (EB5.R64; EB23.R25) to give guidance on this matter to Member States. Generally those resolutions had not been implemented since, for most developing countries, it was difficult to reintegrate staff who had spent several years in an international organization. Difficult administrative procedures were involved, and national civil services were often disrupted by reintegration of former WHO staff. Moreover, the question of reintegration would apply only to a small proportion of staff in WHO, since only approximately 17% of staff were seconded from national services. Many persons, when appointed to WHO, resigned from their national services; many others were recruited from outside the national services, e.g., from universities, research institutions and nongovernmental organizations.

Finally, he felt obliged to reply to the allegation of political discrimination made by the delegate of the USSR. The facts did not support this allegation, since of the nine East European socialist countries, only two - Albania and the German Democratic Republic - were unrepresented, and only one, the USSR, was under-represented. Four countries (Czechoslovakia, Hungary, Poland and Romania) were adequately represented, and two countries (Bulgaria and Yugoslavia) were over-represented. Other socialist countries, such as Cuba, Mongolia and Viet Nam, were adequately represented. Moreover, the USSR had the fifth largest number of nationals in posts subject to geographical distribution - only exceeded by India, France, the United Kingdom and the United States. Furthermore, the USSR, with 30 of its nationals appointed between June 1978 and October 1980, took second place - behind the United States - in the number of nationals appointed in that period. If under-representation was measured by the difference between the actual number of geographically distributable posts occupied at 31 October 1980, and the minima of the proposed new desirable ranges, the USSR was under-represented by 43 staff members. The USSR, Albania and the German Democratic Republic (i.e., the only unrepresented or under-represented East European socialist countries) together were under-represented by only 57 staff members. In comparison, the United States was under-represented by 44 staff members, and the Federal Republic of Germany and Japan, taken together, by 132. There was thus no basis for the claim of political discrimination against the USSR.

Mr MUNTEANU (Director, Division of Personnel and General Services) said WHO had experienced difficulties in meeting the targets set for the recruitment of women, and called upon the governmental authorities of Member States to propose suitably qualified women as candidates for professional posts throughout the Organization. WHO would, of course, make direct and active recruitment efforts to find female candidates, but the Health Assembly afforded an excellent opportunity to draw the attention of delegations to this problem.

Dr VENEDIKTOV (Union of Soviet Socialist Republics) thanked Dr Ridings, Mr Furth, and Mr Munteanu for their answers and for the clarification given.

Referring to his comments on political discrimination, he emphasized that he had deliberately made no direct accusations. However, if a country had for several years expressed the desire to collaborate with WHO and had put forward its experts, and if at the present date that country had less than half its quota of staff, then clearly there must be discrimination somewhere. It might be better to have a business-like arrangement whereby the terms and rules for recruitment from each country were set out in writing.

The Assistant Director-General's detailed reply had convinced him to some extent that the situation in the United Nations was relatively easier since most of their appointments were to generalist posts; technical posts for field projects were not subject to geographical criteria inasmuch as the acceptability of candidates to recipient governments came into play. WHO followed the same practice to some extent. One genuine difference from the United Nations however was that the latter's technical cooperation programmes were not financed from the regular budget and were therefore subject to slightly different rules. WHO's field posts were a charge on the regular budget, as had been emphasized during the discussion on the programme budget for 1982-1983.

On the subject of reintegration of staff into the national services, he felt that in the case of the developing countries there was no serious problem, since they had a perennial need of qualified staff. The policy of reintegration stipulated by resolution EB23.R35 had already been implemented successfully in several countries.

Since many delegates had voiced different opinions in the discussion, since the matter of staff training would be studied by the Director-General, and since the
Executive Board was to re-examine the question of recruitment in the near future, he would withdraw his amendment in the interests of compromise and support the draft resolution recommended by the Executive Board.

Professor HALEEM (Bangladesh) thanked the Assistant Director-General for his comments but felt that he had not answered an important question - whether Articles 11 and 24 of the WHO Constitution were in fact respected as regards technical competence. He asked for further clarification.

He was in agreement with the suggestion by the delegate of the USSR concerning rotation of staff. After several years in an international organization many staff lost interest in their own country. He therefore proposed an additional paragraph to the draft resolution reading:

"Appointment of international staff in WHO should normally be for a period of five years, which may be extended for a further maximum period of five years in extraordinary cases as will be determined by the Executive Board."

He welcomed the suggestion that staff should be appointed for training for higher executive posts, and felt that this should be supported by all developing countries.

Dr JIMÉNEZ DE BETHANCOURT (Panama) expressed concern at the direction the discussion was taking. The problem was not one of political discrimination. Opportunities must be given to nationals of developing countries to compete in the higher hierarchical levels. She expressed her appreciation and respect for the Director-General, confident that he would support the developing countries in this matter.

On the question of recruitment of women, she said that some countries did not receive information of vacancies in time to put forward a woman candidate. It might also be, of course, that women were not given enough chances to show their ability in their own countries.

In answer to the delegate of Bangladesh, the DIRECTOR-GENERAL said that Articles 11 and 24 of the Constitution were addressed primarily to Member States. He did not believe that the Secretariat should challenge Member States as to whether their delegates to the Health Assembly, or the persons they designated to serve on the Executive Board were technically competent. However, he offered to draw the attention of the Executive Board to this question in the context of his follow-up action on the implementation of resolution WHA33.17, relating to the study of WHO's structures.

The CHAIRMAN asked the delegate of Bangladesh where, in the draft resolution, he wished to insert his amendment.

Professor HALEEM (Bangladesh) said that he was very satisfied with the answer from the Director-General.

Concerning the amendment he had proposed to the draft resolution in order to safeguard the interests of individual Member States, he did not himself feel that there was any serious problem in reintegrating national staff. The amendment could be inserted at the end of the draft resolution.

The CHAIRMAN invited the Assistant Director-General to comment.

Mr FURTH (Assistant Director-General) expressed appreciation of the spirit of the amendment proposed by the delegate of Bangladesh, but drew attention to the fact that, as mentioned in the Director-General's supplementary report to the Executive Board, the International Civil Service Commission and the Joint Inspection Unit had been asked by the United Nations General Assembly to study career development of international staff and related questions. He therefore suggested that the Committee should note the proposal of Bangladesh and that the matter should be further considered at the Thirty-fifth World Health Assembly when the Director-General would report on the findings of the International Civil Service Commission and the Joint Inspection Unit.

The draft resolution proposed by the Executive Board in resolution EB67.R25 was approved.

The meeting rose at 19h30.

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA34.15.
1. COLLABORATION WITH THE UNITED NATIONS SYSTEM: Item 42 of the Agenda

General matters: Item 42.1 of the Agenda (Document EB67/1981/REC/1, resolution EB67.R21 and Annex 10; Document A34/18)

Dr MORK (representative of the Executive Board) reported on the Executive Board's consideration of the question of support costs for technical cooperation financed from extra-budgetary resources, to be reimbursed to the executing agencies by the funding agencies. The subject had a long history, and had been discussed in various forums over the past 25 years. In the report submitted to the Board (document EB67/1981/REC/1, Annex 10) the Director-General had outlined that history and the developments leading to an intergovernmental decision by the Governing Council of UNDP in 1980. For the years 1982-1991, reimbursement of support costs relating to UNDP-financed activities would be made at a rate of 13% of annual project expenditure, as compared to the current rate of 14%. The same formula would apply to other programmes or funds under the Governing Council's jurisdiction.

As explained in the Director-General's report, the new formula was expected to have no or little impact on the amount available from that source to help finance the WHO regular budget.

The Governing Council had also urged governments and the governing bodies of executing agencies to apply the new formula to all other extrabudgetary technical cooperation activities. That suggested principle of uniform application of the formula had long been supported by WHO and the other organizations of the United Nations system, and had been previously endorsed by the Health Assembly as a desirable goal. The Director-General therefore, with the approval of the Health Assembly, would apply the formula of 13% to all activities financed from extrabudgetary funds as from 1982, except for special multi-funded WHO programmes, e.g., the Special Programme for Research and Training in Tropical Diseases, where support and services were already included in the budget. The Board had also been informed that the United Nations General Assembly had approved the support cost reimbursement formula of 13% on 17 December 1980, and that the Economic and Social Council had done the same.

The Board therefore endorsed the Director-General's proposals, and recommended that the Health Assembly adopt the draft resolution contained in resolution EB67.R21. The summary records of the Board's discussions were to be found on pages 387-393 of document EB67/1981/REC/2.

Dr ZIESE (Federal Republic of Germany) observed that UNDP's decision to reduce support costs was related to the recommendation that the executing agency should review methods, arrangements and staffing of support systems with a view to reducing costs. He wished to know how the reduction from 14% to 13% had been compensated for by savings in overhead costs.

Mr BOYER (United States of America) supported the observations of the delegate of the Federal Republic of Germany. His delegation gave general support to the resolution presented by the Executive Board. It seemed probable on balance that WHO would have the necessary funds to administer extrabudgetary programmes. He wished, however, to suggest two changes in the draft resolution contained in resolution EB67.R21.

The last two lines of the third preambular paragraph read: "the costs of providing such support and services to activities financed from extrabudgetary funds have traditionally been met in part by the regular budget". That was true, but he believed that money which was part of the regular budget should not in general be used for extrabudgetary programmes. Because the wording in question implied that such expenditure was acceptable, he did not wish to see it written into the resolution. He therefore proposed that the last three and a half lines of the paragraph be deleted, so that the paragraph ended with the words "27% of project expenditures".
His second difficulty lay in operative paragraph 4. The Governing Council of UNDP had requested governments to try to develop information on the support costs of administering extrabudgetary programmes. The paragraph appeared to exempt WHO from finding out what those costs were. While it would be difficult for the Organization to carry out such a task, the effort must be made. All Members wished to know the cost of administering extrabudgetary programmes and the impact of such administration on the regular budget. Operative paragraph 5 gave the Director-General sufficient guidance on how to proceed. Operative paragraph 4 was therefore unnecessary, and he proposed that it be deleted.

Dr GALAHOV (Union of Soviet Socialist Republics) observed that WHO's extrabudgetary resources from UNDP and elsewhere were constantly increasing, and their total was often equal to or more than the regular budget. The number and volume of programmes carried out with extrabudgetary resources were increasing, with a corresponding increase in support costs, which were partly covered from the regular budget. His delegation's position was that support costs should reflect the lowest possible proportion of total programme costs, so that unproductive expenditure was reduced to a minimum. Secondly, support costs should be covered entirely from the corresponding extrabudgetary source of funds, and not from the regular budget. His delegation supported the United States proposal to delete the last part of the third preambular paragraph. In view of the reduction in the proposed level of reimbursement of support costs to 13%, WHO should apply operative paragraph 1 of resolution WHA27.33, in which the Health Assembly had expressed the belief that "the full cost of the technical and administrative services and support necessary for the efficient and effective implementation by WHO of programmes financed from extrabudgetary funds should, in principle, be financed from such funds". Furthermore, if - as the Director-General's report indicated - it was difficult to determine support costs for activities funded from various sources, it might be possible to have a separate account for all programme support costs and return to showing the proportion of administrative costs in the programme budget and financial reports.

With respect to the draft resolution, it would be desirable to refer, in the second preambular paragraph, to resolution WHA24.52, in which the Director-General was requested to take all possible steps to ensure that overhead costs for activities financed by UNDP were adequately covered by UNDP. His delegation also sought clarification on operative paragraphs 3 and 4 of the draft resolution. Paragraph 3 seemed to go beyond the terms of the draft resolution, covering questions which needed separate consideration. He agreed with the United States delegation that paragraph 4 should be deleted. Alternatively, the paragraph, which was unwieldy and difficult to grasp, might be replaced by simplified wording along the following lines: "Authorizes the Director-General as fully as possible to reflect income and expenditure relating to support costs for programmes financed from extrabudgetary sources in the proposed programme budget and the financial report." If that text was not considered appropriate, he would support the deletion of the paragraph.

Lastly, support costs for activities funded by UNDP were shown in the programme budget, for example in the table recapitulating the total regular budget, assessments and effective working budget on page 31 of document PB/82-83. He asked where the sums arising from the 13% formula as applied to other extrabudgetary sources would be shown in the programme budget.

Mr VOHRA (India) agreed that the draft resolution could be condensed or simplified. He wished to know how the figure of 13% had been arrived at, so as to be sure that there had not been even more scope for economy. In other respects his delegation supported the draft resolution.

Mr FURTH (Assistant Director-General), replying to the delegate of the Federal Republic of Germany, said that WHO had followed the recommendations of resolution WHA29.48. More than 20% of the administrative services at headquarters and in the regional offices had been dismantled, thus making more funds available at regional and country levels. The structure, staffing and working methods of the Organization were continually under review, never more so than at present, when an examination of WHO's structure in the light of its functions was in progress. The constant reduction in administrative costs was reflected in the financial reports of the Organization. The 1979 report had shown that WHO's total administrative costs had been 13.3% of all expenditure, a small sum in comparison with such costs in other organizations, and a reduction from the previous year's (1978) figure of 14%. Though successive budgets had increased, administrative costs had not risen proportionally. That trend was expected to continue.
The United States delegate had suggested deleting the last three and half lines of the third preambular paragraph of the draft resolution recommended in resolution EB67.R21, since the lines implied recognition of a partnership between WHO and other agencies in the provision of programme support costs. The organizations of the United Nations system had for many years recognized that the relationship between executing and funding agencies was a partnership. The legislative bodies of many of the organizations had recognized that the reimbursement formulas used by UNDP and other agencies resulted in the absorption of part of programme support costs in regular budgets. The United Nations General Assembly had endorsed the principle that some of the cost of support of extrabudgetary activities should be borne by the regular budget. Paragraph 3 of the Director-General's report indicated that a cost measurement exercise undertaken by the agencies within the United Nations system in 1973 had shown that the full cost of programme support averaged some 23% of direct programme expenditure for the participating organizations. As UNDP was reimbursing agencies only at a rate of 14% or 13%, the organizations were clearly responsible for part of the support costs as part of their regular budgets. WHO had accepted the notion of partnership, knowing that such extrabudgetary funded programmes gave essential support to regular budget programmes. Thus, for example, the smallpox eradication programme could not have been successful without a great part of its funding coming from extrabudgetary sources. The same was true of the malaria control programme, which derived essential extrabudgetary support from the Special Programme for Research and Training in Tropical Diseases. There was thus a justification for provision from the regular budget of at least part of the support costs of extrabudgetary programmes. Nevertheless, there was no objection to omitting the last three and half lines of the third preambular paragraph; the main points of the resolution were not affected by such a deletion.

The United States delegation also wished to delete operative paragraph 4 of the draft resolution. Here it should be said that the Director-General fully intended to cooperate in interagency efforts to develop a relatively simple format for reports on programme support costs requested by the Governing Council of UNDP. The Governing Council, however, had requested "a detailed report showing the elements of support costs incurred in the preceding year in executing operational activities for development", and giving "details on objects of expenditure and the number and grades of staff or staff years in the different support activities (recruitment, procurement, placement of fellows, other backstopping)". The Director-General felt that this request posed a special problem for WHO. Unless an extremely complex system of cost measurement were introduced, WHO could not produce such detailed information. The reason for this was that the Organization had for many years planned, presented and implemented its programme of technical cooperation on a fully integrated basis, regardless of the source of financing. All technical and administrative support costs relating to that integrated programme were consolidated in the regular budget. Thus it was not feasible to isolate the cost under the regular budget of providing support and services to one of the sources of funds available to WHO for technical cooperation with governments unless a detailed cost measurement system were introduced. To do this would require additional staff, without any assurance that results would be different from those obtained by the cost measurement exercise undertaken in 1973. What the Director-General wished to do was to submit a report on programme support costs from information already available in WHO's programme budgets, financial reports and elsewhere. The Consultative Committee on Administrative Questions was currently consulting with UNDP on the format of the requested report. Operative paragraph 4 of the draft resolution would assist the Director-General in making clear WHO's position to UNDP. However, operative paragraph 5 gave the Director-General the authority he needed, so that paragraph 4 could be deleted, if delegates insisted.

The USSR delegate had stressed that the Health Assembly had stated in previous resolutions, particularly resolution WHA27.33, that support costs should be fully borne by extrabudgetary funds, and had quoted a paragraph supporting his argument. He had not, however, quoted the two following paragraphs. These read as follows: "Requests the Director-General to cooperate in the Administrative Committee on Coordination in the development of a system for the allocation of programme support or overhead costs of programmes financed from extrabudgetary funds, which could be uniformly applied to all extrabudgetary-funded activities" and "Expresses its willingness to consider any future long-term proposals which the Economic and Social Council may make to the organizations in the United Nations system on the question of the allocation between regular budget funds and extrabudgetary funds". This had now been achieved. A uniform formula existed, worked out by the Governing Council of UNDP and endorsed by the Administrative Committee on Coordination, the Economic and Social Council and the United Nations General Assembly. That formula did not provide for full reimbursement of support costs, but was based on the principle of partnership between UNDP and the executing agencies in the allocation of programme support costs.
The USSR delegate had also thought it desirable to have a separate account for programme support costs. WHO already had the Special Account for Servicing Costs, referred to in the financial reports. In that account all reimbursed support costs were deposited, whether from UNDP or from elsewhere.

The USSR delegate had also asked what happened to programme support costs reimbursed to WHO. Paragraph 5 of the Director-General's report to the Executive Board indicated that all income from reimbursement of programme support costs was credited initially to the Special Account for Servicing Costs. The portion relating to reimbursement of programme support costs by UNDP was appropriated by the Health Assembly to help finance the regular budget, and was thus used to reduce the assessment on Member States. The other part, the reimbursable programme support costs derived from other funding agencies, was used at the Director-General's discretion to help finance certain necessary additional services. Such financing included allocations to regional offices to reimburse them for technical and administrative support activities in respect of programmes financed from voluntary funds other than UNDP, and at headquarters for expenses for staff, duty travel, consultants and other purposes. Resolutions noting the establishment of the Special Account for Servicing Costs had indicated that the Director-General must have full discretion in making use of such funds.

The delegate from India had asked how the figure of 13% had been reached. A working group, set up by the Governing Council of UNDP to discuss the matter, had considered a number of alternatives, including differential rates. The figure of 13% had been reached by a political compromise not easy to explain. In brief, it had been felt that if total programme support costs amounted to between 22% and 28% of project expenditure, and if the principle of partnership was accepted, a figure of 13% seemed a reasonable compromise.

Mr VAN KESTEREN (Netherlands) considered that the draft resolution was not flexible enough with respect to the 13% rate for the reimbursement of support costs. In some cases a lower percentage might be justifiable, for instance if the contribution of a donor country was limited to the procurement of supplies. However, he did not insist on change, and hoped that other delegates would not do so, since he felt that the draft resolution could be adopted as it stood.

Dr MORK (representative of the Executive Board), referring to operative paragraph 4 of the draft resolution, said that when the Board had considered the item it had not felt that it was economical to set up a costly accounting system. Since the UNDP Governing Council had made its request, however, the Board had included operative paragraph 4 in the draft resolution, considering that the Health Assembly should express its opinion in the form of advice to the Director-General and of support for his efforts in collaboration with other organizations which also objected to UNDP's request, so that a practical, economical solution could be reached, providing rough data for assessment and control.

The CHAIRMAN asked whether, in view of the Netherlands delegate's appeal, the United States and USSR delegates still insisted on the proposed deletions in the draft resolution.

Mr BOYER (United States of America) confirmed that his delegation still wished to have the deletions made. The Assistant Director-General had assured the Committee that WHO would not suffer from them.

The draft resolution, as amended by the United States delegate, was approved. 1

Professor HALEEM (Bangladesh) regretted that he had been unable to attract the Chairman's attention before the draft resolution was approved. He felt that funds for the reimbursement of support costs should be available, and that the Director-General's powers would be better supported by the retention of operative paragraph 4, despite Mr Furth's assurance that paragraph 5 gave sufficient authority. Having heard Mr Furth and Dr Mork, he expressed his support for the retention of paragraph 4 and the approval of the resolution without deletions.

The CHAIRMAN apologized for having failed to recognize the Bangladesh delegate, whose remarks would be reflected in the summary record of the meeting.

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1 Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA34.17.
Dr KILGOUR (Director, Division of Coordination) introduced the Director-General's report in document A34/18, which contained a brief summary of some of the main issues discussed at the United Nations Economic and Social Council's first and second regular sessions held in the spring and summer of 1980, and at the United Nations General Assembly's thirty-fifth regular session. The Director-General had focused on only a few resolutions that had been adopted by the governing bodies of the United Nations and which were considered to be of particular concern and importance to WHO or which called for action by the Organization. The Director-General also briefly reported on WHO's collaboration with UNDP, UNICEF, the World Bank and UNFPA.

Referring to the introduction to the report, he drew attention to the admission of Saint Vincent and the Grenadines to membership of the United Nations. Section 2 of the report referred to questions that had been brought to the attention of the Executive Board at its sixty-seventh session: the adoption of the International Development Strategy for the Third United Nations Development Decade, the World Conference of the United Nations Decade for Women, and the proclamation of the International Drinking Water Supply and Sanitation Decade.

Section 3 of the document, dealing with the implementation of the Declaration on the Granting of Independence to Colonial Countries and Peoples, referred particularly to the liberation struggle in Southern Africa and to the needs of the States concerned and of the national liberation movements recognized by the Organization of African Unity. Additional information on action taken by WHO would be found in documents A34/21 and A34/22 Rev.1, submitted under agenda items 42.6 and 42.7.

United Nations General Assembly resolutions on human rights and apartheid, referred to in Section 4, also called for the Organization's assistance to the national liberation movements recognized by OAU, and to the front-line States. The section also referred to the elaboration of an international convention on the protection of rights of all migrant workers and their families.

Section 5, on drug abuse control, hazardous chemicals and unsafe pharmaceutical products, reported briefly on the United Nations concern over the increased use of illicit drugs. He drew attention in that connexion to resolution WHA33.27. Another issue raised in section 5 of the report related to banned hazardous chemicals and unsafe pharmaceutical products. It would be noted that WHO was cooperating with the Secretary-General of the United Nations in the preparation of the report to be submitted to the General Assembly at its thirty-sixth session.

Section 6, on collaboration with UNDP, UNICEF, the World Bank and UNFPA, briefly described the financial outlook for UNDP for the next programming cycle and reported on the work of intersecretariat consultative bodies, outlined the collaboration between UNICEF and WHO and the strengthening of the cooperation between the World Bank and WHO, and provided information on UNFPA's support to WHO in the area of health, population and development.

The last section of the document mentioned some major United Nations conferences to be held in 1981, as well as international years in which WHO had a role to play. Mention was also made of the General Assembly resolutions concerning respect for the privileges and immunities of officials of the United Nations and the specialized agencies, and regarding supplementary payments made to international civil servants by governments.

The CHAIRMAN said that the discussion of agenda item 42.1 would now be adjourned to enable item 41 to be taken up as previously arranged.

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

2. HEALTH CONDITIONS OF THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 41 of the Agenda (Resolution WHA33.18; Documents A34/17; and A34/INF.DOC./1, 3 and 4)

The CHAIRMAN drew attention to a typographical error on the cover page of the report of the Special Committee of Experts appointed to study the health conditions of the inhabitants of the occupied territories (document A34/17). The provisional agenda item to which reference was made should read 41, and not 4.1.

In addition to the Special Committee's report the Committee had before it a report submitted by the Minister of Health of Israel (document A34/INF.DOC./1), a report submitted by the Palestine Liberation Organization (PLO) (document A34/INF.DOC./3), and an abridged version of the annual report of the Director of Health of the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) for 1980 (A34/INF.DOC./4).

The Committee also had before it the following draft resolution, sponsored by the delegations of Afghanistan, Algeria, Bahrain, Bangladesh, Bulgaria, China, Cuba, Cyprus,
Democratic People's Republic of Korea, Democratic Yemen, Djibouti, Ethiopia, German Democratic Republic, India, Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Maldives, Malta, Mauritania, Mauritius, Morocco, Mozambique, Nicaragua, Oman, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Viet Nam, Yemen and Yugoslavia:

The Thirty-fourth World Health Assembly,
Mindful of the basic principle laid down in the WHO Constitution which provides that the health of all peoples is fundamental to the attainment of peace and security;
Aware of its responsibility for ensuring proper health conditions for all peoples who suffer from exceptional situations, including foreign occupation and especially settler colonialism;
Bearing in mind that the WHO Constitution provides that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity";
Affirming the principle that the acquisition of territories by force is inadmissible and that any occupation of territories by force gravely affects the health, psychological, mental and physical conditions of the population under occupation and that this can be only rectified by the complete and immediate termination of the occupation;
Considering that the States parties to the Geneva Convention of 12 August 1949 pledged, under Article One thereof, not only to respect the Convention but also to ensure their respect in all circumstances;
Recalling the United Nations resolutions concerning the inalienable right of the Palestinian people to self-determination;
Affirming the right of Arab refugees and displaced persons to return to their homes and properties from which they were forced to emigrate;
Recalling all the previous WHO resolutions on this matter, especially resolution WHA26.56, dated 23 May 1973, and subsequent resolutions;
Recalling resolution 1 (XXXVII), 1981, adopted by the Commission on Human Rights, which condemns Israel's violations of human rights in occupied Arab territories, including Palestine;
Taking note of the report of the Special Committee of Experts;

REQUESTS the Director-General to increase collaboration and coordination with the Palestine Liberation Organization concerning necessary assistance to the Palestinian people;

II

Having examined the annual report of the United Nations Relief and Works Agency for Palestine Refugees in the Near East;
Deeply concerned by the deterioration of the situation suffered by the Agency concerning its budget and the services provided, due to the repeated Israeli aggression;
1. REQUESTS States to increase their contribution to enable the Agency to continue carrying out the tasks assigned to it;
2. REQUESTS the Director-General to continue his collaboration with the United Nations Relief and Works Agency for Palestine Refugees in the Near East, by all possible means and to the extent necessary to ease the difficulties it is facing and increase the services it provides to the Palestinian people.

III

1. EXPRESSES its deep concern at the poor health and psychological conditions suffered by the inhabitants of the occupied Arab territories, including Palestine, and condemns Israel's attempts to incorporate Arab health institutions into the occupation authorities' institutions;
2. CONDEMONS all acts undertaken by Israel to change the physical aspects, the geography, the institutional and legal status or context of the occupied Arab territories, including Palestine, and considers Israel's policy in settling part of its population and new settlers in the occupied territories a flagrant violation of the Geneva Convention Relative to the Protection of Civilian Persons in Time of War and the relevant United Nations resolutions;
3. CONDEMNS the establishment of Israeli settlements in the occupied Arab territories, including Palestine, and the illicit exploitation of natural wealth and resources of the Arab inhabitants in those territories, especially the confiscation of Arab water sources and their diversion for the purposes of occupation and settlement;

4. CONDEMNS the inhuman practices to which Arab prisoners and detainees are subject in Israeli prisons, resulting in the deterioration of their health, psychological and mental conditions, and causing death and permanent physical disability;

5. CONDEMNS Israel for its refusal to apply the Fourth Geneva Convention Relative to the Protection of Civilian Persons in Time of War, of 12 August 1949;

6. CONDEMNS Israel for its refusal to implement World Health Assembly and other international organizations resolutions calling upon it to allow refugees and displaced persons to return to their homes;

7. CONDEMNS Israel for its arbitrary practices and its continuous shelling of Palestine refugee housing settlements in southern Lebanon which affects the physical, social and psychological health conditions of the Arab inhabitants, and considers that its refusal to implement resolutions of the World Health Organization constitutes an explicit breach of the letter and spirit of the WHO Constitution;

8. ENDORSES the opinion of the Special Committee of Experts that "the socioeconomic situation of a population and its state of health are closely related" and that the socioeconomic and political situation existing in the occupied Arab territories including Palestine is favourable neither to the improvement of the state of health of the population concerned nor to the full development of services adapted to the promotion of human welfare;

9. CONDEMNS Israel for not allowing the Special Committee freedom to carry out its tasks according to World Health Assembly resolution WHA33.18, especially with respect to visiting prisoners;

10. REQUESTS the Special Committee to continue its task with respect to all the implications of occupation and the policies of the occupying Israeli authorities and their various practices which adversely affect the health conditions of the Arab inhabitants in the occupied Arab territories including Palestine, and to submit a report to the Thirty-fifth World Health Assembly, bearing in mind all the provisions of this resolution, in coordination with the Arab States concerned and the Palestine Liberation Organization.

Dr MEILLAND (United Nations Relief and Works Agency for Palestine Refugees in the Near East) expressed the gratitude of the Commissioner-General of UNRWA for WHO's concern regarding the health of the Palestine refugees, and his deep appreciation to the Director-General of WHO and the Regional Director for the Eastern Mediterranean for the support given by WHO to the Agency.

UNRWA, which had served the refugees for over 30 years, relied almost entirely on voluntary contributions to meet the cost of its activities. High levels of inflation, which had outstripped contributions, made it increasingly difficult for the Agency to cover its budgeted expenditure. The difficulties were increasing annually to such an extent that the Commissioner-General had had to limit the Agency's activities to the most urgent needs and to reduce some of its services. He had even been forced, in 1981, to consider suspending most of the education programme. That drastic measure had so far been avoided, but the financial situation of UNRWA remained extremely precarious. While health services of the Agency had been maintained essentially at the same level as in previous years, badly-needed improvement of facilities and essential maintenance had had to be postponed, and if the financial situation failed to improve sufficiently in the very near future, the present health services were likely to suffer. The Commissioner-General had asked him to appeal to delegations to draw the attention of their Governments to that state of affairs and to ask them to give sympathetic consideration to UNRWA's need for increased donations.

In 1980, the delivery of health services in all areas except Lebanon had continued smoothly. The services in Lebanon had been interrupted on several occasions by sporadic fighting.

The Health Department of the Agency continued to place emphasis on promotional and preventive activities against communicable diseases and on maternal and child health care, including an expanded programme of immunization and nutritional support. The reorganization of the supplementary feeding service had proved very successful and the attitude of the refugees had been encouraging.
Self-help projects aimed at the improvement of environmental conditions had been implemented, and some others were under way. The participation of the refugee communities in those projects had been very rewarding.

The proper control of diarrhoeal diseases in infants and small children had continued to receive special attention and was the subject of a study being carried out in the Gaza Strip under the technical supervision of WHO. The results were expected to be analysed and published later in 1981.

The abridged version of his annual report for 1980 (document A34/INF.DOC./4) included a summary account of the health conditions of the refugees registered with UNRWA, and a brief record of the various health services provided by the Agency.

He recalled the generous assistance provided to UNRWA's health programme by the health authorities of the host countries, which had contributed greatly to the welfare and health of the Palestinian refugees by putting at their disposal some of their hospital services and public health laboratory facilities.

As in previous years, the Palestine Red Crescent Society had continued to provide valuable help to the refugees. He wished to thank the many other governmental and nongovernmental organizations which had assisted the Health Department in the delivery of its services by providing personnel, equipment, medical supplies and food or by meeting in cash the operational costs of some of its health units.

The Commissioner-General of UNRWA wished to express his gratitude to all those organizations for their valuable assistance and to the ministries of health for their close and fruitful cooperation with the Agency.

Dr TABA (Regional Director for the Eastern Mediterranean) said that, in compliance with Economic and Social Council resolutions 2026 (LXI) and 2100 (LXIII), and as a result of various Health Assembly resolutions calling for the provision of assistance to the Palestinian people, WHO had carried out the following activities.

The Organization had, as in the past, provided assistance through close collaboration with UNRWA, and in particular had continued to second a number of staff to UNRWA for the education and health services. WHO also supplied vaccine to UNRWA, and some problems resulting in temporary shortages now seemed to have been overcome.

An annual grant was provided to PLO for payment of salary differentials for some physicians and technicians employed by the Palestine Red Crescent Society, and that had been increased substantially in 1980. A further increase was envisaged for the biennium 1982-1983. The major portion of the allocation was intended to cover the payment of incentives, in addition to other inputs such as supplies, equipment and fellowships.

In July 1980, a further visit had been made by a WHO mental health specialist in order to review the ongoing activities and make proposals with a view to strengthening the mental health programme in the territories. It was envisaged that, as a result of those collaborative efforts, the mental health coverage for the population concerned would be extended and the treatment facilities strengthened. One fellowship, for studies in that field, had been completed, and further candidatures were being processed.

Several missions had been carried out in the West Bank and Gaza by an adviser from the maternal and child health programme and the Expanded Programme of Immunization. To follow up those missions, WHO had provided further funding in 1980 to support tuberculin testing and the BCG programme among schoolchildren. The Organization had also funded the purchase of Salk vaccine for use in a successful combined polio immunization programme, as well as 140,000 additional doses of measles vaccine for the ongoing campaign. A technical mission aimed at reducing the number of poliomyelitis cases had also been planned.

To follow up the technical support already provided for the planning and implementation of a programme for oral rehydration therapy in diarrhoeal diseases, WHO had supported the special effort being made to evaluate the reduction of mortality as a result of that programme and to finalize the analysis procedures. The evaluation, in which a WHO staff member had participated, indicated that the programme was progressing satisfactorily, with a fall in hospital admissions and mortality.

In collaboration with the competent authorities, steps had been taken to organize a visit to work out a detailed plan of action to investigate the oral health sector in Gaza and the West Bank. A consultant would also visit the West Bank to initiate an evaluation of malnutrition clinics in order to identify risk factors. In addition to the direct assistance referred to, WHO had also been involved in the planning of two interagency projects. As a result of the work of an interagency task force and the subsequent interagency meeting in Geneva in April 1979, UNDP was envisaging the establishment of two
projects covering the fields of health manpower development and development and strengthening of health institutions. In October 1980, a meeting had been held between UNDP and WHO representatives to discuss the possibility of WHO support to those projects. It had been felt that they would fit well into WHO's present efforts in those programme areas, and the Organization had assured UNDP of its readiness to assist in implementation by providing technical support. WHO had already assisted in the selection of a consultant to carry out those projects.

In November 1980, discussions had taken place between representatives of UNEP and WHO regarding the collaboration and possible participation of WHO in a UNEP-funded training course for environmental health officers on problems of water supply, sanitation and health for the Palestinian people. WHO had provided a consultant to study the need for sanitarians and to draw up the programme for the course, in consultation with PLO and UNRWA.

Following its visit to the territories in April 1980, the Special Committee of Experts to study the health conditions of the inhabitants of the occupied territories had requested WHO to strengthen the assistance it had already instituted for those territories, and some of the activities to which he had referred resulted directly from the Committee's observations.

Dr TOURÉ (Chairman of the Special Committee of Experts appointed to study the health conditions of the inhabitants of the occupied territories), introducing the Special Committee's report on the health conditions of the Arab population in the occupied territories, including Palestine (document A34/17), said that the report came within the guidelines of resolution WHA33.18. Following the adoption of that resolution, the Special Committee of Experts had met at Geneva to define a method of approach and a strategy in the light of the provisions of the resolution. The Committee had reaffirmed the collective responsibility of its members in all decisions taken on the problem and had requested the Director-General to continue to deal with the diplomatic procedures, including contacts with the parties concerned.

The Committee had decided that its Chairman should introduce its report to the Health Assembly and express to the Director-General, his Legal Adviser and the Secretariat its satisfaction and gratitude for the efficient manner in which they had dealt with the preparation of the mission and for their support throughout its operation. It was not easy to speak of the health situation of a population in such a specific context, particularly in relation to the global definition of health given in the Constitution. Factors that appeared to be divorced from medical questions were involved. The Committee was convinced that health was at the crossroads of development, and was even the result of development. It could not be denied that political, economic and social decisions strongly influenced the health of populations. The approach to health problems therefore had to come within the framework of overall development. The most direct way to achieve health lay in the medical and health facilities of the country concerned, but while there was certainly a relationship between the state of health of the population and health facilities, that was merely a statistical association between two variables and not a causal relationship. The attitude of the individual to sickness was closely linked to the social group in which he lived and was determined by the structure of its social system and its culture. The spirit of resolution WHA33.18 should be interpreted in that way. The analysis of the socioeconomic situation in section 4 of the report should be viewed in that light.

Whether in respect of statistical data, the demographic approach or socioeconomic data, ample information was given in the many documents on the question available to the Health Assembly from various sources. The documents did not, however, use uniform language or evaluation criteria. It was not surprising, therefore, that some of the points raised in the report did not satisfy all the parties concerned. It was frequently stated that statistics was the art of drawing valid conclusions from hypothetical data. The importance to be attached to information systems could therefore be understood. The Health Assembly was aware of the fact, since the programme budget for the financial period 1982-1983 had given them a prominent place. It was impossible to understand a health system that was not integrated within a guiding policy, and the indicator the Committee had considered most relevant was based on a political commitment to promote the health of all the population. The planning process, the development of services and programme management had received the Committee's full attention. The analysis of the health situation placed emphasis not only on the medical aspects, such as endemic and epidemic diseases, infrastructures and health facilities, but also on areas that might influence the health of populations, such as the distribution of drinking water, hygiene, environmental health, food availability and education.
The Committee had noted that, while a real effort had been made to prevent certain diseases, the persistence and development of other diseases were matters of concern. The latter included respiratory disorders, diarrhoeal diseases, which were the main cause of infant mortality, poliomyelitis, leishmaniasis, viral hepatitis A, pulmonary tuberculosis and even more widespread psychiatric illness. Appropriate infrastructures and facilities were needed to deal with those problems.

The report gave a full account of existing health units in the occupied territories. While an improvement in the equipment of surgical services and laboratories had been noted, much remained to be done. The services still depended on Israeli services. The closure of the blood bank and laboratory and of the anti-tuberculosis centre in Jerusalem was deplored by Arab practitioners and by the Arab populations, who saw in such closure a policy of integration that jeopardized their opportunities of finding services available within easy reach. In its previous report, the Committee had noted the deterioration in those services and had recommended their renovation, both as to buildings and equipment. That would be of no avail, however, in the absence of qualified personnel to assure good quality service. In its present report, the Committee noted that the problem of health manpower in the occupied territories was still vital. Because of the unsatisfactory living conditions, inadequate treatment and lack of opportunities for postgraduate training, doctors and nurses were leaving the territory to find better situations elsewhere. The shortage of specialists in all fields resulted in referral to Israeli hospitals.

The trend of the new health policy was towards decentralization of activities, which required a qualitative and quantitative development of the services concerned. For that purpose, health units must be made more operational. The report noted that there was a shortage of qualified personnel, of appropriate equipment and sometimes of drugs, which produced in patients a feeling of frustration and a lack of confidence in the system. Despite efforts in the distribution of health care, such constraints made it impossible to deal with cases on the spot instead of referring them to Israeli hospitals. Economic access - the ability of individuals to meet the cost of health care - was a good indicator of the provision of health care. It was universally accepted that good quality health care to 75% of the population would be a good coverage indicator. In the occupied territories, economic access was determined by the proportion of the population covered by health insurance. Having at first been compulsory for officials and their families, insurance had become general for the residents of the occupied territories. It appeared that 80% of the population of Gaza, and only 40% of the population of the West Bank, were insured. The Committee was not in a position to know the true extent of health insurance coverage, particularly for unsalaried families. A number of services - confinements, infectious disease care, the care of children under six years of age and psychiatric care - were, however, free of charge.

The health activities were of two kinds, curative and preventive. Curative services were provided in hospitals, health centres and dispensaries. They were limited by the constraints to which he had referred - shortage of medical and health facilities and lack of qualified laboratory personnel, which made some diagnostic examinations unreliable. Preventive activities were centred primarily on a vaccination programme, with priority for maternal and child care. A poliomyelitis control strategy was being developed, together with a strategy for the control of diarrhoeal diseases. If preventive activities were to be effective, however, they must be accompanied by public health and environmental sanitation measures, waste treatment, and provision of drinking water. The Committee was recommending the installation, in all districts of the area, of waste purification stations similar to the one in Ramallah, and it was also concerned about the need for sanitation in certain urban centres.

The support of any health activity depended on education in general and health education in particular. There was no systematic health education programme, but every department planned activities in accordance with its particular problems. The Committee realized the effort made in that area.

The Committee's terms of reference had also extended to prison visits. The health services, kitchens and detention rooms at the sites visited appeared acceptable, but the Committee was not in a position to make an objective assessment of the state of health of every category of prisoner, since no authorization had been given for access to certain detention facilities or for interviews with the prisoners.

The Committee was aware of the vast scope and difficulties of its task, and its report did not claim to be complete, but the contribution of health to the New International Economic Order and the role WHO was called upon to play in instituting health for all by the year 2000 had enabled it to make a number of recommendations which, if followed, would improve the health conditions of the Arab population of the occupied territories.
A philosophical reflection was an indispensable part of any evaluation. The Committee considered that the social and political situation in the occupied territories was unfavourable to the improvement of the health of the population concerned and to the full development of services capable of promoting human welfare.

Professor MODAN (Israel) said that it was with great reluctance that he had asked for the floor to present Israel's position on item 41 and on the documents that had been submitted to the Committee, since he felt that, as people who devoted their time, minds and energy to the cause of health, the task of the members of the Committee was to plan and organize medical services, to provide cures to those who needed them, and to prevent disease wherever and whenever they could. It was therefore contrary to their main duties to the people they represented for them to spend so much time and effort year after year in discussing political matters and rebutting false data and hypocritical resolutions.

Under the definition of the much-quoted Alma-Ata Declaration, primary health care entailed a wide spectrum of activities that might affect the health status of the individual, including, among other things, nutrition, income, immunization programmes, control of infectious diseases, sanitation, housing and education.

Over the past 33 years, his country had twice gone through a period in which it had faced the challenge of meeting elementary health needs for a developing society. The first had been in the late 1940s and early 1950s, when hundreds of thousands of displaced persons who had survived the holocaust in Europe and the discrimination and oppression in the Middle Eastern countries, and whose infant mortality had risen to 150 per thousand, had been provided with shelter in barracks and tents. The second had been the period in which it had taken care of the immediate health needs of the residents of the West Bank, Gaza and Sinai and had carried out a rapid development programme to combat malnutrition and infectious disease, and to develop environmental control.

As should be evident from the report of the Special Committee appointed by the Health Assembly to review the health conditions of the territories, Israel had not failed in its duties. An intelligent distinction should be made between the data spelled out in that report and notorious insinuations.

The report of the Special Committee stated more than once that no change had been found since the previous year. It failed to state that, according to health indicators used by the Committee itself, the health status of the population in the area had undergone a major change, already evident in 1980, compared with the situation 14 years earlier. That rapid change, shown by continued improvement of the health services in the area, the establishment of comprehensive immunization programmes and a network of primary health care centres, and the development of environmental control systems, was self-evident. He quoted extracts from the report with respect to Gaza (first paragraph of section 6.2.1), Khan Younis (second paragraph of section 6.2.1), Sinai (third paragraph of section 6.2.2), Hebron (last two sentences of section 6.2.3.4), and the Golan Heights (last sentence of third paragraph of section 6.2.4) and with respect to water supply (second sentence of section 6.2.6.1), sewage (second sentence of section 6.2.6.2), schools (section 6.2.6.4) and food and nutrition (first sentence of 6.4.5).

He was glad to see that the report of the Special Committee, unlike the cruel summary statement of the previous year, took note of the fact that the development of mental health services in the area had led to earlier diagnosis and an earlier recognition of mental disorders, and that the development of community services had enabled people in the early stages of disease to benefit from medical assistance. However the statement on page 17, third paragraph, that the existing sociopolitical situation must affect the state of health was far from fair. Every country had its own sociopolitical conditions; yet all ministries of health were trying hard to alleviate pain as far as possible, to obtain a larger share of the national budget and to set priorities for health as against education, development and defence. That was their responsibility to their society, no matter in what political structure they operated.

The Special Committee's report had the audacity to blame the Israeli authorities for treating the residents of the territories in existing Israeli facilities. That was one of the most absurd accusations with which his country had been confronted. As a physician responsible for the medical services of Israel, trying to provide the utmost in health care to people of any race, colour, creed and residence, he was honoured to share that blame. He wondered what would have happened if any Israeli hospital had rejected a patient residing in Nablus, Jenin, or Gaza who sought medical care. A few years ago, while serving as a physician in one of the major Israeli medical centres, he had provided room for immediate dialysis to a patient referred to the centre directly from Kuwait. Had Israel hampered the development of renal services in Kuwait by accepting that Kuwaiti patient for dialysis, using the same criteria as it used for its own
patients? Had Israel hampered the medical services of surrounding countries whose residents aspired to obtain sophisticated care in its centres, or had it hampered its own services by referring Israeli patients to a modern mental health institution in Bethlehem if they so desired? He believed that patients had the right to choose their services and that the best available treatment had to be given to patients if they desired it on medical grounds.

The report called for support in view of the lack of long-term planning. Long-term planning was a major facet of any health delivery system, but he doubted that any of the countries submitting the draft resolution on health conditions of the Arab populations really wanted Israel to consider long-term planning in the area. Three years before, he had chaired a joint committee for medium-range planning of health care systems on the West Bank, which was mentioned on page 7, second paragraph, of the report of the Special Committee. The joint committee's suggestions for a more concise and integrated health care structure had not been carried out, not because the Israeli Government did not support them, but because the local people felt that any major change in the available health structure would mean an acceptance of a change in the status quo. It was therefore with great disappointment that the joint committee had had to wait.

Israel did not reject the use of any outside resources for the strengthening and the development of health services. Those who really wanted to support and develop were welcome. Israel also called upon WHO to take part in the effort to strengthen training programmes and fellowships. It called upon WHO to accept the Special Committee's recommendation to carry out surveillance of morbidity, and of infectious, chronic and mental disorders. Any help required would be provided. If the epidemiologist who was a member of the Special Committee wished to take part he was welcome. If a local epidemiologist was required, he himself would be ready to help, provided he did not have to spend his time rebutting political issues. He noted that the Special Committee had blamed WHO (page 14, first and fourth paragraphs) for not providing enough help for training. Should the delegates then be asked to vote on a resolution condemning WHO? The results of the improved services could be seen in the dramatic decrease in infant mortality, one of the best indicators of the health status in any population. In 1965, under Jordanian rule, the infant mortality rate on the West Bank had been 55 per 1000. Today that rate had decreased to 26 per 1000. In the Gaza strip the rate had been 120 per 1000; today it was 43 per 1000. In parallel there had been a steep reduction in stillbirths, reflecting the construction and development of prenatal services and improved obstetrical facilities. It was ridiculous to attribute even part of the decline in infant mortality to deficient registration or unreliable statistics, since the dramatic reduction of mortality occurred primarily, as in most of the developed countries, in the post-neonatal age-group, which was the age-group most amenable to rescue by a combination of curative, nutritive and preventive programmes. Indeed, the rate of mortality between the second and twelfth month of life in Gaza had decreased from 60 per 1000 in 1967 to 28 per 1000, and on the West Bank from 45 to 17 per 1000. That reduction was more than highly significant.

In 1965 there had been 97 physicians in Gaza; today there were 224. In 1967 there had been 214 nurses; at present there were 500. In 1965 there had been 74 general clinics on the West Bank; today there were 141. There were now 22 maternal and child centres in the Gaza area, as opposed to none in 1965, while on the West Bank the number of those centres had tripled, from 24 to 74. Basic immunization against diphtheria, pertussis, tetanus, poliomyelitis and measles now covered some 90% of the child population. How many countries could point to such a coverage? Simultaneously, the number of hospital beds had grown by 20% to accommodate the needs of the population, and a wide variety of special services, such as renal dialysis, intensive coronary care, gastroenterology, physiotherapy, ophthalmology, oncology and cardiac rehabilitation units had been set up. New blood banks had been developed in the Ramallah and Beit Jallah hospitals in line with the decentralization concept, and training centres for nurses, medical records librarians and hospital administrators had been initiated. The increase in manpower development had continued even during the previous year when an across-the-board 6% reduction in medical and paramedical personnel had been carried out in all Israeli institutions. The control of infectious diseases made it unnecessary to have special wards or even hospitals for infectious diseases in the territories. Thus, owing to the drastic reduction of tuberculosis, tuberculosis wards had been converted to accommodate much-needed ophthalmological, nephrological and psychiatric care.

That should be the answer to the Committee's request for units specializing in infectious diseases, namely that such units were considered obsolete when infectious disorders had been effectively combated, while the emerging problem of chronic diseases, primarily cardiovascular diseases and cancer, provided the best example of the transition undergone by the area. The change had been so remarkable that the Committee had made a point of stating, on page 10, second paragraph, that the Jenin population suffered from mumps and chickenpox.
Should the Health Assembly be asked to launch a worldwide effort to eradicate chickenpox? Was that the major health issue today?

A remarkable contribution to the achievement of health for all had been the recent introduction of a voluntary health insurance scheme, with a token payment of US$ 5 per month per family. That programme entitled its beneficiaries to free comprehensive coverage, including hospitalization and medication. The Committee blamed Israel for the fact that only 40% of the population on the West Bank and "only" 80% of the population in Gaza shared in that health care structure. Yet the insurance was voluntary. Should Israel have compelled the population to join the programme? If it had done that, it probably would have then been blamed for taking advantage of the population by excess taxation. All the activities he had listed had been carried out with the active participation of the resident population.

Services had been given by the people and for the people in their own environment. No-one knew better what the patient needed than the potential patient himself, and no-one knew better what the people deserved than the community leaders. Therefore, as he had already stated, Israel was ready to transfer the total responsibility for the medical services of those areas - planning, organization, implementation and budgetary control - to a local administrative body at any time. The people must only be ready to accept that challenge; they must not fear the threats of subversive agents to their existence and their families if they were willing to take up that task.

The draft resolution referred to by the Chairman was a continuation of the unrelenting war waged against Israel by the Arab countries, unscrupulously exploiting the forums of international organizations which had been established with the sole purpose of promoting specific technical aims for the benefit of mankind. It constituted another attempt to force WHO to deal with political issues which belonged to the competent organs of the United Nations, namely, the Security Council and the General Assembly. The draft resolution was nothing but a long list of arbitrary assertions unrelated to the actual health situation in the territories or to the Special Committee's report. It did not take into account the practical recommendations of the Special Committee. Instead, it was an attempt to politicize the health field. Furthermore, there was not even a remote connexion between the draft resolution and the health needs of the population of the West Bank and Gaza, a population that had been underprivileged in respect of medical care for many years before becoming associated with the modern Israeli health system. It was time that delegates stopped wasting the money of their taxpayers by diverting attention to health politicking and away from true health issues. He was sure that each delegate, whether a drafter of the resolution or one who had to rebuke it, would have contributed much more to the health needs of the population if his time and energy had been devoted to the real problems the Committee faced. It was time for such senseless discussions to cease and for delegates to strive together for health for all, not for hypocrisy or for brain-washing.

Dr ABU HASSAN (Palestine Liberation Organization) recalled that since WHO had proclaimed the slogan of health for all by the year 2000, that goal had become the main concern of the world and WHO's prime target. It could be achieved only by intensifying the efforts among countries and between countries and international organizations in the social and economic sectors, including education, agriculture, water supplies, protection of the environment, housing, employment and industry at the local level. Health was a basic human right and a worldwide social target, and should be available to all people. Those basic principles had been endorsed by the Commission on Human Rights, the Geneva Conventions and the resolutions of the United Nations and its specialized agencies.

The Committee had before it three different reports by three different authorities. First, there was the three-member Special Committee of Experts. He commended the efforts of that Committee, but still had some reservations about its report, which lacked certain details which would lead to clear and realistic indicators. Secondly, there was the report of the occupying authorities, which contained erroneous allegations supported by concocted statistics that should not deceive anyone. Third, there was the report of PLO, which had tried to make it as comprehensive as possible, with figures reflecting the real suffering of the people fighting for their land and legal rights. In the last paragraph of its report the Special Committee had said it was clear that the sociopolitical situation existing in the occupied territories was favourable neither to the improvement of the state of health of the population nor to the full development of services adapted to the promotion of human welfare. The occupying authorities always claimed that they were improving economic and social conditions, but one close look would show that they were doing everything to cause conditions to deteriorate in order to undermine the morale of the Arab population. The Israeli presence on Arab-owned
land was the harshest form of Zionist colonialist settlement. Expropriation and settlements were the main features of the Zionist movement to obtain Arab land after evacuating its Arab inhabitants. Funds had been allocated to establish settlements in addition to the Judaization of Jerusalem. The occupation of 36% of the lands of the West Bank and the establishment of over 191 settlements on the West Bank, together with extensive occupation of areas of the Gaza Strip which were referred to in the report, all gave clear evidence of Israeli policy.

There was also the question of the annexation of sources of water. On page 15 of the Special Committee's report was a summary of the testimony of Arab inhabitants which countered the allegations of the Israeli authorities. He wished that the Committee had verified the statements made to it. The Zionist presence in Palestine was being furthered by the seizure of Arab land to establish Israeli settlements; and those settlements involved the seizure of sources of water. As described in the PLO report, the Israeli authorities had seized 80% of the sources of water in the occupied territories.

As far as labour conditions were concerned, workers were also victims: 50% of the inhabitants were of working age; about 20% were employed, underlining the high level of unemployment, although the wages of an Arab labourer did not exceed 50% of those of his Israeli counterpart. Those wages were not subject to any law or trade union negotiations. Workers had no severance pay, and 30% of their wages were deducted for social and health insurance from which they did not benefit. Arab youths were employed in a manner contrary to all international labour laws and conditions. That had led to deterioration in economic development and a drop in living standards, which had caused a massive exodus of manpower. That was the aim of the occupying authorities: to evacuate all the inhabitants from the territories.

Agriculture had suffered and deteriorated in the occupied Arab territories for three reasons: first, the seizure of Arab-owned land; second, the seizure of sources of water in the occupied territories; and third, the repression and oppression of Arab farmers by the Israeli occupying authorities. That had led to a drop in agricultural production as a percentage of total production from 46% in 1963 to 23% in 1980.

In violation of the Fourth Geneva Convention, Israeli authorities were seeking to bring educational policies under their complete control. The Military Governor's decision No. 854 of 6 July 1980 had further reinforced that trend. The decision provided the Military Governor with all powers and authority over universities and educational institutions, including the authority to resort to martial law.

As for health conditions, it was obvious that they were influenced by economic and political conditions. Health conditions were continuously deteriorating as a result of deterioration in other sectors and the reduction of health services. The Special Committee's report showed that the Israeli occupying authorities were solely responsible for health policies in the occupied territories and that the centralized form of health services did not allow or encourage local communities to participate in general and public health services. Further, there was a reference in the report to the absence of medium- or long-term planning of health services. Was it the fear of being continuously accused of occupation that had prevented the occupying authorities from planning health services? He did not think that was the real reason. Consequently, health conditions had remained without noticeable improvement.

The budget was administered centrally and a shortage of budgetary allocations prevented improvement; the authorities did not allow the use of resources available from NGOs or from international charities or local or national committees. The authorities deducted about 30% from the health budget and paid it to the Israeli health institutes for treatment of certain Arab inhabitants who could not be treated in Arab health institutions owing to a shortage of equipment and other elements of adequate care. Despite all that, the Israeli authorities dared to say in their report that they had improved the health situation in the occupied Arab territories. That alleged improvement was as follows.

On the West Bank more than four hospitals had been closed down. The local laboratory had been closed; the central blood-bank in Jerusalem had been closed, although the Expert Committee's previous report had said that it needed improvement; a dental clinic had been closed in Ramallah and another in Hebron; an attempt had been made to close down the sole government hospital in Jerusalem; a nursing school in Hebron had been closed down; and the number of hospital beds had been reduced as well as their rate of occupancy.

With regard to the Gaza Strip, two hospitals had been closed down and the number of beds had been reduced from 905 in 1977 to 707. The chest hospital in Gaza was the only specialized hospital in all the occupied territories; the number of beds had been cut from 260 to 70.

The Arab citizens had tried to improve their health conditions by establishing many charitable organizations to undertake health projects; however, the occupying authorities
continued to place as many obstacles as possible in the path of such initiatives. The Special Committee had indicated some of those obstacles, such as the refusal to improve Beir-Jallah hospital, to establish a new laundry in Hebron hospital, and to improve the mental hospital in Bethlehem. Psychiatric disturbances, depression, instability and violence were all increasing as a result of political and social conditions, and the attempts by the authorities to control Arab citizens through its institutions by obliterating the Arab presence and fostering colonization. The inhuman practices and deteriorating health situation were worthy of specific attention, but the Special Committee's report only glossed over them. The authorities had not allowed the Special Committee to visit the Nablus and Ramallah prisons; they had been able to see only what the authorities allowed them to see. Administrative detainees constituted three-quarters of the prison population; the Special Committee had not been allowed to visit them or communicate with them. Rarely had a detainee or a prisoner come out of a prison or detention centre without some form of permanent disability.

He thanked the Special Committee for its efforts to overcome the obstacles raised by the occupying authorities in order to hide many facts, for had the Committee been able to see those facts its report would have reflected many of the violations and practices which had greatly contributed to the deterioration of the health situation in the occupied territories. He hoped that the Special Committee's endeavours had helped to increase awareness of public opinion about the health situation of the population in the occupied territories, but the proposals and recommendations contained in the report only sought to cure results and not the root cause, which was the occupation. Health would not have a genuine meaning unless that cause was removed. By recognizing the legitimate inalienable right of the Palestinian people, including the right of self-determination, it would be possible to achieve health for all, including those in the occupied Arab territories - that health which the Constitution had defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Consequently he invited all the delegates to support the draft resolution on the health conditions of the Arab population, which had been sponsored by 38 Member countries.

Mr ABBASSI TEHRANI (Iran) said that the account given in the report by the Israeli Ministry of Health of its successes in providing health and medical services for the occupied territories was merely a cover for the crimes inflicted upon the population of those territories, particularly in Palestine. The inhuman attitude of Israel and its supporters towards helpless Moslem nations in the area was all too evident.

The imperialistic Zionist Government was pursuing its policy of bombing southern Lebanon, causing the deaths of thousands of innocent persons. Although the Health Assembly had for a number of years urged Israel to change its policy, the Zionist Government had ignored all resolutions addressed to it and had disregarded the most fundamental human rights in pursuing the worst type of colonialism and barbarism. It was therefore incongruous to hear an account by the delegate of Israel of medical services in the occupied territories. He called upon the awakened conscience of the delegates in the Committee, requesting them not only to condemn the Zionist Government for its barbaric and criminal actions towards the innocent nations in the region, but also to condemn the supporters of such a notorious Government and the Great Satan which had created that dangerous tumour in the region.

The Great Satan pursued an imperialistic policy by creating new tumours in the region as a barrier against the cry for independence of oppressed nations. In that way its satanic conspiracies encouraged the lackey regimes to ignite the fire of war, to occupy other nations, lands and territories, causing millions of people to be displaced. Cancer was cured by diagnosing and finding the root of the tumour and wiping it out. For a long time the Zionist regime of Israel had been condemned for its inhuman behaviour and flagrant infringement of human rights in the region, but the Zionist aggressor ignored the resolutions and paid no attention to the objections in that regard. There was no alternative but to mobilize the powers of the nations, and to pass from mere slogans to action, as his country had done. After the Islamic revolution the Iranian nation, inspired by Islamic ideology, had cut off all its relations with the Zionist regime and the Great Satan. That was the meaning of supporting an oppressed nation such as the Palestinian nation against an oppressor. His delegation therefore stood firm by the draft resolution.

Mr TAWFIQ (Kuwait) reaffirmed that the inhuman acts of oppression perpetrated in the occupied Arab territories by the Israeli authorities were a dangerous violation of all human principles and values. They were in flagrant contradiction with the Fourth Geneva Convention of 1949, with resolutions of the United Nations General Assembly on the subject, and with
successive resolutions adopted by WHO and other international bodies. The present Committee fully realized that the health conditions of the inhabitants of those territories were influenced by the occupation and by infringements of human freedom. The people of Palestine could not accede to health by the year 2000 unless and until they had been given freedom from occupation, injury, and oppression. To uphold the contrary was pure imagination.

The delegate of Israel had referred to a kidney transplant operation carried out on a patient of the West Bank. But that patient was certainly one of the native sons of the West Bank who had returned from Kuwait. The operation had obviously been undertaken for publicity reasons; had the objective of the operation been purely humanitarian, the delegate of Israel would not have boasted of it at the Health Assembly. Successful kidney transplants were frequently performed in Kuwait, on patients of all nationalities, but Kuwait did not boast of that fact in an international forum.

If members of the Committee had at heart the provision of health assistance to the Arab population of the occupied territories, they would give their full support to the draft resolution under consideration.

Mrs LUETTGEN (Cuba) said that, once again, the Special Committee of Experts responsible for studying health conditions in the occupied Arab territories had reflected the health drama that was one of the consequences of Israeli aggression. The military occupation, and the consequent denial of all rights to the Arab population, could not be separated from the health situation - which was very far from corresponding to the definition given in the WHO Constitution. The minimum requirements for health would not be available for the men, women and children subjected to a foreign yoke so long as the Palestinian people could not exercise its right of self-determination and so long as the refugees and displaced persons could not return to their own homes and lands.

The situation in the Middle East was deteriorating, as was instanced by the recent attacks of Israeli forces against Lebanon, attacks that inevitably worsened the health situation of the population. In expressing once again its solidarity with the struggle for liberty of the Palestinian people, lawfully represented by the Palestine Liberation Organization, the Cuban delegation solemnly declared that the grave crisis in the Middle East could be solved only by the withdrawal of all Israeli forces, and by a respect for the rights of the people of Palestine. Until a solution was reached on those grounds the health conditions reflected in part in the Special Committee's report would continue. Her delegation was pleased to co-sponsor the draft resolution introduced earlier in the meeting. That resolution reflected the health conditions of the Arab population of the occupied territories, including Palestine, and would permit the Special Committee's work to be supported and continued.

Dr LUBANI (Jordan) said that health defined as "a complete state of physical and social wellbeing" could not be achieved by the peoples of the occupied Arab territories in the conditions of repression, terror, famine, and displacement that were being enforced by the Israeli authorities. Reports received by the Health Ministry in Jordan from health administrators on the occupied West Bank indicated a deterioration in the health services provided. In 1980, for example, 379 clinics had been in operation on the East Bank, as opposed to 140 on the West; there had been 36 dental clinics on the East Bank, but none on the West; 76 maternal and child health clinics on the East Bank, and 54 on the West; 41 laboratories on the East Bank as against 12 on the West; 10 blood banks on the East Bank and only one on the West Bank, which had now been closed; 24 X-ray centres on the East Bank as against 6 on the West; and 263 pharmacies on the East Bank as compared with only 113 on the West.

What the Committee had heard from the representative of the Special Committee of Experts was a clear denial of the allegations in the report submitted by the Israeli occupation authorities to the Health Assembly. The delegation of Jordan expressed its concern at the deteriorating health conditions and at the psychological climate from which the population of the occupied territories suffered. It condemned the occupying authorities for having refrained from implementing the resolutions adopted by WHO and other international organizations and it emphasized that the social conditions prevailing in the occupied Arab territories could not be conducive to the overall development of health services.

Mr HELMAN (United States of America) said that it was with regret that he addressed the item under consideration and the draft resolution submitted. Once again a draft resolution had been proposed that divorced rhetoric from reality. Once again the Health Assembly was
asked to waste its time by considering political issues over which it had no authority and concerning which no statement it made could carry any weight.

Part I of the draft resolution asked the Director-General "to increase collaboration and coordination with the Palestine Liberation Organization". The United States Government would oppose such collaboration, both as proposed in the resolution and subsequently.

Part II of the resolution dealt with UNRWA and asked States to increase their contributions to it. Noting that the Governments sponsoring the draft resolution wished such contributions to be increased, he expressed the hope that they would themselves announce increased contributions. As a matter of record, 31 of the 35 original co-sponsors of the draft resolution had thus far in 1981 contributed nothing to UNRWA. The four Governments who had - Iraq, Kuwait, Libyan Arab Jamahiriya and Saudi Arabia - had given about $13 million out of the $176 million so far contributed, i.e., some 8% of the total. In view of that poor record, he agreed that there was considerable room for an improvement in contributions. Moreover, could the co-sponsors of the draft resolution really believe that they would improve the chances of an increased contribution from the United States Government by embodying their appeal in a resolution so totally unacceptable as the draft under consideration?

Part III of the draft resolution amounted to a long series of condemnations of Israel. It addressed issues and adopted positions that were completely outside the competence of WHO. It would thus do nothing to advance the health conditions of the people of the occupied territories. The best thing WHO could do for those people was to reject resolutions such as the one before the Committee and instead to consider seriously the other documents placed before it, including those from the Special Committee of Experts and from Israel. He hoped that, in the future, the Health Assembly would be allowed to address itself solely to the question of health conditions in the occupied territories and what WHO could do to assist in improving them.

Mr ZENKER (German Democratic Republic) expressed the hope that the draft resolution under consideration, of which his delegation was a co-sponsor, would be approved by the Committee and subsequently by the Health Assembly in plenary session.

After studying the documents before the Committee, he wished to emphasize that normal health conditions for the Arab population of the occupied territories could be established only when the appropriate political conditions had been achieved, by the establishment of a just and lasting solution to the Middle Eastern problem. The basis on which that problem must be settled had long been known. He had drawn attention at the Thirty-third World Health Assembly to the three principles that must be followed, namely: the withdrawal of Israel from all the territories occupied in 1967; the right of the Palestinian people to self-determination, including the right to a State of their own; and the security and sovereignty of all States in the Region. The path to be followed had recently been indicated by the USSR when it proposed the convening of an international conference on the Middle East.

Dr ESHJA (Albania) said that the state of misery, suffering and privation currently being endured in the occupied Arab territories was inextricably linked with the serious situation created in the Middle East by the Israeli Zionist imperialists. Continual acts of aggression and massacre, arrests, deportations, and imprisonments had led to a mass exodus of Arabs from their enslaved fatherland and had resulted in more than a million-and-a-half Palestinian refugees.

The aim of the Israeli Zionists was to annihilate the Palestinian people, their latest action being to legalize the annexation of Jerusalem. Dozens of Israeli colonies had been established in the occupied Arab territories. The Israeli leaders, taking advantage of the situation, were attempting the genocide of the Arab population: a significant example of that was currently taking place in southern Lebanon, where armed attacks were being launched daily by air, land and sea, causing destruction and death among the innocent population.

In all those criminal acts, the Israeli Zionists were supported by American imperialism. In addition, they had taken advantage of the anti-Arab attitude and the hegemonistic designs of Soviet imperialism.

The people of Albania condemned the criminal acts of the Israeli Zionists and their policy of aggression towards the Arab population, and also the intrigues of the superpowers, particularly against the Palestinian people. Only a just solution to the Palestinian problem, by putting an end to those barbaric practices, would permit an improvement in the deplorable health conditions of the Arab population.
Mr HASSAN (Egypt) said that the item under consideration remained on the Health Assembly's agenda because health conditions in the region to which it related continued without improvement. WHO was involved in the question because of the overwhelming international support for the Arab occupied territories that had been expressed in international forums and was embodied in the many resolutions adopted by the United Nations and its specialized agencies with a view to restoring the legitimate rights of the Palestinian people.

He had studied the valuable report of the Special Committee of Experts set up by WHO in accordance with resolution WHA33.18, and expressed appreciation of the Committee's efforts to fulfill its task. The Egyptian Permanent Mission in Geneva had met members of the Special Committee in March 1981, immediately prior to their visit to the occupied territories. The Special Committee had visited Egypt on 26-29 March 1981; it had met officials in the Ministry of Health and other officials dealing with the question and had reviewed the information available in Egypt on the subject. In the Special Committee's report on its visit, his delegation had noted in particular its comments on the suffering endured by the population and the harsh conditions under which they lived, which had a direct impact on their health and psychological condition. The Special Committee had stated that many Arabs continued to live under unsatisfactory conditions, and that there had been no noticeable improvement in health services in the area in the past two years. Communicable diseases were still prevalent among young people and psychological and mental illness was on the increase. The Special Committee had also recorded that political prisoners and detainees were being mistreated in detention centres in Israel.

The policies adopted by the Israeli authorities in the occupied Arab territories took the form of expropriation of land, seizure of water resources, and establishment of settlements, as well as mistreatment of prisoners. Those policies were condemned by the international community, which had repeatedly called on Israel to refrain from policies that represented a flagrant violation of the principles of international law and of the United Nations Charter as well as of the provisions of the Fourth Geneva Convention of 1949. Moreover, Israel had prevented all efforts to establish a just and lasting peace in the Middle East. Its illegal practices had affected not only the physical but also the mental well-being of the population to an extent which had become a matter of great concern.

He drew attention to the report submitted by the Israeli authorities on health conditions in the occupied Arab territories (document A34/INF.DOC/1) and recorded his delegation's total rejection of all changes introduced in Arabic place names in the occupied territories, which demonstrated a continuing attempt by the occupying authorities to change the established geographical terminology of the area. He also noted that the Israeli report did not refer to Arab Jerusalem, and he reaffirmed once more that occupied Arab Jerusalem was an integral part of the West Bank, and its Arab population an integral part of the Palestinian Arab nation.

The great importance his delegation attached to the mandate and task of the Special Committee led it to believe that that Committee should not limit itself merely to the collection of data on the health conditions of the population in the occupied territories, but should go further and make proposals that would enable adequate solutions to be found to the health problem of the area. In its report the previous year, the Special Committee had submitted a number of recommendations, many of which had not been implemented. In its present report (document A34/17), the Special Committee recalled those recommendations and added new ones. It had pointed out the previous year - and now reaffirmed - that a final settlement of the problem could only come about if an atmosphere of peace and security could be established in the area.

He expressed his delegation's support for the report of the Special Committee of Experts and its proposals and recommendations, and invited the present Committee to ask the Special Committee to continue its work. Finally, his delegation supported the draft resolution under consideration.

Mr SOKOLOV (Union of Soviet Socialist Republics) said that, although the item on the health conditions of the inhabitants of the occupied Arab territories had been on the agenda of the Health Assembly for many years, it was still of burning actuality. It was clear that the situation had degenerated in recent years.

At past Health Assemblies his delegation had made clear its position. It continued to believe that a solution to the problem depended on a political solution to the Middle East conflict and on the elimination of the basic cause of the problem, namely, the occupation of the Arab territories in question, which had been described by previous speakers.

His Government's position had been reaffirmed in a report by Mr Brezhnev to the XXVI Congress of the Communist Party of the Soviet Union, to the effect that the Soviet Union proposed to renew, together with the Arab countries - including the Palestine Liberation
Organization - with Israel, with the United States of America, with the European States, and with all those who had a sincere desire to provide a just and durable peace in the Middle East, collective attempts for a comprehensive settlement of the Middle East problem on a just and realistic basis. This could be done within the framework of a specially convened international conference. The Government believed that a useful role could continue to be played by the United Nations in that respect.

With regard to the substance of the problem, the position of the Soviet Union was based on the need for three interrelated conditions to be fulfilled: (1) the end of Israeli occupation of all territories occupied in 1967; (2) the implementation of the inalienable rights of the Arab people of Palestine by the setting up of an independent State; and (3) the provision of security and sovereignty for all States in the area, including Israel. In connexion with the need for a political settlement of the Middle East conflict, the burning problems linked to the degrading and unhealthy conditions in which the population of the occupied territories was at present living must not be lost from sight. The statements made by a number of delegates on that issue, the report of the Special Committee of Experts, and the report of the Permanent Observer for the Palestine Liberation Organization contained much information that gave rise to concern and anxiety regarding the health and living conditions of the population of the occupied Arab territories. His delegation had always supported WHO measures to provide health assistance to that population and it was in favour of their continuation.

He expressed his support for the draft resolution under consideration and thanked members of the Special Committee of Experts for their work.

Mr BAATH (Syrian Arab Republic) said that it was apparent from the reports of the Special Committee and of the UNRWA representative that the health conditions of the Arab population in the occupied territories and in the Palestinian refugee camps were continuing to deteriorate. Israel continued to ignore all the United Nations resolutions and the international conventions and agreements relating to the subject, despite the condemnations repeatedly levelled at it. It was continuing its occupation of the Arab territories under discussion in order to build up its colonies there; it was violating water supply sources and treating the Arab population in a manner that was inhuman and barbaric. He mentioned Israel's continued aggression and its bombings of refugee camps, particularly in southern Lebanon. The report of the International Red Cross showed the deterioration in the health services and in the condition some of whom had had to wait for months or even years for operations. Skin disorders and other communicable diseases were increasing.

He emphasized that it was the right and indeed the duty of the Organization to study the health conditions of the Arab population. It had been suggested at the Health Assembly that the item under consideration was a political question - an allegation repeated each time the item was taken up. That was not so, however, and those who suggested it were either trying to deceive delegates or to exert pressure on them. The health of the Arab population in the occupied territories was indeed a health matter; its consideration should remain a priority for the Health Assembly until the situation had been remedied. As the head of his delegation had stated a few days previously in the plenary meeting, the social contract of health for all by the year 2000 of which the Director-General had spoken could not be achieved unless all peoples were liberated. In the hope that such liberation would soon be achieved, he stood by the proposals made in the draft resolution before the Committee.

Mr JIN Chung Kuk (Democratic People's Republic of Korea) said that his delegation strongly commended the draft resolution.

Mr NGUYEN VAN TRONG (Viet Nam) said his delegation condemned the Israeli violation of human rights in the occupied Arab territories and expressed its total support for the struggle of the Palestinian people against the forces of Israeli aggression.

The Vietnamese people had itself just emerged from a terrible war against imperialism and was now under threat from expansionist forces in the north. In view of the sufferings which war had brought to his country, nothing was more precious to his people than their independence and freedom. In the same way they cherished the independence and freedom of others. They therefore expressed warm sympathy for all those peoples who were carrying the struggle against imperialism and colonialism in the pursuit of national liberation. That the world had reached a period when progressive peoples understood the difference between an aggressor and his victim, when the strong could no longer impose their will on the weak, had been eloquently demonstrated by the struggle of the Vietnamese people. They considered their victory as a joint victory of all oppressed peoples, and they were certain that the Palestinian
and Arab peoples would triumph in the end and would defend their territorial rights and natural resources against imperialist Zionist aggression.

His delegation had for that reason asked to be a co-sponsor of the draft resolution under consideration.

Mr SOOS (Hungary) expressed appreciation for the excellent work of the Special Committee. His delegation considered that the health conditions of the Arab populations in the occupied Arab territories could be improved only through a peaceful settlement of the political situation in the Middle East, and not through the recommendations or decisions of the Health Assembly. Without a solution to the problem of the long-suffering Palestinian people, there could be no lasting peace in the Middle East. A peaceful settlement, which should guarantee the independence and development of all the States of the area, was in fact a prerequisite for world stability and peace.

The delegation of Hungary supported the draft resolution.

Mrs PÁROVÁ (Czechoslovakia) said that her delegation would vote in favour of the draft resolution.

Mr AWAN (Pakistan) commended the efforts made by WHO, in collaboration with UNRWA, to improve health conditions in the occupied Arab territories. His delegation wished to join the co-sponsors of the draft resolution.

Professor HALEEM (Bangladesh) said that his delegation, as a co-sponsor, fully supported the text of the draft resolution. Recalling the objectives of the Organization as defined in Article 1 of its Constitution, he emphasized that the sociopolitical situation in the occupied territories as described in the Special Committee's report was not conducive to the attainment of even a minimum level of health. He referred to Articles 2(a), (c) and (i) of the Constitution, and urged the Director-General to continue to take appropriate measures, in cooperation with other specialized agencies, to alleviate the situation. And he appealed to Member States to respect both the Constitution of WHO and the Fourth Geneva Convention of 1949, which was so often ignored in time of war.

Dr AL SHABANDER (Iraq), whose delegation was among the co-sponsors of the draft resolution, confirmed and emphasized the unsatisfactory health and living conditions of the populations in the occupied Arab territories, conditions that were the result of injustice and oppression. Reminding delegations of the global objective of health for all, he called upon members of the Committee to support the draft resolution.

Mr GROZDANOV (Bulgaria) stated that his delegation, a co-sponsor of the draft resolution, shared the view that the health of the Arab populations in the occupied territories was a direct result of the political situation. It endorsed the approach advocated by the delegations of the Soviet Union and the German Democratic Republic.

Mr KAKOMA (Zambia), endorsing the draft resolution, believed that health for all would be unattainable as long as populations remained oppressed as in the Middle East.

Mr ARSLAN (Mongolia) said that in line with the Mongolian people's continuing support for the just struggle of the Arab people, including the Palestinians, for the liberation and independence of the occupied Arab territories, his delegation would vote in favour of the draft resolution.

Dr AL-SARRAG (Sudan) said that the many delegates who came from countries that had fought to achieve independence and self-determination were well placed to appreciate the difficulties of those still living under colonial conditions. While the report of the Special Committee of Experts correctly reflected the health situation of the Arab populations in the occupied Arab territories, he regretted the absence of proposals for a solution of the problem. The second generation of Palestinians was today suffering the results of the loss of their territory through aggression.

He noted that many States that supported a programme of assistance also continued to support the aggressor by supplying weapons and finance. He appealed to those who had achieved their freedom to show solidarity and assist the Palestinian people in their efforts to reach the independence that was a sine qua non for their attainment of a satisfactory health situation by the year 2000. To this end he urged delegates to approve the draft resolution, which would thus reflect the joint efforts of all peoples who had fought for independence and freedom.
Dr SAIED (Tunisia) endorsed the views put forward by earlier speakers in favour of the draft resolution.

Dr ALUOCH (Kenya) emphasized that good health was a basic requirement for all people, regardless of race or of political, religious or socioeconomic considerations.

Dr AHMAD (Afghanistan), supporting the draft resolution, endorsed the view that the global strategies for attaining health for all by the year 2000 could not ignore the health status of the Palestinian people.

Miss ILIČ (Yugoslavia) said that her delegation, deeply concerned at the reports under consideration, shared the view expressed by other speakers, that the objectives of the Organization could not be attained under conditions of foreign occupation and violation of human rights.

As emphasized by the emergency special session and the thirty-fourth regular session of the United Nations General Assembly, an urgent settlement of the Palestinian crisis was required in the interests of both Middle Eastern and global stability. Such a settlement could only be achieved within a framework that combined the essential elements of self-determination, independence, and free national and social development. It thus required the urgent implementation of the numerous resolutions passed by United Nations organizations, the consequent withdrawal of Israel from the occupied Arab territories, and cooperation between all the parties concerned - including the Palestine Liberation Organization, as legitimately representing the Palestinian people. The Yugoslavian delegation, as a co-sponsor of the resolution, sought the support of other delegations for its approval.

Mr TEKA (Ethiopia), also a co-sponsor of the draft resolution, referred to the statements of earlier speakers who had described the sufferings and the health conditions of the Arab population in the occupied Arab territories, including Palestine. He strongly urged all members of the Committee to support the draft resolution.

Mr SMIT (Netherlands), speaking on behalf of the 10 Member States of the European Communities, indicated that they were unable to support the draft resolution, since they did not believe the Special Committee's findings justified the condemnation contained in that text. The political aspects of the Middle East question should be dealt with in other forums of the United Nations system, notably the General Assembly and the Security Council.

The ten delegations wished to reiterate their support of the efforts continuously deployed by the international organizations to reach a just solution. As evidenced by the considerable contribution of both the European Economic Community and its members to UNRWA, WHO, and other relief agencies, the Member States of the European Communities were deeply conscious of the health problems of refugees and displaced persons both in the Middle East and elsewhere. They attached great importance to the achievement of conditions in the occupied Arab territories that would permit their inhabitants to enjoy adequate health care and they intended to follow the question closely. They urged Israel to give particular attention to the recommendations of the Special Committee of Experts.

Professor MODAN (Israel), replying to the statements made by certain delegations, said that the issue was one of data versus polemics, of health versus demagogic accusations. The statements made by the delegations of the USSR on occupation, the German Democratic Republic on sociopolitical conditions, Bangladesh on housing and sanitation, the Syrian Arab Republic on bombing and oppression, and Iran on human rights had not advanced the discussions. He particularly regretted the statement of the delegate of Egypt, who in the discussions on another item of the agenda had made the point that health issues should not be confused by politics.

He reminded the delegates of Egypt and of Jordan that the conditions they now considered unsatisfactory in the occupied Arab territories had been present under their respective rule and occupation. Israel had cooperated with the Special Committee in its review of the health situation; he wished that Special Committee could undertake similar reviews in Jordan, Bangladesh and the Syrian Arab Republic, bringing their findings to the next Health Assembly, which could then make a comparison with the present report.

His reference to a Kuwaiti patient in a hospital in Israel had been put forward as an example that medical care in that country was open to all patients from surrounding countries, as well as the territories under discussion.
Following recent events in Iran, he did not think the delegate of that country was in a position to speak of human rights; he might better have spoken of prisoners and of summary executions.

Among the few medical references in the present largely political discussions there had been one to cancer. That disease provided a metaphor for the present situation. Once the primary tumour had developed in the Middle East, the metastases invaded all the surrounding countries, including Israel and the territories under discussion.

Requesting the right of reply, Mr ABBASSI TEHRANI (Iran) observed that the very presence of Israel in the occupied Arab territories was a danger to health in those territories, in terms of the definition of health in the preamble to the WHO Constitution.

The draft resolution was approved by 63 votes to 23, with 15 abstentions.1

Mr PALIHAKKARA (Sri Lanka) indicated that his delegation's support of the draft resolution derived not only from the documentation before the Committee but also from the first-hand knowledge of conditions acquired by his country's representative on the Special Committee to Investigate Israeli Practices Affecting the Human Rights of the Population of the Occupied Territories.

Mr UTHEIM (Norway) explained that his delegation had not supported the draft resolution, which it considered transcended the competence of the Health Assembly. Moreover it shared the opinion expressed by the representative of the European Economic Community that the report of the Special Committee of Experts did not justify the condemnation contained in the draft resolution. The Norwegian Government's views on the question of the territories occupied by Israel since 1967 had been repeatedly stated in the United Nations General Assembly and the Security Council. The position of the Norwegian Government was based on the Fourth Geneva Convention of 12 August 1949, which it had repeatedly called upon Israel to respect.

Dr STOKE (New Zealand) explained that his delegation considered the text of the draft resolution went beyond the subject and substance of the Special Committee's report. However, New Zealand supported the Director-General in his continuing efforts to provide health assistance to the Palestinian people.

Mr JEANRENAUD (Switzerland) noted that the Special Committee had accomplished its mission for the third time, thanks, in particular, to the cooperation of the Israeli authorities. The delegation of Switzerland considered that, on the basis of the balanced and objective report prepared by the Special Committee after numerous visits to the area, it was unable to accept the condemnation of Israel contained in part III of the draft resolution. While voicing its concern at the major political problems disturbing the Middle East, his delegation nevertheless supported the conclusion of the Special Committee in section 8 of its report that responsibility for the solution of these problems lay with bodies other than the Health Assembly.

Dr JIMÉNEZ DE BETHANCOURT (Panama) said that her delegation had voted against the draft resolution, since it considered that the Health Assembly should be a forum for the discussion of technical and scientific, rather than political issues. Moreover, it believed that populations in the territories of many of the Member States represented on the Committee were exposed to similar or worse conditions than the people in the occupied Arab territories. Her delegation, while properly concerned with human rights, considered that WHO's emblem should not be used by Member States as a cover for ulterior motives. The attainment of, and the right to, health should outweigh all other considerations.

Dr ALUOCH (Kenya) said his delegation had abstained from voting since it did not believe that health problems could be solved by passing highly emotional and political resolutions in the Health Assembly.

1 Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA34.19.
Mr MAGNUSSON (Sweden), explaining his vote against the draft resolution, said that the occupation of the Arab territories and the Israeli policy of settlement in themselves created a number of problems in various sectors, including the health sector. Those in the health sector had to a large extent been identified by the Special Committee of Experts which, while noting that Israel had already taken some of its earlier recommendations into account, made further recommendations to the Israeli authorities. The Special Committee, concluding that the solution of many of the problems depended on bodies other than the Health Assembly, gave on the whole a balanced picture of the situation; this was not however reflected in the draft resolution just approved by the Committee.

The organizations in the United Nations system should, each in its own sector, do what they could to improve the conditions of the population in the occupied Arab territories. But the Swedish Government believed that a lasting solution would only result from a just and all-embracing political settlement in the area. The draft resolution that had been voted introduced political considerations that went far beyond the competence of the Health Assembly.

Sweden would continue to support the efforts of WHO, UNRWA and other United Nations agencies to provide assistance to the area concerned and in this connexion gave explicit support to operative paragraph 1 in part II of the draft resolution, which requested Member States to increase their contribution to UNRWA. Sweden also considered the Fourth Geneva Convention, relative to the protection of civilians in time of war, to be applicable to the occupied Arab territories.

The meeting rose at 12h 55.
TWELFTH MEETING

Tuesday, 19 May 1981, at 14h30

Chairman: Dr Z. M. DLAMINI (Swaziland)

1. THIRD REPORT OF COMMITTEE B (Document A34/37)

The CHAIRMAN invited the Committee to adopt its draft third report.

The report was adopted (see document WHA34/1981/REC/2).

2. COLLABORATION WITH THE UNITED NATIONS SYSTEM: Item 42 of the Agenda (continued)

General matters: Item 42.1 of the Agenda (Document EB67/1981/REC/1, resolution EB67.R21 and Annex 10; Document A34/18) (continued from the eleventh meeting, section 1)

Dr CHRISTIANSEN (Norway) emphasized that WHO was the lead agency and coordinator where international health work was concerned. Two years ago, the Thirty-second World Health Assembly had adopted a resolution (WHA32.24) on coordination of activities with other organizations of the United Nations system and had requested the Director-General to conduct a study on the strengthening of WHO's cooperation with other bodies within the system. He believed that such strengthening was both timely and necessary, since the target of "Health for all by the year 2000" would not be achieved unless the entire United Nations system, including funding agencies, was actively involved.

In future, he would like information on collaboration with the United Nations system to be more pertinent, and to indicate more clearly where progress had been made, where setbacks had been encountered, and where greater effort was needed. The report should include an incisive and critical review of collaboration efforts that would help future Health Assemblies to define WHO's role of coordination and leadership in international health work.

Mr VOHRA (India) suggested that the review of collaboration within the United Nations system might also touch on the all-important subject of the New International Economic Order. At the Thirty-third World Health Assembly it had been agreed that WHO would make efforts not only within the United Nations system but in related quarters to see what could be done to secure greater support for objectives related, directly or indirectly, to the attainment of the goal of health for all. Considering the relative brevity of the report (document A34/18), it gave a good overall picture of the more important aspects of coordination and collaboration.

Dr KILGOUR (Director, Division of Coordination) thanked delegates for their comments, which would be taken into account in the preparation of the report for the next Health Assembly. He agreed with the delegate of Norway that the report could well present a more detailed analysis of the success or failure of collaboration activities in the course of the year. As the delegate of India had indicated, the report was short, but a balance had to be struck between a brief document, highlighting essential points, and a long document, which would in fact be easier to produce.

It was very true that the New International Economic Order was an important element in international collaboration; he recalled that at the previous Health Assembly the Technical Discussions had dealt with the contribution of health in that area, and the results of those discussions had been an important part of WHO's input to the New International Development Strategy.

The Director-General's report (document A34/18) was noted.
The CHAIRMAN drew attention to the following draft resolution, sponsored by Bahrain, Democratic Yemen, Gambia, Iraq, Jordan, Kuwait, Lebanon, Mauritania, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Singapore, Tunisia, Turkey and Yemen:

The Thirty-fourth World Health Assembly,
Noting with grave concern the serious flood situation in the Somali Democratic Republic;
Aware of the health and medical assistance urgently required by the Government of the Somali Democratic Republic to cope with the situation;
1. CONSIDERS that the serious health and medical problems arising from heavy rains and flood which have now created a disaster situation constitute a source of major concern to the international community thereby necessitating urgent and substantial health and medical assistance to the Government of the Somali Democratic Republic;
2. REQUESTS the Director-General to mobilize on an emergency basis health and medical assistance programmes to the Government of the Somali Democratic Republic and allocate the necessary funds for this purpose to the best extent possible;
3. CALLS upon specialized agencies and other United Nations agencies concerned, as well as all governmental and nongovernmental organizations, to provide their cooperation with WHO in this field.

Mr TEKA (Ethiopia) said, while he had no objection to the appeal made on behalf of Somalia, he would nevertheless like to point out that other countries in the area were also seriously affected by floods. He proposed that the co-sponsors of the draft resolution amend it to include Djibouti, Ethiopia and Democratic Yemen. That amendment would make the resolution more comprehensive and help to secure its adoption by consensus.

Dr LUBANI (Jordan) said that the recent floods in Somalia had rendered many homeless and had caused many human tragedies. All countries should combine in helping to alleviate that situation. His delegation declared its support for the people of Somalia in their plight and endorsed the draft resolution.

Dr FERNANDES (Angola) said that, since the disaster had also struck other countries of the area, it was right that assistance should be extended to them as well as to Somalia. He endorsed the proposal of the Ethiopian delegation.

Mr AL-SAKKAF (Yemen), Mr GROZDANOV (Bulgaria), and Mrs LUETTGEN (Cuba) also supported the proposal.

The draft resolution, as amended, was approved.1

(For continuation, see summary record of the sixteenth meeting, section 3.)

Health care of the elderly (preparations for the World Assembly on Aging, 1982): Item 42.2 of the Agenda (Document EB67/1981/REC/1, decision EB67 (13) and Annex 15)

Dr RIDINGS (representative of the Executive Board) recalled that in December 1980 the United Nations General Assembly had adopted a resolution reaffirming an earlier decision to convene a World Assembly on the Elderly as a forum for launching an international action programme aimed at guaranteeing social and economic security to older persons, and at providing opportunities for them to contribute to national development. Since the question of services to the elderly was closely bound up with the aging of populations as a whole, the General Assembly had decided to change the name of the 1982 forum to "World Assembly on Aging", to suggest continuing change and development during the later stages of a life-span, rather than a fixed or static period of life.

A brief description of the coordinated efforts of the United Nations in this area was given in section 1 of the Director-General's report to the sixty-seventh session of the Executive Board (Annex 15 to document EB67/1981/REC/1). It would be noted that the United Nations Centre for Social Development and Humanitarian Affairs in Vienna would be responsible for the 1982 Assembly.

1 Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA34.18.
Reference was made in Annex 15 to the important WHO Preparatory Conference that had taken place in Mexico City in December 1980; the report of that Conference would be a valuable contribution both to the preparatory meetings and to the World Assembly.

The Board had stressed the need for the global programme to be carried out through collaboration among WHO’s six regions. It had noted that the Eastern Mediterranean, South-East Asia and Western Pacific Regions had all received a report on health services for the elderly in the developing countries of Asia and the Pacific, as a basis for the two regional preparatory meetings for the World Assembly which were being convened by the United Nations Economic and Social Commission for Asia and the Pacific.

The Board had also noted that provision for global activities relating to the care of the aging had been made by WHO for the first time in the proposed programme budget for 1982-1983.

Particular attention had been paid to national preparations by Member States. Several members of the Board had expressed the view that the World Assembly would provide a unique opportunity to begin the renewal of society by giving more civilized and humane care and consideration to aging people. It would be a means of enabling aging people in both developing and industrialized countries to continue their efforts to obtain a decent life for themselves and their families.

Dr KAPRIO (Regional Director for Europe) said that, after the Board’s sixty-seventh session, preparations for the World Assembly had continued; the latest development had been an interagency coordination meeting in Vienna (April 1981) and there was to be a whole series of technical and regional meetings with various United Nations bodies leading up to the World Assembly in 1982. The two co-Chairmen of the Preparatory Conference in Mexico City, as well as the programme manager of the programme concerned, were present at the current Health Assembly, and some of the technical elements of the programme had already been discussed.

Dr RODRÍGUEZ (Argentina) said that the importance of preventive medicine in the care of the elderly could not be overstressed. He suggested the use of certain terms in preference to others in referring to older people and their problems.

Dr VERGNE SABOIA (Brazil) said that his Government was dealing with the problems of the elderly within the framework of primary health care. Average life expectancy in Brazil had been gradually rising and the proportion of elderly people in the population was fairly high. The Brazilian health authorities were therefore working towards the improvement of the quality of life of elderly people, bearing in mind that the elderly were entitled to full participation in family and community life both from the socioeconomic and from the psychological point of view.

His delegation was following with interest the preparations being made for the forthcoming World Assembly on Aging.

Mrs OLESEN (Denmark), speaking on behalf of the five Nordic delegations, expressed her appreciation of the Director-General’s efforts in preparing for the World Assembly on Aging. One of the most important steps taken by WHO had been the Preparatory Conference held in Mexico City in December 1980. The Conference’s report would serve as a basis not only for the work of the World Assembly itself, but also for WHO’s future work in the field.

The report stressed that the consequences of the increase in the numbers of elderly people would be most serious for developing countries. It also pointed out that both developed and developing countries could learn from the experience of other societies how to integrate the elderly into the family and into society as a whole. Finally, the report showed that the elderly would be able to play a role in achieving health for all by the year 2000 by being part of the caring process at primary level in families and in communities.

In the Nordic countries, those over 60 constituted almost 20% of the population, those over 80 some 3%. Over the last 20 years those figures had risen by 40% and 100% respectively, and forecasts for the year 2000 showed that those of 80 years of age were likely to increase by some 40%. Health care of the aged called for an integrated approach, with the stress on multisectoral responsibility shared between social, medical, housing and transport services.

Since the older element of the population in the year 2000 would be those who had benefited from the high standard of living that had developed during the 1950s, they would expect higher standards of assistance and care from society. It might therefore be appropriate to plan for the care of elderly people whose background was different from that of the present older generation. The World Assembly, though it was an important event, should be seen as
only one of the steps to be taken towards promoting the health and well-being of the elderly. The Nordic countries were gratified that adequate support was being given to the global programme on health care of the elderly now being carried out by the Regional Office for Europe, and would be glad to cooperate in that programme in future years.

Ms LOWE (United States of America) was glad to note that progress was continuing in the Director-General's preparations for the World Assembly. Elderly citizens represented a vast reservoir of talent and experience that could be invaluable in helping to solve both national and global problems. Society as a whole should work to promote a better quality of life for the aging, and to take full advantage of the unique contribution they could make to the community.

Her country planned to participate actively in the World Assembly and had set up an interagency committee to coordinate preparations, a committee on which the National Institute on Aging, as well as the Administration on Aging, were represented. Its Government had contributed $250,000 to the United Nations Voluntary Fund for the World Assembly on Aging. A conference to be held at the White House later that year would focus on the needs and problems of the elderly in the United States and would define the role of the Government and the private sector in assessing those needs. She would be happy to make known the results of that conference to WHO and any interested Member countries.

Dr BOOTH (Australia) said that the theme of WHO's contribution to the World Assembly on Aging would be the well-being of the world's elderly citizens in the year 2000; by that time the majority of the aging population of the world would be in the developing countries. In Australia the aged had represented 9.2% of the population in 1978 and it was estimated that, by the year 2011, that proportion would have risen to 11%.

The Federal Government provided considerable funds for the maintenance of the aged but the major responsibility for the provision of care fell on the state governments, on religious and charitable organizations, and on the private sector. The various agencies ensured that private beds were provided for the care of the aged in both hospitals and nursing-homes, but it was felt that aged persons should be able to remain within their own environment whenever possible.

The Government endeavoured to contain the cost of nursing-home accommodation by various means, including control of the fees paid and of the maximum bed ratio, which was set at 50 beds per 1000 persons aged 65 years and over. Excessive provision of nursing-home beds was avoided and facilities were equitably distributed. Furthermore, only those persons requiring nursing-home care were admitted. Non-institutional care was provided through a domiciliary nursing care service which had been introduced in 1973 for the specific purpose of encouraging people to care for the aged in the home. In order to maintain a desirable nutritional level for the elderly living at home, the Government subsidized a voluntary organization which provided a well-balanced hot meal daily.

His Government would contribute its own experience to the World Assembly on Aging and expected to benefit greatly from the experience of other participating countries. In that connexion it had hosted the Working Group on Health Services for the Elderly in the Developing Countries of Asia and the Pacific, which had met in Melbourne in December 1980.

Dr PLIARANGCHANG (Thailand) said that his Government would participate fully in the work of the World Assembly on Aging. It had already taken part in the Preparatory Conference held in Mexico City, in the Working Group referred to by the delegate of Australia and in the technical meeting on aging for Asia and the Pacific Region held in Bangkok early in 1981.

Government policy recognized the vulnerability both of the young and of the elderly. A programme of free medical care for those groups was being gradually developed and expanded. Thailand had several homes for the aged, under the Ministry of the Interior; training programmes on care of the elderly had been organized for health personnel at all levels; general hospitals were encouraged to set up geriatric units; and an association of the elderly provided health education and care services for old people on a voluntary but limited scale.

A systematic assessment of the health needs of the elderly had not yet been made but had been suggested as a collaborative activity with WHO. It would include: an epidemiological study of the health situation of the elderly; a strategy for the integration of their health care; the development of a mechanism for coordinating related activities in the public and private sectors; the strengthening of training programmes for health and related personnel in gerontology and geriatrics; the setting up of demonstration and training centres in community-based services for the elderly; and technical support to medical institutions to strengthen
their geriatric and gerontology programmes. Those steps envisaged care of the elderly as part of the strategy for the attainment of health for all. By maintaining the elderly population as an integral and respected part of society, Thailand would conserve its cultural values and meet the challenges of health for all by the year 2000.

The country's developing services for the elderly were therefore based on the principles that the place for the elderly was in their own home, in their community, and not in an institution; that support for the elderly must come from the community to which they belonged; and that general health support and referral services must be made available. As part of its preparatory activity for the World Assembly, his Government proposed to convene a national inter-agency and interdisciplinary seminar on health care for the elderly during the second half of 1981.

Mr CHIBUTUTU (Nigeria) said that his country's preparations for the World Assembly were a spin-off from an earlier initiative designed to evolve a social welfare policy and services for the aging. In February 1980, a national seminar on aging had brought together representatives of the relevant ministries, voluntary organizations and certain United Nations agencies. A research study on the situation and care of the elderly had been commissioned in 1980 and it was hoped that its findings would contribute to the development of a national policy. Nigeria had participated in a number of international meetings on the problems of aging, including the Preparatory Conference in Mexico City, and had hosted the regional technical workshop held in Lagos in February 1981 under the sponsorship of the United Nations. His Government supported all the recommendations contained in the draft report of that workshop and in the report of the Preparatory Conference. It was also in the process of setting up a national committee for the World Assembly comprising representatives of the relevant federal ministries as well as voluntary and religious organizations and United Nations agencies. It was hoped that the national committee would provide the nucleus of a national association of the aging in Nigeria.

Mr VOHRA (India) said that, apart from the institutional framework required for the care of those who had to be placed outside their own families, the main problem - in particular in the developing countries - was in the area of primary health care and concerned the social and economic levels of the community in which an aged person lived as well as its cultural traditions, which might be in process of fragmentation as a result of industrial and other pressures of modern life. That aspect would in time become increasingly important as part of the approach to the achievement of health for all.

Dr LITVINOV (Union of Soviet Socialist Republics) said that the rising percentage represented by the aging component of the population was a worldwide phenomenon; the holding of the World Assembly on Aging was therefore of great importance as it would contribute to the development of a comprehensive solution to the problem through the combined efforts of the organizations in the United Nations system and of nongovernmental and social organizations.

In the Soviet Union the medical and social aspects of the problem as well as the question of occupational adjustment of the aging were matters of continuing concern to the authorities. Medical care included an enhanced level of general prophylactic care for the elderly, and special training in geriatrics was provided for intermediate health workers. Consultative geriatric centres represented an important link in the system in as much as they worked closely with local social and community organizations. The number of homes for the aged continued to rise, as did pensions.

Research in gerontology and geriatrics was coordinated by the Institute of Gerontology of the Academy of Medical Sciences of the Soviet Union, which had carried out extensive epidemiological research on the needs of the elderly in medical and social care. In preparation for the World Assembly on Aging and in association with the United Nations Centre for Social Development and Humanitarian Affairs, a regional conference had brought together gerontologists from the socialist countries and had prepared a report on the position of the aged in Eastern Europe for presentation to the World Assembly.

Increasing longevity had led to changes in the pattern of morbidity and causes of death, including an increase in degenerative diseases, which must be taken into account in organizing the appropriate medical care and deciding the level required. Attention was also being given to extending the active life and working capacity of the elderly.

His delegation fully supported the preparations which WHO was making for the World Assembly and also the measures adopted by the Organization on ways and means of providing medical care for the elderly.
Professor HALEEM (Bangladesh) considered that, in accordance with the principles of "Health for all by the year 2000", coverage of the health needs of the entire population must include provision for the aging. It had not yet been possible for the developing countries to reach an adequate level of health with the result that life expectancy in those countries - 47 years - was much lower than in the developed countries. The latter were able to provide hospitals and other facilities for the aging population, whereas the developing countries, lacking adequate food, clothing and housing, could not contemplate establishing separate homes for the aged.

The Health Assembly must develop action at global level to meet the social and health security needs of the aging. He appealed to the developed countries to devote a part of the enormous expenditure currently being lavished on space research and armaments to developing the highest possible level of health for aging people throughout the world.

Dr HAVRILIUC (Romania) said that in Romania health care for the aged was a State responsibility as part of the national health protection programme that was elaborated and coordinated at governmental level by the Ministry of Health and territorially by district health boards. To deal with the specific organization of medical care for the elderly, active or retired, the Ministry of Health had established the National Institute of Geriatric Research. Its activities covered the main gerontological fields, including biology of the aging, and clinical and social gerontology. On the basis of epidemiological studies of the health status of the aging population, gerontological prophylactic measures had been developed to preserve the working capacity of active elderly people and to prevent the phenomenon of premature aging. Priority was being given to such medico-social questions as: the aging of the population and its impact on changes in the pattern of morbidity and mortality; the impact of the social environment on health status and on the biological aging process; and the functioning of institutions supplying medical and social assistance to the aging, including homes for the aged and nursing-homes for the chronically sick. Research undertaken by the Institute had promoted measures to maintain the health status of the aging and to eliminate the risk factor in disease and pathological aging. On the initiative of the Ministry of Health, studies on morbidity had been undertaken on a representative group of the elderly population. Through such studies Romania had participated in the research programme of WHO. It had also hosted a number of internationally sponsored meetings covering the entire field of gerontology.

Dr JIMÉNEZ DE BETHANCOURT (Panama), welcoming the preparations for the World Assembly on Aging, expressed support for the concept that the aged were the responsibility both of governments and of families. It was not a solution for them to be thrown into heartless institutions: the family must keep in touch with the aged since only that could ensure the necessary element of human warmth in their lives. The Health Assembly should plan its strategy around the concept of such human warmth. Although the community must participate in the care of the aged, it was essential that the family should be involved.

Mr BENAVIDES (Peru) welcomed the organizing of a World Assembly on Aging. The problems of older persons, like those of young children, were universal, involving in each case a human group of major importance in both quantitative and qualitative terms. It was to be hoped that the World Assembly would institute a new approach to the problems of aging, and he welcomed the contribution made by WHO in that connexion.

Mr HOYOS-SOSA (Venezuela) said that his country, despite a high proportion of young people, was increasingly interested in geriatric and gerontological developments. A far-reaching programme in that connexion was currently being implemented by the National Institute of Gerontology, the Venezuelan Institute of Social Security, and the Venezuelan Society of Geriatrics and Gerontology. His delegation therefore welcomed and supported the objectives of the World Assembly. It was important that members of the community should be educated from their earliest years to understand what was meant by the so-called "third age". Geriatrics and gerontology constituted a relatively new branch of medicine, and legal, social, economic and collective psychological changes would be required if the process of aging was to be accomplished in healthy and happy conditions.

Dr RIDINGS (representative of the Executive Board), replying to comments by delegates, said that the Executive Board would be delighted at the general approval given by the Committee to collaborative efforts in the field of aging and at the progress achieved in a number of Member States.
A number of delegates had said that support for aging people must begin in the community and within the family circle. He had noted with interest the comment of the delegate of Denmark to the effect that, in the industrial countries, where the people getting older had been used to a higher standard of living, there must by the year 2000 be planning for a different type of older person.

The delegate of India had stressed that the crux of the problem lay in the community and that measures for the aged rightly belonged in the area of primary health care. The report of the Preparatory Conference in Mexico City stressed that point, under item 3.2.2.

The delegate of Panama had emphasized that there must be family as well as governmental concern for aging people. The solution was for concerned and loving people to show the warmth needed to retain aging persons as part of the community and within the family.

Dr KAPRIO (Regional Director for Europe), referring to terms designating advancing age, said that it was necessary in the context of different countries and different languages to find proper terms for expressing respect and love for the older section of the population. The industrialized countries were learning in their contacts with societies in other parts of the world that the elderly still had a respected and important role in the family and the community.

International Year of Disabled Persons, 1981: WHO's cooperative activities within the United Nations system for disability prevention and rehabilitation: Item 42.3 of the Agenda (Document EB67/1981/REC/1, decision EB67(12) and Annex 14)

Dr RIDINGS (representative of the Executive Board) said, in connexion with the International Year for Disabled Persons, the Board had particularly noted the coordinated efforts by WHO headquarters, regional offices, and other organizations in the United Nations system. It had emphasized the role of WHO in studying the prevalence of disability and the need to give priority to preventing disability through better nutrition, improved maternal and child care, control of communicable diseases, sanitation and safe water, and promotion of mental health. It had also emphasized the need for research to identify predictors and precursors of disabilities in general, and causes of brain damage in particular. The effects of toxic chemicals should be investigated, and studies of attitudes towards disability should be made in order to enhance understanding and facilitate appropriate action.

In the rehabilitation of the disabled, sophisticated technologies were beyond the means of most governments and the methods adopted by countries must be in accordance with the means at their disposal. Simpler approaches - social rather than technological - were needed, based on the primary health care approach and community-level action. In addition, adequate support and guidance should be provided for families and friends of the disabled.

The International Year of Disabled Persons was an important year that should be seen as the beginning of a better life for disabled people throughout the world. It should lead to a continuous follow-up process involving the staff of ministries of social affairs and education as well as health workers. Efforts should focus on integration of disability prevention and rehabilitation into existing national health services at all levels, and on the appropriate research. In decision EB67(12), the Executive Board had requested the Director-General to pursue activities already being undertaken and continue to collaborate closely with the Secretariat of the International Year in order to ensure its success.

Dr KROL (Strengthening of Health Services), referring to examples of new developments that had taken place since the preparation of the Director-General's report, said that the WHO Expert Committee on Disability Prevention and Rehabilitation had met in February, with the participation of representatives of all the major United Nations agencies. Participants had fully endorsed WHO's strategies in the field of disability prevention and rehabilitation as part of the effort to achieve the goal of health for all by the year 2000 and had provided guidelines and recommendations for integrating disability prevention and rehabilitation into existing national health systems at all levels, particularly in the context of primary health care. The UNICEF/WHO Joint Committee on Health Policy had prepared an outline for a joint programme on childhood disabilities that emphasized concrete activities at country level, including training, testing and evaluation of new approaches, and research to promote programme development.

Concerning public information, the Director-General of WHO and the Executive Director of UNICEF had issued a joint statement on the International Year in January 1981. The January edition of World Health had been devoted to the International Year and material for it had been
Training the Disabled in the Community, had received the support of other United Nations agencies, UNICEF in particular.

All regional offices were contributing to the activities of the United Nations regional economic and social commissions and were providing background and technical material on which to base decisions relating to plans of action in the regions. Both headquarters and regional offices were cooperating with countries in formulating national policies and programmes not only for the International Year but also for long-term programmes for disability prevention.

Dr SEBINA (Botswana) said that the general theme of full participation by the disabled was very important because, with assistance, disabled persons could become an asset to society, be fully integrated into the community, and engage in agricultural and industrial activities. He was pleased to note that the Director-General's report highlighted the role of the nongovernmental organizations, since such organizations had been pioneers in work related to the disabled and their rehabilitation, particularly in the developing countries.

He noted the cooperation between WHO and other United Nations agencies in the context of primary health care and of community participation, which involved both the disabled themselves and their families. Such an approach represented a departure from the previous system, which tended to keep the disabled in institutions. However, the approach could only be effective if carried out in accordance with the guidelines set out in the manual to which Dr Krol had referred; these emphasized the need for simpler, appropriate technology using local materials and equipment that could be easily maintained locally.

He shared the view of the representative of the Executive Board that the International Year should be regarded as a first step in tackling the problems of the disabled through intersectoral cooperation. Research into those problems was an important element as was also the role of WHO in the prevention and control of communicable diseases.

In conclusion, he stressed the need for countries to receive the full support of regional offices in their programmes for the disabled.

Dr FERNANDES (Angola) drew attention to the increasing numbers of disabled persons throughout the world in general and in Africa in particular. Although the main causes of disability were natural, one type of disablement that tended to be neglected was that inflicted as a result of war or armed aggression. Nor was that type of disability only physical: the trauma sustained by children and young people subjected to war situations must also be taken into account. In that context therefore, his delegation, in collaboration with a number of other delegations was proposing a draft resolution whose aim was the inclusion in existing programmes of persons disabled as a result of armed conflict.1

Ms LOWE (United States of America) said that, as a sponsor of the United Nations General Assembly resolution which had established 1981 as the International Year of Disabled Persons, her country had supported the Year from the beginning and was committed to expanding opportunities that would allow disabled persons in the United States to make a fuller contribution to their society. A high level interagency committee was coordinating federal efforts to ensure that disabled persons had the same access as other citizens to such services as health care, education, housing, and transport. The United States Council for the International Year, a private body, was promoting partnership between the Government and the private sector at the federal, state and community levels. In addition, action programmes were being instituted by federal agencies to integrate disabled persons into community life; they dealt in particular with prevention and rehabilitation, demonstration projects and programmes, research, and public information.

The Director-General's report was particularly noteworthy for its emphasis on prevention of disability; on practical community-based services; on cooperation with other United Nations agencies, especially the UNICEF/WHO joint programme on childhood disabilities; and on public information endeavours to focus attention on the needs of disabled persons and the contribution they could make.

Existing rehabilitation services tended to emphasize sophisticated technologies, so that an extension of the current pattern of services was not likely to meet the needs of most

1 See summary record of the thirteenth meeting, section 3.
countries, particularly in the developing world. Her delegation therefore endorsed the approach outlined by UNICEF and WHO in document JC23/UNICEF-WHO/81.6.

The International Year of Disabled Persons should be seen as a beginning that provided an opportunity to strengthen programmes for the prevention and rehabilitation of disabilities in all countries as a regular part of WHO programmes.

Mr NYGREN (Sweden), speaking on behalf of the five Nordic delegations, expressed full support for WHO's activities in connexion with the International Year of Disabled Persons, a year that constituted a long overdue recognition of the fact that there were a vast number of disabled persons in the world whose full and equal participation in society must be ensured. He was particularly pleased that the three components of the definition established by WHO - impairment, disability and handicap - had been adopted by the international community as a whole. The third component, handicap, was essentially a society-centred rather than an individual-centred problem.

A variety of measures were called for if the objective of full and equal participation in social life by disabled persons was to be attained. As a minimum, he strongly urged the amelioration of physical facilities (e.g., doors, lifts, stairs, etc.) in all buildings of the United Nations system to ensure that no practical barriers of that kind prevented participation by disabled persons in the work of the United Nations.

He was convinced that a productive approach to improving the situation of disabled persons was dependent upon collaboration between the State and the organizations grouping the disabled themselves. In addition, the strong emphasis on the prevention of disablement should never overshadow the fact that some 450 million people were in need of rehabilitation.

Lastly, he emphasized that a great deal could be achieved without access to high-level technology or extensive financial resources. It was possible to develop techniques and aids using readily available local resources; in that connexion he referred to the work currently being carried out by WHO. The development of adequate techniques was of great importance and should be seen in the context of primary health care and of appropriate technology, particularly adapted to the facilities available in remote areas, in both the developing and the industrialized countries.

Mrs LUETTGEN (Cuba) said that, to mark the International Year of Disabled Persons, Cuba had set up a national committee to study the recommendations of the WHO Executive Board with a view to their application in that country. Because of the vast social, cultural and political implications, responsibility for the disabled population was incumbent upon the entire community. A multidisciplinary effort must be made to promote disability prevention and rehabilitation and to ensure the full integration into community life of persons suffering from sensory, motor or mental disorders. Cuba, which had embarked upon a large-scale poliomyelitis vaccination campaign as part of its free medical service, was fully aware of the importance of taking the appropriate steps, at every stage of a person's development, to prevent those causes of disability which it was possible to combat with modern scientific and technological means. Unfortunately, rehabilitation was so costly that many of those who required treatment had no access to it. The publication of teaching material designed not only for the disabled but for the members of their families and the community at large was a particularly useful initiative, as was the organization of regional and international seminars and workshops on the subject.

Her delegation believed that activities such as those carried out in connexion with the International Year of Disabled Persons should not be limited to a single year but should be established on a permanent basis, so that the general public could be educated in the concept of solidarity, as opposed to charity, and come to appreciate that the well-being of disabled persons was everybody's responsibility.

Professor HALEEM (Bangladesh) feared that, once the International Year of Disabled Persons was over, the subject would quickly be forgotten. The issue was whether people were really determined to tackle the problem globally and to practice what they preached. In a sense the term "disabled" could be applied to all those in the developing world who were homeless or suffering from malnutrition.

Emphasis must be placed first and foremost on preventive measures. He urged the leaders of States throughout the world to meet in an effort to find appropriate solutions; that was the only way of ensuring that activities such as those embarked upon by WHO were effective
and were not abandoned as soon as the International Year had ended. Health for all by the year 2000 was an objective for each State to attain, but no significant achievement was possible unless each individual was properly motivated. Equal development, the promotion of health, and the control of disease were the basic principles of WHO and required the combined efforts of all countries, large or small, developed or underdeveloped, under the strong leadership of WHO. If States really believed in the principles embodied in the Organization's Constitution, they had no alternative but to take their responsibilities seriously by tackling, first, the problems facing them at national level and then moving on to the regional plane whence they could eventually set out to attain the global objective of health for all. It was for WHO to devise a standardized programme that could be implemented by every country.

Mr VERGNE SABOIA (Brazil) said that, in accordance with United Nations General Assembly resolution 31/123, the Brazilian Government had established a national committee for coordinating activities and programmes in that field. Projects mainly directed at the prevention of physical and mental disabilities through early diagnosis and treatment were being prepared at federal, state and local level for implementation over the next 10 years. Educational measures were being introduced to promote a general awareness in the public of the problems of the disabled and of their right to full and equal participation and integration in community life. Safety norms were also being devised with a view to preventing physical and mental disability and facilitating rehabilitation. Brazil greatly appreciated the activities which WHO was undertaking to ensure the success of the International Year.

Dr IBRAHIM (Egypt) said that the problem of disability was a challenge to society as a whole and must be tackled courageously so that handicapped persons could live a fruitful life, using their energy and potential to the maximum. The slogan "Health for all by the year 2000" presupposed that even disabled persons were entitled to health. It was impossible to ignore them or their need to adapt to society. That task involved not only professional educators and therapists but the community as a whole. Rehabilitation called for vast financial and material investment and posed a particularly serious problem for developing countries with limited resources. Even where rehabilitation centres existed, they were not always able to provide care and attention for all the disabled persons who required them. Her delegation agreed with the Director-General's conclusion that developing countries needed a great deal of assistance from international organizations.

With regard to the integration of rehabilitation services in the primary health care network, emphasis must be placed on the prevention of as many causes of infirmity as possible and on health education as a means of avoiding many forms of disability. Early diagnosis, too, was a valuable safeguard against the development of physical and mental handicaps. Egypt had already gone beyond its original goals and no longer depended on paramedical staff for primary health care, which was extensively provided by Government health services throughout the country. Given the great variety of disabilities, however, there was still a need for better equipped specialized rehabilitation centres. Highly specialized medical surveillance was also necessary for the blind and the deaf and in the treatment of ambulatory problems in children.

WHO had an important part to play, particularly in the provision of back-up facilities for rehabilitation centres. Technical cooperation, seminars and regional workshops could all serve to assist countries in formulating policies and strategies for the prevention of disability. Epidemiological studies must also be carried out so as to provide reliable information as to the real extent of the problem as a basis for setting up rehabilitation services on an international scale. Research was required on the medical, social, psychological and other factors that might affect the situation of disabled persons.

A major programme for the rehabilitation of the handicapped had been under way in Egypt for several years already, involving both State and private organizations. There was still considerable scope for improvement, however, and it was hoped that the necessary help would be forthcoming from the international organizations.

Dr VARGAS (Nicaragua) said that the right to work and to integration in the life of the community was a fundamental right of disabled persons. Unfortunately, rehabilitation services were often based on sophisticated technology that benefited only a small proportion of the disabled population. Preventive action, in the form of an intersectoral and multidisciplinary approach to primary health care, was therefore more appropriate.
Primary health care in Nicaragua was an integral part of the country's health scheme, which was designed first and foremost to provide medical assistance as close as possible to a person's place of residence or work; care for the disabled involved the combined efforts of auxiliary personnel, members of the family, community organizations, and the disabled persons themselves. In conclusion, he observed that no disability research programme had been formulated for any Latin American country. He hoped that that state of affairs would soon be remedied.

Dr XU Shouren (China) said that the Chinese Government gave its full support to the work carried out by WHO in the field of disability prevention and rehabilitation, and planned to participate actively in the International Year of Disabled Persons. A national committee had been set up to coordinate activities connected with the International Year. A conference had recently been held on the subject and the mass media had been encouraged to promote public awareness of the problems involved; information on prevention and rehabilitation and the care to be afforded to disabled persons had been widely disseminated. Specialized meetings had also been organized by the Ministry of Health to consider means of improving prevention and rehabilitation measures; for example, consultative centres had been set up for training in hygiene and prenatal care. All health personnel were being mobilized to improve the living and working conditions of disabled persons, an aspect that was of particular concern to the Government.

The Chinese delegation hoped that WHO would take steps to make available to all Member States the extensive experience that certain countries had acquired in disability prevention and rehabilitation, and that countries encountering difficulties would receive appropriate assistance in terms of manpower, financial support, and equipment.

Dr FERREIRA (Mozambique) said that her Government had set up a national committee for the International Year of Disabled Persons, which had drawn up a long-term programme in the light of national requirements and WHO guidelines. Priority was given to prevention and information, the aim being the integration of the disabled in the family and in society. WHO documentation on the subject had been found most useful. Mozambique's programme for the disabled devoted particular attention to three causes of disability: endemic communicable diseases; occupational injuries and road accidents; and the war of liberation and armed aggression by South Africa. The entire population, whether disabled or not, was encouraged to participate in the collective struggle to transform the country's society and to develop its natural resources for the benefit of the community.

Mr CHIBUTUTU (Nigeria) said that Nigeria had established a 47-member national committee for the International Year of Disabled Persons. In order to attain the objectives of the Year, as reflected in the theme of full participation and equality, the national plan included a survey of disabled persons, the promotion of disability prevention, and the provision of community-based rehabilitation services. The creation of a Commission and Trust Fund for the Disabled had been proposed, together with comprehensive legislation to govern the provision of services for the disabled. It was also planned to hold a regional seminar in Nigeria in November 1981. WHO and other United Nations agencies were actively cooperating in Nigeria's short-term and long-term programmes, as a result of which it was hoped to be able to fulfil many of the aspirations of the country's disabled population.

Mr ARSLAN (Mongolia) said that, although disabled persons did not account for a very large proportion of the population of Mongolia, the Government had shown great concern for them. A special school had been set up for the mentally retarded and for deaf and dumb children, where studies up to secondary level were combined with practical activities. Persons whose disability prevented them from pursuing their earlier career were retrained so that they could continue to be active in the labour market. In 1978 an association of deaf and dumb persons had been created with a view to increasing their participation in community life.

To mark the International Year, a national committee had been set up to coordinate activities, which included various comprehensive programmes to provide medical, welfare and social services for the disabled, increase their pensions, and promote their participation in cooperatives. Standards were being introduced to permit factories and social institutes to hire disabled persons, and laboratories were developing equipment to enable them to overcome their disabilities. Particular attention was paid to research into the root causes of disability and occupational diseases.
In conclusion, he joined with those delegates who had emphasized that a large proportion of disabilities were caused by war and armed aggression. Disability prevention and rehabilitation therefore were not isolated issues, but were closely bound up with other aspects of health for all. WHO was to be complimented on the work it had undertaken, and it was to be hoped that all countries would be able to benefit from the measures it had introduced.

Dr ALUOCH (Kenya) said that, in line with WHO activities for disability prevention and rehabilitation, Kenya had already taken practical measures for the welfare of disabled following the designation of 1980 as National Year for the Disabled, a successful national fund-raising meeting had been held in Nairobi (October 1980) and had produced almost US$ 3 million. A survey had been undertaken by the Kenya Bureau of Statistics to determine the number of disabled persons being treated in the country's specialized institutions, and particularly of those suffering from major disabilities. Another survey was being carried out into the number of disabled persons outside such institutions. The information collected would help the Government in its future plans for the disabled. A national committee had now been formed and several major projects on behalf of disabled persons were already under way.

Dr AMATHILA (Namibia) said that the number of war victims among the South West Africa People's Organization (SWAPO) was increasing daily as the war for national liberation intensified. They included not only men on active military service but also women and children maimed in the course of indiscriminate bombing of refugee camps. SWAPO planned to set up a rehabilitation centre for war victims that would care for both the physically and the mentally handicapped and would provide occupational retraining services. The most serious problem faced was blindness brought on by the gases and other modern weapons employed by the enemy.

In view of SWAPO's lack of experience, she appealed to all Member States to provide facilities for training rehabilitation workers. On behalf of SWAPO she thanked the socialists who had come to the aid of the maimed refugees from the 1978 Kasinga massacre in Angola, and looked forward to receiving the expert assistance which ILO had promised to provide for its rehabilitation centre.

Dr RODRÍGUEZ (Argentina) said that a large treatment and rehabilitation centre had been operating for several years in Buenos Aires and that Argentina felt it could provide useful assistance to other countries, particularly in Latin America. It possessed a training school run by the Medical School of Buenos Aires and a number of protected workshops where disabled persons were able to work and lead a normal social life.

Dr JIMÉNEZ DE BETHANCOURT (Panama) said that her Government had followed closely activities carried out by WHO within the framework of the International Year of Disabled Persons. However, the problem of disablement was so vast that it could not possibly be resolved in one year. A comprehensive intersectoral approach was needed encompassing prenatal care, health education, accident prevention, social security and better working conditions. Rehabilitation, however, raised the problem of the possible unemployment of disabled persons.

The Panamanian Government urged WHO and all Member States to work together to ensure that the children born today did not become the disabled persons of tomorrow.

Dr MORKAS (Iraq) said that many specialized rehabilitation centres had been set up in Iraq so that disabled persons could become productive members of society and be afforded suitable job opportunities. Specialized institutes had been set up in various regions and a great deal of thought had gone into measures to provide primary and secondary health care, in addition to the more advanced forms of rehabilitation. The approach to rehabilitation was multisectoral and involved many organizations, ministries and the community.

Dr FERGANI (Oman) noted that speakers had emphasized the importance of prevention, rehabilitation, treatment, early detection, and diagnosis, but there were two other points that were particularly important: the scientific planning of medical care, and the long- and short-term provision of supplies. He had visited several countries and had found that most health care programmes covered only a small proportion of the population. In the programmes for disabled persons, the main emphasis was on the provision of centres for physical disabilities, but these did not cover the whole area of need. Research and evaluation were also very important; the services provided for rehabilitation should be evaluated on the basis of two
factors - adequacy and effectiveness. The object should be to enable disabled persons to be reintegrated into the community.

He appealed to the Organization to support programmes along the lines he had outlined and to follow their progress closely, at both national and regional level, so that periodic reviews could be made.

(For continuation, see summary record of the thirteenth meeting, section 3.)

The meeting rose at 18h20.
THIRTEENTH MEETING

Wednesday, 20 May 1981, at 8h30

Chairman: Dr A. HASSOUN (Iraq)

1. FOURTH REPORT OF COMMITTEE B (Document A34/40)

The CHAIRMAN read out the fourth report of Committee B (document A34/40).

The report was adopted (see document WHA34/1981/REC/2).

2. PERIODICITY AND DURATION OF HEALTH ASSEMBLIES: Item 36 of the Agenda (Resolution WHA33.19; Document EB67/1981/REC/1, decision EB67(6) and Annex 13; Document EB67/1981/2, pages 284-295) (continued from the tenth meeting, section 1)

The CHAIRMAN invited the Committee to consider the draft resolution prepared by the Rapporteur, which read:

The Thirty-fourth World Health Assembly,
Having considered the reports and recommendations of the Executive Board and the Director-General on the periodicity and duration of Health Assemblies;
Recalling resolution WHA33.19, which expressed the belief that Health Assemblies in even-numbered years should be limited to not more than two weeks' duration;

1. DECIDES that the duration of the Health Assembly shall be limited to not more than two weeks in even-numbered years, when there is not a proposed programme budget to consider;

2. REQUESTS the Executive Board, after consideration of proposals to be submitted by the Director-General, to consider how this objective may best be achieved, and to submit specific proposals to the Thirty-fifth World Health Assembly for experimental introduction or adoption on a permanent basis as the Health Assembly may decide.

Mr GILBERT (United Kingdom of Great Britain and Northern Ireland) pointed out that there would be no consideration of the programme budget in 1982. His delegation therefore urged the Director-General and the Executive Board, in the meantime, to bring forward proposals for shortening the duration of the Health Assembly experimentally, since no progress would otherwise be made on the matter until the next even-numbered year, namely, 1984.

He proposed that, in operative paragraph 1 of the draft resolution, the words "commencing in 1982" should be inserted after the words "DECIDES that"; and that, in operative paragraph 2, the words "to consider how this objective may best be achieved" should be replaced by the word "to determine how this objective may best be achieved", the remainder of the paragraph thereafter being deleted. That wording would give the Director-General and the Executive Board a measure of flexibility.

Dr GALAHOV (Union of Soviet Socialist Republics) observed that the substance of operative paragraph 1 of the draft resolution was already present in operative paragraph 6 of resolution WHA33.19. He could see no reason for again including it in a resolution.

Adoption of the draft resolution as it stood, and even more if it were amended as proposed by the United Kingdom delegate, would restrict the Executive Board unduly. The Board should be allowed greater initiative.

If the Board could formulate an agenda for a two-week Health Assembly, or if it could curtail the Health Assembly by even a day or two, well and good. He recalled, however, that
participants in the last two Health Assemblies had been required to work up to 10 hours a day and to attend night meetings. Such working methods were not conducive to the health of delegates or to the credit of the Organization.

His delegation supported the idea of limiting the duration of the Health Assembly and improving the effectiveness of its work. Nevertheless he proposed that operative paragraph 1 of the draft resolution should be deleted; and that in the present operative paragraph 2 the words "this objective" should be replaced by: "the objective to limit the duration of the Health Assembly".

Dr Cissé (Niger) proposed that there should be a single operative paragraph, reading:

"REQUESTS the Executive Board, after consideration of proposals to be submitted by the Director-General, to consider and formulate specific proposals for the experimental application of this procedure by the Thirty-fifth World Health Assembly which, on its conclusion, would decide on its adoption or rejection".

The intention of his amendment was to ensure that there was some deadline for introducing the proposed procedure on an experimental basis.

Dr Booth (Australia) observed that, with four different versions of the draft resolution now before the Committee, the situation was becoming confused. The proposals of the delegations of Niger and the United Kingdom were designed to introduce the limitation of two weeks as soon as possible. The Australian delegation was also anxious that the Health Assembly's work should be speeded up. There were many possible ways of doing this, but unless specific proposals were made to the Board, and unless the Board was obliged to concentrate on these proposals, there would be nothing but procrastination and waste of time whenever the item came up for discussion by the Health Assembly. He supported the United Kingdom delegation's proposal that, commencing in 1982, the duration of the Health Assembly should be limited; that would certainly crystallize the Board's thoughts on the agenda for that year. He could see some merit in the proposal by the delegate of Niger. The Soviet Union delegate's proposal would mean further discussion and procrastination.

It might be necessary to establish a drafting committee to reach a conclusion on the issue and draft a clear resolution. His delegation was unable to support the draft resolution as it stood.

Dr Broyelle (France) said that it was important to retain operative paragraph 1 of the draft resolution, which clearly indicated a decision to limit the duration of the Health Assembly every second year to two weeks. Unlike the delegate of the Soviet Union, she did not consider that to do so would duplicate the Health Assembly's previous decision. The text of resolution WHA33.19 was less mandatory, and the word "devrait" in the French text expressed a certain doubt, as was proved by the fact that the resolution had not been implemented. It was therefore necessary to state in so many words that the duration in even-numbered years should be limited to two weeks. In the text before the Committee, no deadline had been established, whereas it was important to establish such a deadline. Her delegation was in favour of the United Kingdom proposal for the insertion of the words "commencing in 1982" after the words "DECIDES that".

With respect to operative paragraph 2, it had been suggested that there should be some experimentation, but, in her delegation's view, that should not be allowed to affect the duration of the Health Assembly. What should be subject to experimentation were the methods to be used in achieving that end, which should be worked out by the Executive Board. She was not opposed to the retention of operative paragraph 2 on the understanding that it related only to experimentation with methods. She was however unable to support the USSR proposal for making operative paragraph 2 more flexible, since such flexibility clearly related to duration, and her delegation was against any change in that respect.

The Chairman suggested that a working group, composed of the delegations of Australia, France, Niger, the Soviet Union, the United Kingdom and any other delegations that so wished, should meet in order to draft an agreed text.

It was so agreed.

Mr Gilbert (United Kingdom of Great Britain and Northern Ireland) reminded the Committee that operative paragraph 6 of resolution WHA33.19 read:
"BELIEVES that, as soon as possible, in the meantime Health Assemblies in the even years (when there is not a full programme budget to consider) should be limited to not more than two weeks' duration."

His suggestion was that the draft resolution under discussion should reflect that belief, but using the words "DECADES that, commencing in 1982, ...". He welcomed the support given to his proposal by the delegations of France and Australia.

Because of the economic recession, there were severe pressures on the budgets of many countries throughout the world, and international organizations were not immune to such pressures. Even large organizations could make economies in their working methods if delegates gave them the opportunity rigorously to reappraise their programmes.

Lastly, he suggested that the Director-General and the Executive Board should be given the discretion to look into the matter urgently. The basis of the social contract referred to by the Director-General was that they should be trusted and given the necessary discretion and flexibility to adapt their processes to more efficient working methods. His delegation's amendments therefore deserved to be adopted. It would, however, be glad to take part in the working group.

Dr STOKE (New Zealand) said that his delegation supported the United Kingdom proposals in principle and would like to be associated with the working group.

Dr GALAHOV (Union of Soviet Socialist Republics) said that he was prepared to join the working group. Time was short and it would be preferable to settle the matter at the present stage. His delegation would not object to the indication of a deadline, as advocated by the delegations of the United Kingdom, France and Australia, but it considered that operative paragraph 1 could be dispensed with. The proposal by the delegate of Niger was well founded. Referring as it did to the Thirty-fifth World Health Assembly as a deadline, that proposal should be acceptable to all delegations.

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

3. COLLABORATION WITH THE UNITED NATIONS SYSTEM: Item 42 of the Agenda (continued)

International Year of Disabled Persons, 1981: WHO's cooperative activities within the United Nations system for disability prevention and rehabilitation: Item 42, 3 of the Agenda (Document EB67/1981/REC/I, decision EB67(12) and Annex 14) (continued from the twelfth meeting, section 2)

Mrs SUMNER (Sierra Leone) thanked the Director-General and the Executive Board for the useful work WHO was doing for disabled persons. The disabled had hitherto been neglected and ignored as far as full participation and equality in the community were concerned. Her country fully realized and accepted the urgency of the need for prevention of disability and rehabilitation, and attention was being focused on that important issue at national level. The Sierra Leone delegation therefore fully supported WHO's activities in favour of disabled persons, particularly in developing countries. She looked forward to seeing greater efforts to provide international assistance for the prevention of disability and rehabilitation of the disabled.

Dr BOOTH (Australia) said that his country appreciated the initiatives taken by WHO for the International Year of Disabled Persons, and he wished to echo the remarks made by other delegates concerning the catalytic effect of such initiatives in drawing to the attention of governments and communities at large the special problems faced by the disabled.

His delegation shared the resolve to carry into the years ahead the stimulus provided not only in the field of rehabilitation but also in that of disability prevention. It wished to encourage the Director-General to continue WHO's close collaboration with the Secretariat of the International Year of the Disabled.

Dr RIDINGS (representative of the Executive Board) said that the statements made by delegates, particularly with regard to activities within their countries, had shown that the WHO initiative was having an effect in Member States. That was the aim of the whole programme of the International Year of Disabled Persons. He was convinced that the Executive Board would be gratified at the reception of WHO's action.
Dr KROL (Strengthening of Health Services) said that the Secretariat had taken careful note of the opinions and concerns expressed by the delegates. The valuable information and suggestions they provided would be fully taken into consideration in the further development of programme activities.

The delegate of Egypt had emphasized the role of specialized institutions in rehabilitation of the disabled. He himself was convinced that there was a place for the specialized services in community-based programmes, namely, the very important role of supporting community activities and, even more, of initiating them where they did not exist.

The delegate of Sweden had shown great realism in emphasizing that, although prevention of disability was a top level priority, the International Year was primarily concerned with the 450 million persons who were already disabled. WHO's programme of community-based disability prevention and rehabilitation, within the context of primary health care, was really bringing hope to the disabled, especially the under-served groups in developing countries. It was a challenge to all delegates at the Health Assembly.

He thanked countries for their involvement and commitment to the support of disability prevention and rehabilitation and of WHO activities in that field, mentioning particularly Botswana, India and Nigeria - countries with which WHO was fruitfully cooperating in the development of a community-based approach.

The DIRECTOR-GENERAL recalled that the Health Assembly had always been very conservative when it came to global conferences or international years, except in cases where it was absolutely sure that there would be a proper follow-up. If the effort was only symbolic it was not worth very much. His plea to Member States was that the programme should not become an episodic affair, of interest only during the International Year, but that it should be followed up after 1981. He suggested that WHO should be charged with monitoring what was done over the next two years; and should report back to the Health Assembly in 1983, when it reviewed this programme in the proposed programme budget for 1984-1985, on whether the Year had really had a cumulative gross impact in increasing efforts for the disabled throughout the world. He stressed that only with the cooperation of Member States could it be seen whether real progress was being made.

The CHAIRMAN drew attention to the draft resolution sponsored by the delegations of Algeria, Angola, Botswana, Congo, Cuba, and the German Democratic Republic, which read:

The Thirty-fourth World Health Assembly,
Recalling resolution 31/123 of the United Nations General Assembly proclaiming the year 1981 as "International Year of the Disabled Persons";
Recalling resolution WHA31.39 requesting the Director-General to contribute extensively to the success of the International Year;
Considering that the disabled, rather than being a load on society and nations, should benefit from the effort of prevention, treatment, readaptation and rehabilitation to enable them to effectively share in the normal activities of society;
Noting that, beside traffic and work accidents, wars and armed aggressions constitute a factor in the considerably increasing number of physically, psychotraumatically and mentally disabled persons;
Noting the efforts deployed by the Director-General in favour of the disabled;
1. CONGRATULATES the Director-General on his report and on the action already taken;
2. REQUESTS the Director-General to continue and to increase his efforts with a view to ensure success for the International Year of Disabled Persons;
3. DECIDES that WHO must continue to contribute with efficacity to permanent programmes in favour of the disabled;
4. DECIDES to accord a special attention to those persons disabled by wars and aggressions in the world;
5. DECIDES to give its support to the current programmes in countries, especially the developing countries, particularly within the framework of the cooperation existing between WHO and regional intergovernmental organizations.

Dr FERGANT (Oman) proposed the addition to operative paragraph 2 of the words: "as a beginning of a decade in favour of the disabled, and to report periodically to the Health Assembly on the increasing efforts of WHO and their consequences". In operative paragraph 3, after the word "disabled", he would also add: "and to contribute to the evaluation, especially as regards adequacy and effectiveness".
Mr BOYER (United States of America) was in agreement with the general sentiments expressed in the draft resolution but was concerned about its form and language. Traditionally, if action was required, a resolution would request the Director-General to carry it out. The correct form for operative paragraph 5 would therefore be similar to that of operative paragraph 2. The two paragraphs could in fact be combined to read:

"REQUESTS the Director-General:
(1) to continue and increase his efforts with a view to ensuring success for the International Year of Disabled Persons;
(2) to ensure that support . . ., etc. [Here the substance of paragraph 5 would be inserted]."

It seemed to him that operative paragraph 4, urging that special attention be given to persons disabled by wars and aggressions, was unnecessary. A distinction should not be made between the different causes of disablement. The concern should be for all disabled people, without special attention to any one group. Operative paragraph 4 should therefore be deleted.

The reference in operative paragraph 3 to "permanent programmes" seemed to have budgetary implications that might lead to difficulties. The paragraph should also be deleted, or the amendment proposed by the delegate of Oman could be substituted.

If there was support from the Committee for changes along these lines, a drafting group, or the Rapporteur, could be asked to revise the language of the resolution.

The DIRECTOR-GENERAL suggested that if a working group was formed it might wish to specify in drafting the resolution that WHO's support was to be given within the context of primary health care.

Mr VAN KESTEREN (Netherlands) noted that the delegate of Oman had proposed that the International Year of Disabled Persons should be extended to an International Decade. He drew the Committee's attention to the fact that the question of international years and decades had been discussed by the Economic and Social Council, and that there were guidelines for their establishment. WHO would wish to act in conformity with those guidelines, and he therefore had some hesitation about the proposal.

Dr MWAMBAZI (Zambia) said that the initiative of launching the International Year of the Disabled had stimulated an unprecedented national campaign in Zambia, specifically to reach disabled children. The campaign had revealed that the seriousness and magnitude of the problem had previously been underestimated. During the past year his Government, in conjunction with a number of charitable organizations and individuals, had resolved to set up rehabilitation services, including a rehabilitation centre costing US$ 3 800 000. It was in that spirit that his delegation was ready in principle to support the resolution.

Dr FERGANI (Oman), replying to the Netherlands delegate, said that the proposal for a Decade for Disabled Persons was not his own but had been made by a committee convened under the auspices of the United Nations in 1979 in conjunction with the International Year. An international year was in any case intended merely as the beginning of programming and activities.

Mr BOYER (United States of America) asked if the Director-General could clarify the matter. It seemed inappropriate in any resolution to mention a decade that had not been formally established by the Economic and Social Council.

The DIRECTOR-GENERAL said that there was a legitimate concern on the part of the Economic and Social Council at the proliferation of international years and decades. He suggested that "Health for all by the year 2000" would make an ideal framework for continuing assistance to the disabled on a permanent basis.

The CHAIRMAN suggested that the delegates of Oman, Netherlands, United States of America, Zambia, and any other interested delegations, should form a working group.

It was so agreed.

(For continuation, see summary record of the sixteenth meeting, section 3.)
Health assistance to refugees and displaced persons in Cyprus: Item 42.4 of the Agenda (Resolution WHA33.22; Document A34/19)

Dr TABA (Regional Director for the Eastern Mediterranean), introducing the item, said that the Director-General's report (document A34/19) had been submitted in compliance with resolution WHA33.22 of the previous Health Assembly. That resolution had requested the Director-General "to continue and intensify health assistance to refugees and displaced persons in Cyprus, in addition to any assistance made available within the framework of the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus, and to report to the Thirty-fourth World Health Assembly on such assistance."

The report thus covered the activities carried out jointly with UNHCR and the Coordinator of United Nations Humanitarian Assistance in Cyprus during 1980-1981. It also provided information on the sources of funds, which were mainly from WHO's regular budget and from UNHCR.

During 1980-1981 WHO had continued its technical collaboration with the health authorities in strengthening of health services, training of health manpower, and development of rehabilitation services. It also had an active programme in the prevention of communicable diseases, especially with regard to the risk of reintroduction of malaria into Cyprus, which had been free of the disease for over thirty years; so far that risk had been successfully averted. Total WHO assistance during the period had amounted to some US$ 362 000 and there was an allocation for 1982-1983 of $ 525 000. WHO had continued to collaborate with UNDP and UNHCR in strengthening some of the institutions in Cyprus, and especially in equipping the main hospitals.

UNHCR had allocated $ 400 000 for that purpose; UNDP had provided fellowships. In addition, a hospital funded by UNHCR was being constructed in Larnaka for the benefit of some 65 000 displaced persons as well as for the regular population of Larnaka. He confirmed that WHO would continue its collaboration with UNHCR and the health authorities of Cyprus.

Mr BORG (Malta) introduced a draft resolution sponsored by the delegations of Cuba, Ghana, India, Malta, Togo, United Republic of Tanzania, and Yugoslavia. Every Health Assembly for the past six years had adopted a resolution on this subject. The international community was very conscious of the health problems of refugees and displaced persons in Cyprus; and it appreciated the work of WHO and the Coordinator of United Nations Humanitarian Assistance in Cyprus in contributing in no small way to the alleviation and solution of those problems. His delegation wished to express its gratitude and hoped that the adoption by consensus of the draft resolution would enable those efforts to continue and increase.

The draft resolution read:

The Thirty-fourth World Health Assembly,
Mindful of the principle that the health of all peoples is fundamental to the attainment of peace and security;
Recalling resolutions WHA28.47, WHA29.44, WHA30.26, WHA31.25, WHA32.18 and WHA33.22;
Noting all relevant United Nations General Assembly and Security Council resolutions on Cyprus;
Considering that the continuing health problems of the refugees and displaced persons in Cyprus call for further assistance;
1. NOTES with satisfaction the information provided by the Director-General on health assistance to refugees and displaced persons in Cyprus;
2. EXPRESSES its appreciation for all the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus to obtain the funds necessary for the Organization’s action to meet the health needs of the population of Cyprus;
3. REQUESTS the Director-General to continue and intensify health assistance to refugees and displaced persons in Cyprus, in addition to any assistance made available within the framework of the efforts of the Coordinator of United Nations Humanitarian Assistance in Cyprus, and to report to the Thirty-fifth World Health Assembly on such assistance.

The draft resolution was approved.¹

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA34.20.
Mr VAKIS (Cyprus) said that, as was apparent from the Director-General's report and the statement of the Regional Director for the Eastern Mediterranean, the assistance made available by the Health Assembly had been effectively used for the benefit of all displaced persons and refugees in Cyprus, regardless of their place of residence or origin. Cyprus had thereby proved in practice its respect and gratitude to WHO and its Member States. In expressing his thanks, he reaffirmed his country's commitment to use whatever further assistance might be forthcoming in a similarly constructive way.

In spite of difficulties, Cyprus had not shrunk from international and regional responsibilities and commitments. Over the last two years it had extended its cooperation by setting up and running courses at various levels on the repair and maintenance of medical equipment. It had also hosted a number of seminars and other meetings organized by the Regional Office. It was hoped in the very near future to give further assistance to countries of the Region in the form of the newly established thalassaemia centre, which was now in operation with WHO's cooperation. Continuation of that cooperation was essential, in view of the considerable technical coordination entailed. He reiterated his thanks to the delegations who had supported the resolution, in particular the co-sponsors; to the Director-General, the Regional Director, and their staffs; and to all the international organizations and friendly governments that had helped Cyprus to achieve its health objectives.

Health and medical assistance to Lebanon: Item 42.5 of the Agenda (Resolution WHA33.23; Document A34/20)

Dr TABA (Regional Director for the Eastern Mediterranean) said that the Director-General's report on health and medical assistance to Lebanon (document A34/20) was submitted in compliance with resolution WHA33.23 of the Thirty-third World Health Assembly, which requested the Director-General:

"to continue and intensify the Organization's health and medical assistance to Lebanon, allocating for this purpose, and to the extent possible, funds from the regular budget and other financial resources, and to report to the Thirty-fourth World Health Assembly."

The report covered the activities of WHO, in collaboration with the health authorities and other United Nations agencies concerned, during the biennium 1980-1981. Section 2 dealt with assistance provided and the source of funds. Close technical collaboration had been maintained with the national authorities concerned (the Ministry of Health and the Council for Development and Reconstruction), with other agencies of the United Nations system (UNDP, UNICEF, UNHCR and others), and with the International Committee of the Red Cross. In addition, several nongovernmental organizations had participated in health-related programmes, with WHO coordinating activities. WHO's main area of assistance to Lebanon was, as in the case of Cyprus, the strengthening of health services and manpower training. A WHO programme coordinator in Lebanon coordinated all health and medical collaboration with the national authorities and the Ministry of Health. A number of consultants had been sent to the country. UNDP assistance had been received for two important technical activities, for which WHO was the executing agency: (1) the national waste management project for collection and disposal of wastewater and solid wastes, and (2) the strengthening of national public health laboratories. The UNDP budget for those programmes was some US$ 739 000 and $ 554 000 respectively. Under the regular WHO budget for the current biennium, the amount allocated for Lebanon was $ 512 915; and for the biennium 1982-1983, $ 1 045 800 had been foreseen. During the period 1976-1980, $ 2 840 500 from the United Nations Trust Fund for Assistance to Lebanon had been utilized by WHO for health-related projects.

Paragraph 2.6 of the report gave details of some of the activities and areas of expenditure. In addition to the regular budget allocation, savings had also been used as required especially during the recent outbreak of hostilities, when special allocations had been made for provision of vaccine, antibiotics, blood grouping sera, etc. He emphasized that WHO would continue the humanitarian operation in Lebanon in collaboration with the resident coordinator of the United Nations, and with UNHCR, UNDP, UNICEF, the International Committee of the Red Cross, and other organizations concerned.

Mr Kharma (Lebanon) said that the Director-General's report provided ample evidence of the health and medical assistance given to Lebanon during 1980-1981. He expressed his Government's gratitude to the Organization and its Director-General for that assistance, which was helping greatly to improve the health conditions of the population as a whole, and particularly of disadvantaged groups in the rural areas of Southern Lebanon.

It was in the spirit of the last paragraph of the Director-General's report that his delegation submitted the following draft resolution, which was intended to enable the
Director-General to continue and substantially intensify WHO's health and medical assistance to Lebanon:

The Thirty-fourth World Health Assembly,
Recalling its resolutions WHA29.40, WHA30.27, WHA31.26, WHA32.19 and WHA33.23 on health and medical assistance to Lebanon;
Taking note of General Assembly resolutions 33/146 of 20 December 1978, 34/135 of 14 December 1979 and 35/85 of 5 December 1980 on international assistance for the reconstruction and development of Lebanon, calling on the specialized agencies, organs and other bodies of the United Nations to intensify their efforts in this field;
Having examined the Director-General's report on the action taken by WHO, in cooperation with other international bodies, for emergency health and medical assistance to Lebanon in 1980-1981;
Taking note of the health and medical assistance provided by the Organization to Lebanon during 1980-1981;

1. EXPRESSES its appreciation to the Director-General for his efforts;

2. EXPRESSES also its appreciation to all the international agencies, organs and bodies of the United Nations and to all governmental and nongovernmental organizations for their cooperation with WHO in this regard;

3. CONSIDERS that the growing health and medical problems in Lebanon, which have attained lately a critical level, constitute a source of great concern and thereby necessitate a continuation and a substantial intensification of health and medical assistance to Lebanon;

4. REQUESTS the Director-General to continue and intensify substantially the Organization's health and medical assistance to Lebanon and to allocate for this purpose, and to the best extent possible, funds from the regular budget and other financial resources;

5. CALLS UPON the specialized agencies, organs and bodies of the United Nations and on all governmental and nongovernmental organizations, to intensify their cooperation with WHO in this field;

6. REQUESTS the Director-General to report to the Thirty-fifth World Health Assembly on the implementation of this resolution.

The resolution was co-sponsored by the following delegations: Argentina, Australia, Canada, Colombia, Cuba, Cyprus, Egypt, France, India, Iraq, Jordan, Kuwait, Libyan Arab Jamahiriya, Mauritania, Morocco, Nigeria, Norway, Pakistan, Saudi Arabia, Somalia, Syrian Arab Republic, Tunisia, United States of America, and Yemen.

All delegations were fully aware of the tragic situation which his country had been enduring for the past six years. Recent events had aggravated the situation and created health and medical problems of unprecedented magnitude. He would not dwell on the political aspects of that distressing situation, since he did not consider the Health Assembly the appropriate forum for such a debate. His country was one of those that were less well-equipped to face health problems of such magnitude and he hoped that the international community would continue and substantially increase its assistance. The adoption of the draft resolution would constitute a reassurance to Lebanon and other less well-equipped countries that they could rely on international cooperation and solidarity in emergency situations: while for WHO it would reaffirm the Organization's ability to meet a challenge and to fulfil its humanitarian vocation. He expressed the hope that the Committee would adopt the resolution by consensus.

Mr Van Kesteren (Netherlands) thanked the Secretariat for its report and the Organization for its efforts in connexion with assistance to Lebanon. His Government was seriously concerned about the victims of the violence and conflict in that country and had already given it considerable humanitarian aid, particularly through the International Committee of the Red Cross. It was currently considering additional relief aid to Lebanon. The Netherlands was playing an active part in efforts to preserve peace in Lebanon by providing troops for the United Nations Interim Force in Lebanon (UNIFIL). Participation in that Force had led to a greater awareness in the Netherlands of the humanitarian problems in Lebanon.

His delegation wished to become a co-sponsor of the draft resolution before the Committee.
Dr THOMSON (Australia) said that his delegation was happy to co-sponsor the draft resolution on health and medical assistance to Lebanon. The sad situation prevailing in Lebanon was well known and its human consequences were summed up in operative paragraph 3 of the draft resolution, which referred to "the growing health and medical problems in Lebanon, which have attained lately a critical level". His delegation hoped that the Committee would give unanimous support to the draft resolution, and that ways would be found to improve the situation in Lebanon, to the lasting benefit of its people.

Mr MAGNUSSON (Sweden) stressed his delegation's support for the assistance programmes of WHO and other United Nations agencies in Lebanon. His Government also supported and wished to further encourage collaboration between WHO and other United Nations agencies in this connexion. It had itself made a small contribution in the form of staff for the UNIFIL hospital. He earnestly hoped that the critical situation in Lebanon could be solved in a peaceful manner and that, when normal conditions returned, WHO's programmes in primary health care and other fields could be more effectively pursued.

He fully supported the draft resolution before the Committee.

Mr AL-BAKRI (United Arab Emirates) said that his delegation wished to co-sponsor the draft resolution.

Mr HASSAN (Egypt) said that his delegation, which was a co-sponsor of the draft resolution, had attentively studied the Director-General's report. He expressed his appreciation of the praiseworthy efforts being made by the Director-General, the Regional Office for the Eastern Mediterranean, and other specialized agencies in the United Nations system; he referred in particular to the efforts being channelled through UNICEF, UNHCR, the International Committee of the Red Cross, and the League of Red Cross Societies.

The tragic situation of the Lebanese people should be a spur to renewed efforts by WHO, in cooperation with other specialized agencies, to increase health aid to Lebanon. Plans and programmes for such health support should be developed. In a spirit of sympathy with the hopes and sufferings of the Lebanese people, he invited the Committee to adopt the draft resolution under consideration.

Mr FIGUEIREDO MACHADO (Brazil) expressed his delegation's strong support for the draft resolution, and congratulated the Organization and the Director-General on the efforts being undertaken to improve the health situation in Lebanon.

Dr BAMATRAF (Democratic Yemen) welcomed the report by the Regional Director for the Eastern Mediterranean. He supported the draft resolution, and appealed to the Director-General to continue WHO's support to Lebanon by continuing to supply antibiotics and other drugs, as mentioned in the Regional Director's statement.

Dr AL-SARRAG (Sudan) said that his delegation wished to co-sponsor the draft resolution. He expressed his sympathy with the Lebanese people and his thanks to the Director-General and the organizations of the United Nations system for the humanitarian assistance they were providing to alleviate their suffering.

Miss GARRIDO-RÚÍZ (Mexico) congratulated the Organization on the health assistance it was providing to Lebanon and expressed her delegation's full support for the draft resolution.

Mr AGUILAR PARDO (Venezuela) said that his delegation wished to co-sponsor the draft resolution.

Mr ABBASSI TEHRANI (Iran) and Dr FERNANDES (Angola) expressed support for the draft resolution.

The draft resolution was approved. 1

1 Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA34.21.

The CHAIRMAN said that, at its sixty-seventh session, the Executive Board had considered three resolutions that had been adopted by the Regional Committee for Africa in compliance with operative paragraph 3(1) of resolution WHA33.17. The Board had subsequently adopted resolution EB67.R7, concerning support in the health field to national liberation movements recognized by the Organization of African Unity, to the front-line States, and to Swaziland and Lesotho; resolution EB67.R8, concerning the special programme of cooperation with the Republic of Equatorial Guinea; and resolution EB67.R9, concerning the special programme of cooperation with the Republic of Chad. All three resolutions contained draft resolutions for the consideration of the Health Assembly.

Dr QUENUM (Regional Director for Africa) said that the Director-General's report (document A34/21) brought up to date the information on health cooperation with the front-line States and the national liberation movements recognized by the Organization of African Unity. The introduction to the report recalled the political basis of the action already taken or to be taken in the future. Section 2 summarized the measures taken during the biennium 1980-1981 to help the front-line States, Lesotho and Swaziland. Section 3 dealt with health cooperation with national liberation movements such as the Pan Africanist Congress of Azania, the African National Congress in South Africa, and the South-West Africa People's Organization (SWAPO). It should be noted that all those activities were being carried out in close collaboration with all interested bodies in the United Nations system, the Organization of African Unity, and bilateral cooperation agencies.

Mr IDRIS (Sudan) said that many members of the African Group, including Sudan, wished to commend the efforts of WHO and the action taken to meet the public health requirements of certain African States and of the national liberation movements recognized by OAU. He urged WHO to continue to cooperate, in formulating programmes and activities to ensure health cooperation, with the South-West Africa People's Organization, the Pan Africanist Congress of Azania, and the African National Congress of South Africa. He quoted an essential principle in the WHO Constitution: "The health of all peoples is fundamental to the attainment of peace and security."

In the light of that principle, members of the African Group had noted with appreciation that the Secretary-General of the United Nations had convened at Geneva (April 1981) an international conference on assistance to refugees in Africa. This conference had urged all organizations to take steps to aid those refugees. On that occasion the Secretary-General had stated: "I believe I also correctly reflect the consensus of this meeting in expressing the view that all relevant international agencies should give priority to the African refugee problem, giving due weight to the massive size and expense involved." And the African Group's chairman had referred to the need for all United Nations bodies "to embark on giving definition, by their institutional organs, to the policies and programmes they should assume to contribute to refugee assistance in the African countries", emphasizing that "coordination of these policies and programmes is an obvious exercise which also requires careful attention". African Group members urged WHO to give high priority, within its own area of competence, to assistance to refugees in Africa, and asked the Director-General to report to the Thirty-fifth World Health Assembly on measures taken in this area by WHO. The African Group would shortly submit a draft resolution to that effect.1

Dr FERREIRA (Mozambique) congratulated the Director-General on the measures taken to give health support to liberation movements, the front-line States, Lesotho and Swaziland. By so doing, WHO helped to improve the precarious conditions in States under attack from the racist regime in South Africa. But there was still much to be done.

She noted that, in paragraph 2.5 of document A34/21, against the heading "Mozambique", a sum of US$ 1 267 360 was mentioned as being "mobilized from extrabudgetary sources". Did this figure refer to the budget of other United Nations bodies (e.g., UNICEF or UNDP)? If so, then the Mozambique delegation had reservations as to the sum being presented as an outcome of WHO's efforts to mobilize funds under resolutions WHA33.33 and WHA33.34; it was merely the result of the application by the United Nations agencies of various principles governing budget allocation (number of population, gross national product, etc.) and ultimately the result of efforts made by the countries themselves to obtain international financing for their development programmes.

1 See summary record of the sixteenth meeting, section 3.
Moreover, the Lesotho regime was that health policies of the future. As a result, the number of patriots fleeing their country to take refuge in front-line States was increasing daily. The leaders of the front-line States had to care for those refugees in addition to their own people, although the means at their disposal were meagre enough. Moreover, the South African racist regime continued its sabotage and terrorism abroad. Its troops had invaded Mozambique during January and February 1981, with disastrous effects on the health of the people. For 17 years Mozambique had been at war - against Portuguese colonialism, against the Smith regime in former Southern Rhodesia, and now against the South African minority regime.

South Africa continued its attacks because Mozambique supported the South African people's struggle for liberation. But Mozambique was conscious of its responsibilities to the peoples of Namibia and South Africa, as it had been in the case of Zimbabwe. No blackmail and no attacks would make Mozambique abandon that solidarity and internationalism, conscious as it was that health for all by the year 2000 could not be realized in Southern Africa if the racist regime in South Africa and Namibia continued. The Mozambique delegation urged WHO to intensify cooperation with Southern African liberation movements, the front-line States, and Lesotho and Swaziland.

Dr. Fernandes (Angola) would have preferred the report in document A34/21 to have been in greater depth, highlighting the most important programmes in the context of Health Assembly resolutions on the subject.

In a statement at a plenary meeting, the Angolan Minister of Health had unambiguously denounced the attacks made on Angola by the illegal South African regime. In aiming at health for all by the year 2000, it must be understood that the health situation in Southern Africa could not be separated from the apartheid policies applied by the South African regime. Like other front-line States, Angola had difficulty in implementing on national level the programmes developed at world level by WHO; it also had to face the problem of the increasing number of refugees pouring in from other countries that were fighting for their independence.

The Government of Angola supported direct assistance to SWAPO, so that independence in Namibia might be achieved the sooner. At present the Namibian people had no opportunity to draft a health policy or to plan for the future; nor could they put WHO's action programmes, or their own ideas, into practice. Support in health matters from the Regional Committee strengthened the assistance supplied by Angola to the liberation movements.

The Angolan delegation had the honour to present two resolutions. The first was sponsored by the delegations of Algeria, Angola, Benin, Botswana, Cape Verde, Cuba, Guinea-Bissau, India, Lesotho, Mozambique, Swaziland, United Republic of Tanzania, Yugoslavia, Zambia and Zimbabwe. It read:

The Thirty-fourth World Health Assembly,
Recalling resolutions WHA29.23, WHA30.24, WHA31.52, WHA32.20, WHA33.33 and WHA33.34; further recalling the relevant resolutions of the United Nations General Assembly and Security Council concerning the liberation movements in Southern Africa recognized by the OAU;

Noting the escalation of aggression perpetrated by the racist minority regime of South Africa against the People's Republic of Angola, the People's Republic of Mozambique and the Republic of Zambia;

Considering the effects of the attacks and bombings of the civilian population and the destruction of the health infrastructure in front-line States, coupled with economic blackmail of the above States, including Lesotho and Swaziland;

Considering that the persistent refusal of the racist South Africa regime to negotiate with the legitimate representatives of the people of Namibia and South Africa poses an additional threat to security and welfare of the peoples of the front-line States and Lesotho and Swaziland;

Reaffirming the right of the people of Namibia and South Africa to determine their own health policies and to participate in the global strategy of health for all by the year 2000;

Bearing in mind that the deterioration in the situation in Namibia and South Africa leads to an increase in the number of refugees in the front-line States, Lesotho and Swaziland;
Bearing in mind that, despite action taken pursuant to resolution WHA33.34 concerning the Republic of Zimbabwe, the health situation in this newly independent country still remains serious;

1. EXPRESSES once again its satisfaction at the concerted efforts made by WHO and other United Nations agencies and the international community in their technical cooperation with the above-mentioned Member States;

2. THANKS the Director-General for his commitment to technical cooperation with the above-mentioned Member States;

3. GIVES its full and entire support to the front-line States, Lesotho and Swaziland for the assistance given to refugees from South Africa and Namibia;

4. REQUESTS the Director-General to:

   (1) intensify cooperation in the field of health with the front-line States, victims of repeated aggressions by the South African regime, as well as with Lesotho and Swaziland, which have also suffered provocations and economic blackmail;
   (2) give special priority, in the health assistance programmes within the WHO African Region, to the front-line States, Lesotho and Swaziland;
   (3) continue the collaboration with the United Nations agencies and the international community in order to obtain the necessary support in the health sector for national liberation movements recognized by OAU;
   (4) accelerate the implementation of the special action programmes for support to Zimbabwe, in collaboration with other United Nations agencies;
   (5) submit a detailed report to the Thirty-fifth World Health Assembly of the progress made in the implementation of this resolution.

The second resolution - sponsored by the delegations of Angola, Benin, Botswana, Cape Verde, Cuba, Gambia, Guinea-Bissau, India, Lesotho, Mozambique, Sao Tome and Principe, Swaziland, Tunisia, United Republic of Tanzania, Yugoslavia, Zambia and Zimbabwe - read:

The Thirty-fourth World Health Assembly,
Recalling the provisions of resolutions WHA30.24 and WHA32.21;
Considering the deterioration of the situation in Namibia resulting from intransigence of the racist regime of South Africa to grant early independence to Namibia, in accordance with United Nations Security Council resolution 435 (1978);
Taking into account the fact that the so-called "internal settlement" in Namibia constitutes another threat to the security and welfare of the people of Southern Africa;
Reaffirming the right of the people of Namibia to national independence, which would ensure its full contribution to the achievement of the objective of health for all by the year 2000;

1. THANKS the Director-General for the assistance received in the field of health by the liberation movements in Southern Africa;

2. URGES the Director-General:

   (1) to continue and increase, in collaboration with the other organs of the United Nations system, WHO's assistance in the health sphere to the South West Africa People's Organization (SWAPO) as the true representative of the Namibian people;
   (2) to report to the Thirty-fifth World Health Assembly on the implementation of this resolution.

Mrs WOLF (German Democratic Republic) said that her country, as part of its socialist foreign policy, had always extended political, moral and material assistance to the struggle for national and social liberation of the peoples of Africa, Asia and Latin America. Thus it considered the support of the special agencies, including WHO, to national liberation movements as especially important. The German Democratic Republic noted with satisfaction that WHO, as shown in document A34/21, had given support in health matters to the South West Africa People's Organization and the African National Congress, as legitimate representatives of their respective peoples. Referring to the Declaration on Granting of Independence to Colonial Countries and Peoples, she said that the German Democratic Republic not only supported liberation movements but deemed it necessary to do everything possible to bring into the open the policy of South Africa against its neighbour States, Angola and Mozambique and its subversive activities against Zambia and Zimbabwe. It would be appropriate for WHO to increase its support for the
victims of such aggression. The German Democratic Republic fully supported the programme of assistance to the front-line States.

Her delegation would support both the draft resolutions before the meeting.

Mr VERGNE SABOIA (Brazil) said that his country had consistently shown support, both in the United Nations and in other bodies, for the struggle for liberation and against racism in Southern Africa. Brazil also gave its support to programmes for the establishment or reinforcement of cooperation with newly independent and emerging States. It was therefore in favour of the similar initiatives at WHO, as contained in draft resolutions recommended by the Executive Board and the two further draft resolutions before the Committee.

Both in bilateral and in multilateral programmes, Brazil was cooperating in the fields of health and medicine with newly independent African countries, especially those with which it shared a common language. Such programmes were designed to fit the specific needs of each country and to ensure effective transfer of knowledge. They included: long-term and medium-term advisory services, notably in psychiatry and public health planning; fellowships for postgraduate study in medicine, psychology, nutrition, public health, pneumology, dental prosthesis, and basic sanitation; professional training of paramedical personnel; and provision (through WHO) of sanitation personnel and veterinarians.

Dr NSUE-MILANG (Equatorial Guinea) thanked the Director-General, the Regional Director for Africa, the Executive Board, and the countries sponsoring the two draft resolutions for the sympathy they had shown. As its Minister of Health had said, Equatorial Guinea, after 11 wasted years, had probably the lowest health standards of all the countries represented at the Assembly. The Regional Director for Africa had visited Equatorial Guinea in order to evaluate the situation; and the Regional Committee had decided that massive aid was necessary if health for all was to be attained by the year 2000.

He regretted that the Committee had not approved in the form in which it had been originally proposed the resolution on the Real Estate Fund authorizing the financing from that Fund of the construction of a small office building and staff housing in Malabo, Equatorial Guinea. The incorporation in the resolution of the United States amendment - requesting the Director-General to minimize the financial impact of that construction and to report back to the Executive Board - was not calculated to help Equatorial Guinea. The building in question would be the physical embodiment of WHO's presence in his country, and was urgently needed; it formed part of the emergency assistance that Equatorial Guinea hoped could be extended by the Organization.

Dr SEBINA (Botswana) welcomed the Director-General's report (document A34/21). He was glad to see, from section 2 of the report, that the list of front-line states was increasing, and from section 3 that the number of liberation movements was decreasing. That was an indication of progress in the struggle for liberation in Southern Africa, which, through the help of WHO, other agencies and other countries, was nearing its conclusion. By an accident of history and geography, the front-line States had that struggle on their borders, so that the assistance given to them was a contribution to humanity and to the rights of the peoples of the region.

WHO should continue assistance to the South West Africa People's Organization (SWAPO) in Namibia, the Pan-Africanist Congress of Azania, and the African National Congress. It was a most difficult time in the history of the struggle. The situation in Namibia had been very hopeful some time before; it had even been hoped that Azania might soon be free. But now hope seemed to be receding, and the situation became progressively more difficult. He welcomed any assistance, moral or financial, which would help to bring about a final and fruitful solution.

His delegation was a sponsor of two draft resolutions submitted by a number of delegations and hoped that all friends of the struggle would give them their support.

Mr MUSIEI (Poland) said that his country had always supported the struggle for national independence and those decisions in the United Nations system intended to assist the winning of independence. It had spoken out against racist practices and South African aggression against the security and independence of neighbouring countries with the consequent effects on the health of their peoples. He supported the two draft resolutions submitted by a number of delegations; at the same time, he expressed appreciation for the Executive Board's stand on the matter and the efforts of the Director-General.

Dr AMATHILA (Namibia) welcomed WHO's efforts in assisting liberation movements in Southern Africa, and thanked the committee for its concern about her country. It was to be hoped that there would be a speedy change, but those who had dealt with the South African racist regime
would know that not much could be expected from it. However, SWAPO - and Africa - had shown willingness to cooperate at the abortive Geneva conference of January 1981. South Africa must now comply with United Nations Security Council resolution 435, calling for internationally supervised elections in Namibia. Namibia could not hope for health for all by the year 2000 if the colonial occupation was not brought to an end. Many countries had been independent for 20 years and had still not achieved health for as much as a quarter of their population. Only 20 years remained before the turn of the century.

The pattern of exodus from Namibia had changed. Formerly whole families had emigrated; now children left the country in order to avoid conscription into the South African army. Since 1981 children had been entering Angola at the rate of 100-300 a week. Many were starving and needed hospital care before they could resume school. The first SWAPO refugee transit camp in Angola was seven days' walk from the border. Since it was in the war zone, the children who reached it had to be removed immediately to another camp; this entailed another journey of 15 hours. The Angolan Minister of Health had already described the state of health in the war zone at a plenary meeting. There was no respect for health workers, ambulances were attacked and food, medicines and manpower were in short supply.

She was grateful to the United Nations agencies for their help but the pace was desperately slow. Drugs and equipment from UNICEF took a whole year to reach Namibia. A joint WHO/United Nations project of health assistance to SWAPO in Zambia and Angola had been very successful but had ended in 1979. A request for its renewal had been bogged down by bureaucracy, whether at headquarters or at country representative level was not known. The situation was now critical; aid to SWAPO was urgently necessary. The project must be renewed as soon as possible if the children were not to die. There were 50 000 Namibian refugees in Angola alone; of these, 20 000 were children under the age of 17.

Namibia was indebted to the front-line States and governments, particularly to Zambia and Angola, which had suffered racist aggression and blackmail for giving homes and security to Namibian refugees. They had selflessly shared the little they had. She was sure that such sacrifices would not be in vain, that Namibia would soon be independent, that her people would have the right to self-determination, and that a global strategy of health for all by the year 2000 would be evolved. On behalf of SWAPO she thanked all members of the Organization, through the Director-General and the Regional Director of Africa, for their help.

Mrs LUETTGEN (Cuba) observed that the situation regarding cooperation with newly independent and emerging States continued to deteriorate, particularly as the United States of America supported South Africa and prevented Namibia from achieving independence. Every day saw a new provocation. Mozambique was attacked; preparations were made for incursions into southern Angola. Moreover the major powers gave economic and military support to the regime in South Africa. At the last session of the Security Council the representatives of France, the United Kingdom and the United States of America had vetoed a resolution to apply sanctions against South Africa for its violation of the Charter of the United Nations.

The peoples of South Africa and Namibia urgently required increased assistance from WHO. The freedom fighters too needed assistance. The international community must do its utmost to help those populations whose health situation was so precarious. For those reasons Cuba was a co-sponsor of the two draft resolutions before the Committee.

Mrs ENO-HASSAN (Somalia) said that her delegation wished to associate itself with the appeal made by the delegation of Sudan for increased assistance to the millions of refugees in Africa. Such an appeal was in keeping with the spirit of the conclusions of the recent conference that had called upon all international organizations to accord high priority, each within its own sphere of competence, to the refugee problem in Africa. Expressing appreciation for WHO's efforts to bring relief to refugees throughout the world, she was confident that the Organization would intensify its action in relation to refugees in Africa.

Mr KAKOMA (Zambia) expressed his appreciation to WHO and Member States for the interest, sympathy and aid extended to the front-line States and liberation movements in Africa. He had already voiced his concern in the plenary meeting that, if the prevailing political situation continued, the peoples of Southern Africa would be unable to attain the Organization's goal of health for all by the year 2000.

Zambia, as an active front-line State, believed that WHO should provide for assistance to the front-line States, Swaziland and Lesotho, and also to the legitimate liberation movements. The independence of Zimbabwe had marked an important step in the decolonization of Africa. But there was still cause for grave concern at the destabilization policy practised by South Africa and some of her allies against the new States. Independence had enabled close cooperation to be established between Zambia and Zimbabwe at both regional
and bilateral levels and in all sectors, including health. He thanked the Director-General for his efforts to foster cooperation with the front-line States, and for his concern for the health problems of Southern Africa, as demonstrated by his visit to the area. But, in view of the critical situation, he urged increased assistance.

Mr NGUYEN VAN TRONG (Viet Nam) said that his country, which had continuously supported the struggle for independence and liberty of other peoples, condemned the repeated attacks of the racist regime of South Africa on the front-line States. Assistance to Lesotho, Swaziland, and the front-line States was a priority, and his delegation fully supported the draft resolutions on that subject.

Mr ABBASSI TEHRANI (Iran) said that the new Constitution of Iran, inspired by the principles of Islam, did not permit racism or discrimination based on colour, religion or nationality. In line with Iran's support to all liberation movements fighting racism and colonialism, his delegation gave strong support to the draft resolutions on assistance to the front-line States in Africa.

Dr YAGHILIAN (Jordan), reaffirming his delegation's support of the draft resolutions and its solidarity with the struggle for the liberation of the peoples of Southern Africa, noted that the racist treatment from which they suffered was analogous to the repression by Israeli forces in the occupied Arab territories.

Mr SOKOLOV (Union of Soviet Socialist Republics) said his delegation attached great importance to WHO's technical cooperation with, and medical assistance to, the front-line States, the peoples of Southern Africa, and the national liberation movements recognized by the Organization of African Unity. It believed that such activities must continue, financed both from the regular budget of WHO and from bilateral sources in Member States. The Soviet Union followed a consistent policy of support to colonized peoples in their struggles to achieve independence and autonomous economic development.

The Soviet delegation would support the two draft resolutions proposed by a number of delegations. It also supported the resolutions recommended by the sixty-seventh session of the Executive Board, namely resolutions EB67.R7, EB67.R8 and EB67.R9, dealing respectively with cooperation with the front-line States in Africa, with Equatorial Guinea, and with Chad.

Dr CISSE (Niger) expressed his satisfaction at the unanimity regarding the content of the draft resolutions before the Committee and indicated his delegation's wish to join in sponsoring them. WHO's cooperation with the front-line States in Africa was rightly considered a public health matter. He stressed the need for the world to focus its attention on the problem of racism in South Africa. It was inadmissible that race, colour, creed, or politics could continue to isolate pockets of humanity. The regime in South Africa continued to flout international opinion, in the United Nations as in WHO, by its attacks on defenceless people, young and old.

The Committee should unanimously approve the draft resolutions, which would facilitate the provision of much-needed aid to front-line countries and liberation movements.

Dr GAMA (Swaziland) commended the Director-General on the action taken to implement resolution WHA33.33. The health situation in Southern Africa, compounded by acts of aggression and the refugee problem, was deteriorating, and he called upon the international community as a whole to continue its collaboration with the front-line States. He appealed to the Committee to support the draft resolutions under consideration.

Mr VOHRA (India) congratulated the Director-General and his staff on WHO's methodical organization of assistance to liberation movements in Africa. India itself, having struggled so long to achieve independence, had been among the first to offer material and moral aid to oppressed peoples in Africa. It had consistently supported, for example, the African National Congress, the South West Africa People's Organization, the International Defence Aid Fund for Southern Africa, and the Solidarity Fund for the Liberation of Southern Africa. In the field of education and training, in addition to the contribution made by India to the United Nations education and training programme and the Special Commonwealth Programme for Namibia and Zimbabwe, over 100 Zimbabwe nationals and 25 Namibians were currently receiving professional training in Indian institutes.
Noting the unanimity of the views expressed by members of the Committee, he moved that it proceed with the approval of the draft resolutions.

Dr AHMAD (Afghanistan) also congratulated the Director-General and his staff on their activities in relation to the newly independent and emerging States in Africa, the liberation movements in Southern Africa and the front-line States. His country supported national liberation movements throughout the world in the belief that national independence was vital to peace and socioeconomic progress, including health. His delegation therefore supported the draft resolutions before the Committee.

The meeting rose at 12h25.
FOURTEENTH MEETING

Wednesday, 20 May 1981, at 14h30

Chairman: Dr A. HASSOUN (Iraq)

1. COLLABORATION WITH THE UNITED NATIONS SYSTEM: Item 42 of the Agenda (continued)


Mr TEKA (Ethiopia) expressed appreciation for the concern WHO had shown in the past for national liberation movements and the front-line States. He urged that WHO should continue and expand such assistance in line with the objectives of health for all by the year 2000. His delegation supported both new draft resolutions and wished to be included among their co-sponsors.

Dr FRITZ (Austria), commenting on the resolution recommended by the Executive Board in its own resolution EB67.R7, said that although Austria did not support liberation movements directly, it did support the relevant United Nations funds which aimed at alleviating the situation of the victims of apartheid. Austria therefore favoured continued support to national liberation movements in the field of health, in particular, because of the urgent humanitarian needs in the present deplorable situation. Her delegation would therefore support the resolution mentioned.

It was her understanding that the text of the second new draft resolution contained certain political aspects on which, as a representative of the health authorities of her country, she was not in a position to comment. Her delegation could not therefore participate in the vote on that draft resolution.

Mr MOYILA (Zaire) supported the contribution of WHO to the liberation struggle in Southern Africa as set out in the Director-General's report on cooperation with newly independent and emerging States in Africa (A34/21). His delegation was confident that the complete liberation of Africa would ultimately be achieved. He supported both the new draft resolutions.

Miss BETTON (Jamaica) expressed strong support for the two new draft resolutions before the Committee and joined previous speakers in thanking the Director-General for WHO's continuing positive role in giving technical assistance in the field of health to the front-line States and to the liberation movements in Southern Africa. She endorsed the request for increased assistance in the field of health.

Jamaica had consistently supported the struggle for liberation and independence in Southern Africa both morally and materially by giving technical assistance in training to Namibian students and by contributing annually to the Special Solidarity Fund for Namibia. Jamaica reaffirmed its support for the just struggle for freedom in Southern Africa in full awareness of the urgency of the problems which were being perpetuated by the racist apartheid policies of the Government of South Africa. Jamaica therefore supported both new draft resolutions and wished to become a co-sponsor of both.

Mr THABANE (Lesotho) congratulated the Director-General and the Regional Director for Africa for the actions they had taken to implement earlier resolutions on cooperation with newly independent and emerging States in Africa and with national liberation movements.

Dr NSUE-MILANG (Equatorial Guinea) supported and wished to co-sponsor both the new draft resolutions.
Mr GILBERT (United Kingdom of Great Britain and Northern Ireland) requested that further consideration of the two new draft resolutions before the Committee be postponed until delegations had had an opportunity to study them and their relationship to the Executive Board’s recommended resolutions in resolutions EB67.R7, EB67.R8 and EB67.R9.

Following a procedural discussion, in which Dr FERNANDES (Angola), Mr VAN KESTEREN (Netherlands), Mr THABANE (Lesotho), Dr MAWAMBIZI (Zambia), Mr McKINNON (Canada), Dr MUVUTI (Zimbabwe), Dr LANG (Federal Republic of Germany) and Dr FERREIRA (Mozambique) took part, the CHAIRMAN said that, if there were no objections, he would take it that delegates would establish informal contacts regarding the two draft resolutions before the Committee and inform him of the results in due course.

It was so agreed.

(For continuation, see summary record of the sixteenth meeting, section 3.)

Cooperation with the Republic of Zimbabwe: Item 42.7 of the Agenda (Resolution WHA33.34; Document A34/22 Rev.1)

Dr QUENUM (Regional Director for Africa), at the invitation of the CHAIRMAN, introduced the report of the Director-General on technical cooperation with the Republic of Zimbabwe (document A34/22 Rev.1).

Paragraph 1 explained the context in which technical cooperation on health with the people of Zimbabwe had been carried out in close liaison with national leaders, the OAU, UNDP and UNICEF. The political basis of the action taken was explained in paragraph 2. Paragraph 6 covered the general aims of technical cooperation in health in Zimbabwe while paragraphs 7-23 summarized activities undertaken or planned for the 1980-1981 period.

The transition from support provided by WHO to the population of Zimbabwe through national liberation movements recognized by the OAU to technical cooperation with the Government of the Republic of Zimbabwe had been made rapidly and efficiently by means of intercountry projects, as a result of close cooperation between WHO headquarters and the Regional Office for Africa, including a continuing dialogue between nationals and WHO staff at different organizational levels.

Dr MUVUTI (Zimbabwe), referring to the Director-General’s report, said that the people of Zimbabwe deeply appreciated the concern and willingness to assist in the field of health which WHO had manifested since the time of their armed struggle. WHO had started to take positive action at an early stage even before Zimbabwe had become a Member State.

The health infrastructure in Zimbabwe, particularly in the rural areas where it was most needed, had been destroyed and the situation demanded immediate and speedy action. Infectious diseases and malnutrition were rife and thousands of returning refugees, the many war-wounded and the disabled were susceptible to disease. The meagre resources of the country were inadequate and therefore Zimbabwe had requested support in planning efforts and in obtaining medical equipment and supplies.

At the same time as the country was tackling immediate problems, it had also to look ahead and develop medium-term and long-term programmes. In that respect, assistance from the Director-General’s and Regional Director’s development programmes, as well as missions and the sending of consultants, had enabled the country to initiate projects and programmes ranging from crucial manpower training and reorientation to construction work and the provision and distribution of vaccines. However, although his country fully appreciated the assistance already being provided by WHO, there was still need for increased assistance to enable it to develop its own strength. It would then be able to play a major role in supporting other underprovided and disadvantaged nations and as a front-line State would be able to facilitate health provision for the oppressed peoples of Namibia and South Africa. In that context there had already been a valuable exchange of experiences with other front-line States which had enabled his country to draw up a three-year health programme aimed at achieving equity in health.

A number of national projects of vital importance were currently under way, including training of health cadres, disease control programmes, development of information systems, nutrition education, the setting up of institutions for the expanded programme of immunization, and the repair and maintenance of equipment. Given the seriousness of the health situation and in view of the possible political and economic consequences which might arise from inaction or delay, he once more appealed for speedier execution of requests for assistance in the health field.
The CHAIRMAN suggested that the Committee take note of the Director-General's report contained in document A34/22 Rev.1.

It was so agreed.

2. UNITED NATIONS JOINT STAFF PENSION FUND: Item 43 of the Agenda

Annual report of the United Nations Joint Staff Pension Board for 1979: Item 43.1 of the Agenda (Document A34/23)

The CHAIRMAN called the attention of the Committee to the summary of the annual report of the United Nations Joint Staff Pension Board for 1979, which was contained in document A33/23.

Mr FURTH (Assistant Director-General) said that document A34/23 was presented to the World Health Assembly in conformity with the Regulations of the Joint Staff Pension Fund; it briefly highlighted the financial situation of the Fund and summarized the action taken by the Pension Board at its last session. Full details would be found in United Nations document A/35/9, which had been made available to governments; copies were available in the meeting-room for consultation by delegates.

The only action to be taken by the Health Assembly was to note the status of the operation of the Joint Staff Pension Fund, as indicated by its annual report for the year 1979 and as reported by the Director-General.

Decision: Committee B decided to recommend to the Thirty-fourth World Health Assembly to note the status of operation of the Joint Staff Pension Fund, as indicated by its annual report of the United Nations Joint Staff Pension Board for the year 1979 and as reported by the Director-General.1

Appointment of representatives to the WHO Staff Pension Committee: Item 43.2 of the Agenda (Document A34/24)

The CHAIRMAN observed that the item covered the designation of a member and an alternate member of the WHO Staff Pension Committee to replace the member and alternate member whose terms were now expiring, in accordance with a rotation schedule which enabled the various regions to be represented. It would be recalled that, apart from the decisions taken in 1976 and in 1979 by the Health Assembly to designate one Assembly representative by name and to appoint him for an additional term of three years in order to ensure greater continuity in the representation of the Assembly on the WHO Staff Pension Committee and the United Nations Joint Staff Pension Board, it had been the practice of the Assembly to appoint as its representatives persons serving on the Executive Board by designating the names of Member States entitled to appoint a person to serve on the Board.

The Thirty-fourth World Health Assembly was now invited to appoint one member and one alternate member for a period of three years, and it was suggested that the usual practice should be followed.

If that was agreed, nominations were invited for the designation of a member and an alternate member from the Member States recently appointed to designate a person to replace the member of the Executive Board designated by the Government of China and the member of the Executive Board designated by the Government of Burundi.

Dr Xu Shouren (China) nominated the member of the Executive Board designated by the Government of Japan as member of the WHO Staff Pension Committee.

Dr MPTABAKANA (Burundi) nominated the member of the Executive Board designated by the Government of the Seychelles as alternate member of the WHO Staff Pension Committee.

Decision: Committee B decided to recommend to the Thirty-fourth World Health Assembly to appoint the member of the Executive Board designated by the Government of Japan as

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1 Transmitted to the Health Assembly in the Committee's fifth report and adopted as decision WHA34(11).
member of the WHO Staff Pension Committee, and the member of the Executive Board designated by the Government of the Seychelles as alternate member of the Committee, the appointments being for a period of three years.1

3. HEALTH FOR ALL BY THE YEAR 2000: Item 21 of the Agenda

Global Strategy: Item 21.1 of the Agenda (Resolution WHA32.30, para.9 (1); Document WHA32/1979/REC/1, Annex 2, para. 134; Document A34/52 and Add.1)

Dr BARAKAMFITIYE (representative of the Executive Board) said that, after years of effort to define a valid health policy and to formulate principles for its implementation, an excellent draft at last existed of a Global Strategy for achieving the target of health for all by the year 2000. Since the Thirty-second World Health Assembly launched the Global Strategy in 1979, a large number of developing and developed countries throughout the world had formulated national strategies and all the regions had drafted regional strategies. The draft Global Strategy before the Committee, which was based on the report of the International Conference on Primary Health Care, Alma-Ata, 1978, and on the guiding principles laid down by the Executive Board, reflected those national and regional strategies as seen from a global perspective.

The draft Strategy, which was not intended to be a detailed global programme, set out the health and related socioeconomic problems and trends of the modern world and the corresponding policies that WHO had adopted in recent years. It laid down the fundamental principles of health for all and showed how health development and socioeconomic development were inextricably linked and how action in the health sector was a contributing factor to the establishment of a new international economic order. It further indicated the action that must be taken at the national and international level in order to establish and maintain health systems based on primary health care, with due emphasis on the establishment of an adequate infrastructure, coordination within the health sector, intersectoral action, the use of appropriate technology, the activities carried out by individuals, families and communities, and the role of health personnel in guiding and supporting them, as well as on the social control of the infrastructure and technology that was specific to each country’s conditions and traditions. In order to arrive at such health systems, the Strategy outlined ways of ensuring political commitment, economic support and adequate professional and managerial backing.

It would not be possible to carry out the Strategy, however, without mobilizing the necessary human, financial and material resources, and it accordingly stressed the importance of technical and economic cooperation between countries in their efforts to attain individual and common objectives. National monitoring and evaluation processes and a limited number of indicators must be established in order to assess the progress being made; a number of global indicators were also presented for evaluation at the regional and global levels. The Strategy further specified the role of all WHO organs in its implementation and proposed that the Thirty-fourth World Health Assembly request the Executive Board to prepare an appropriate plan of action with the assistance of the Director-General and the entire Secretariat.

Because of the cardinal importance for WHO of the target of health for all by the year 2000, the Executive Board had examined the draft Global Strategy in considerable detail in the light of the precise guidelines set out in resolution WHA32.30 and in United Nations General Assembly resolution 34/58. Describing the Strategy as a "monumental document", the Board had formulated a number of comments which had resulted in the version that was now before the Committee. As regards the style of the document, the future tense had been chosen as the best way of expressing the voluntary commitment of countries to do their utmost to implement the Strategy. A certain amount of repetition had been eliminated and every effort made to render the text as precise and clear as possible. It was suggested that the Assembly should request the Executive Board, with the Director-General’s assistance, to draw up a plan of action on a concrete basis after consultation with the Member States, in particular within the regional committees. It was further proposed that the Board should submit its plan of action to the Thirty-fifth World Health Assembly in 1982.

1 Transmitted to the Health Assembly in the Committee’s fifth report and adopted as decision WHA34(12).
2 The revised version of this document was later published (Global strategy for health for all by the year 2000, Geneva, World Health Organization, 1981 ("Health for All" Series, No. 3)).
Finally, he had taken the liberty of preparing the following draft resolution for consideration by the Committee in the hope that it might serve as a basis for the historic decision which it would no doubt wish to take on the subject.

The Thirty-fourth World Health Assembly, 
Recalling resolutions WHA30.43, WHA32.30, and WHA33.24 concerning health for all by the year 2000 and the formulation of strategies for attaining that goal, as well as resolution 34/58 of the United Nations General Assembly concerning health as an integral part of development; 
Having reviewed the Strategy submitted to it by the Executive Board in the document entitled "Global Strategy for health for all by the year 2000"; 
Considering this Strategy to be a contract for health between governments, people and WHO, and an invaluable basis for attaining the goal of health for all by the year 2000; 
1. ADOPTS the Global Strategy for health for all by the year 2000;
2. PLEDGES WHO's total commitment to the fulfilment of its part in this contract for health;
3. INVITES Member States:
   (1) to enter into this contract for health of their own volition and to formulate or strengthen their strategies for health for all accordingly;
   (2) to enlist the involvement of people in all walks of life, including individuals, families, communities, all categories of health workers, nongovernmental organizations and other associations of people concerned;
4. REQUESTS the Executive Board:
   (1) to prepare without delay a plan of action for the immediate implementation of the Strategy and submit it, in the light of the observations of the regional committees, to the Thirty-fifth World Health Assembly;
   (2) to formulate the Seventh and subsequent General Programmes of Work as WHO's support to the Strategy;
5. REQUESTS the regional committees:
   (1) to review their regional strategies and update them as necessary in the light of the Global Strategy;
   (2) to review the Executive Board's draft plan of action for implementing the Strategy and submit their comments to the Board in time for it to consider them at its sixtieth session in January 1982;
6. REQUESTS the Director-General:
   (1) to ensure that the Secretariat at all operational levels provides the necessary support to Member States for the implementation of the Strategy;
   (2) to follow up all aspects of the implementation of the Strategy on behalf of the Organization's governing bodies, and to report annually to the Executive Board on progress made and problems encountered;
   (3) to present the Strategy to the United Nations Economic and Social Council and General Assembly in 1981, and report to them subsequently at regular intervals on progress made in implementing it as well as United Nations General Assembly resolution 34/58.

Professor JAKOVLJEVIC (Yugoslavia) said that his country had introduced primary health care prior to the Alma-Ata Conference. The decision to do so had been taken at the highest political level in response to a widening gap between urban and rural health facilities that was judged to be socially, economically and politically unacceptable. Primary health care, as an integral part of the national health scheme, was established by a federal law guaranteeing equal rights to all citizens. Twelve years later, the entire population of the country now received comprehensive health care free of charge. Various changes had been made in public health laws in all the republics and autonomous provinces since the Alma-Ata conference. The concept of health was defined in the same terms as in WHO's Constitution and the attainment of the highest possible level of health had been declared as the most important social and economic goal of society. The highest priority was given to the development of health services in order to meet the needs of the population at their places of work and at home.
With regard to appropriate health technology, which was one of the key issues of the strategy, the Yugoslav delegation fully agreed that its professional, commercial and political implications were enormous. One aspect of that technology was related to the health services provided; under Yugoslavia's social and economic development plan for the next five years, which gave priority to peripheral health services, only limited resources were available for hospital construction and equipment. Another aspect was medical education. In Yugoslavia medical schools were viewed as an integral part of society that should prepare doctors for work in and for society. Although appropriate health technology depended very much on teaching methods, it was sometimes more difficult to change the system of training than the health system itself.

The Yugoslav delegation firmly believed that health for all was a realistic goal but one which required continued efforts to be made to gear health systems to primary health care so as to meet the real needs of the population. International cooperation, too, must be directed towards primary health care rather than the construction of expensive hospitals. Yugoslavia, for its part, would continue to cooperate with WHO and its Member States, and especially with the developing countries.

In conclusion, the Yugoslav delegation welcomed the draft Global Strategy before the Committee, although it felt it might benefit from being rendered more flexible; and it firmly supported the draft resolution proposed by the representative of the Executive Board. In accordance with the views it had expressed, it had also decided to co-sponsor a draft resolution, on encouraging cooperation to support countries in developing and implementing their national strategies for health for all by the year 2000, together with the delegations of Afghanistan, Angola, Cape Verde, Cuba, Cyprus, Democratic People's Republic of Korea, Guinea-Bissau, Iraq, Libyan Arab Jamahiriya, Mozambique, Nicaragua, Sao Tome and Principe, Sri Lanka, and the United Republic of Tanzania. It read as follows:

The Thirty-fourth World Health Assembly,
Taking into consideration the importance given by the countries members of the Non-aligned Movement and other interested developing countries to the strategy for health for all by the year 2000;
Aware that some countries have not yet completed the first essential steps required to develop and implement their national strategy for health for all;
Convinced that the afore-mentioned countries urgently require special support to enable them to overcome their difficulties and take an active part in the tasks to be fulfilled by all Member States in developing their national strategies;
Considering the estimated costs summarized in document A34/5 entitled "Global Strategy for health for all by the year 2000", and taking into account that developing countries, which in their majority are members of the Non-aligned Movement, do not have such resources available;
1. URGES all Member States to support the financial efforts of WHO and its governing bodies aimed at matching resources with needs and at obtaining the utmost from available resources in support of those countries most in need;
2. INVITES Member States to cooperate with the developing countries and to support them in overcoming the obstacles impeding the development of their strategies for health for all;
3. CALLS on all Member States that are in a position to do so to increase their voluntary contributions to WHO for the purpose of implementing strategies for health for all in those countries that are unable to implement them with their own resources alone;
4. INVITES the relevant agencies, programmes and funds of the United Nations system, as well as other bodies concerned, to provide financial and other support to developing countries for the implementation of national strategies to achieve health for all by the year 2000;
5. REQUESTS the Director-General to take the necessary steps to ensure that WHO contributes significantly to the promotion of cooperation in support of the implementation by developing countries of their national strategies for health for all, and to report on the results of these efforts to a future World Health Assembly.

Mr VOHRA (India) said that the document presented by the representative of the Executive Board was neither a compendium of regional programmes nor a global programme but, first and
last, a proposed strategy. After the most careful scrutiny, he was unable to find a single issue which had not been referred to in the right context and in the correct proportion. The substance of the Strategy had been discussed in the past under various headings - whether in connexion with primary health care, technical discussions or, in certain aspects, the restructuring of WHO. That was inevitable in so far as the basic concerns were much the same, whatever the angle from which they were viewed. The formulation of a meaningful plan of action, therefore, was the logical outcome of the general recognition of the fact that health was an essential part of development.

It had rightly been pointed out that the essential ingredient of the Strategy was political commitment. Since the Alma-Ata Conference, a growing political awareness in all countries was paving the way towards a practical commitment to the Strategy's goals, without which it would remain a dead letter. Once political support had been secured, the next major ingredient were economic support and managerial backing. With regard to the mobilization of the vast economic resources that were required to tackle a task of such magnitude, it was regrettable that the Executive Board had not agreed to grant the Health Resources Group for Primary Health Care the kind of mandate that rapid success in that area demanded. It was hoped that, in the course of time, the Board would choose to place complete faith in the Director-General's ability to exercise judicious discretion in mobilizing and allocating resources.

One major question which remained was exactly how WHO headquarters proposed to measure success in the implementation of the Strategy by individual States. Ultimately, the only way of assessing progress in the application of such a large and multisectoral programme was to establish national indicators for all areas for which specific goals had been set. The resulting statistics based on broadly recognized principles should earn universal acceptance, whether they related to infant mortality, the incidence of communicable diseases or any other sphere.

Another point that must be decided upon was the part to be played by the regional committees. Extensive exercises had already taken place in the various countries and regional offices and had produced a large volume of material representing national needs and aspirations. The regional directors should perhaps take the initiative in holding such further consultations as were necessary to draw up an agreed list of indicators to serve as a yardstick for future activities. The Executive Board could then use those indicators to review the progress achieved by each region. Unless all countries moved together in a given direction and at a given pace, the Strategy would not function.

In conclusion, therefore, the Indian delegation gave its firm commitment to the document before the Committee and the parameters and possibilities indicated, with the provision that the proposed draft resolution should place more emphasis on the role to be played by the regional committees and Regional Directors, so that the countries themselves could be made aware of any shortfalls.

Dr HAPSARA (Indonesia) said that in his country the reorientation of national health institutions started one-and-a half years ago was still in progress. The draft Global Strategy in document A34/5 would be most useful as a guide to that reorientation.

If the strategy document was to be used as a guide for national strategies, it should lay greater stress on the national development process; in particular, a section should be added on national long-term development planning. Such an addition would have a number of advantages; emphasis on long-term planning would act as a stimulus on decision-making and on public opinion, and would also be beneficial from the educational point of view.

The Strategy did not sufficiently emphasize primary health care. It should also be more helpful in indicating how countries were to formulate their specific national plans of action. National efforts should rely first and foremost on national staff, and only secondly on the help of outside agencies such as WHO.

He drew attention to certain errors and omissions in document A34/5. In section III, paragraph 28, there was reference to paragraph 38 of the same section, which did not in fact exist. There was not sufficient emphasis on the essential drugs programme, and the question of evaluation of national health systems was not adequately dealt with.

His delegation could in principle support the draft resolution proposed by the representative of the Executive Board.

Mr JIN Chung Kuk (Democratic People's Republic of Korea) said that, in order to carry out the strategy successfully, each country had to mobilize its own resources and rely on its own efforts, as well as endeavouring to strengthen mutual cooperation among Member States. It was
in that belief that his country was co-sponsoring the draft resolution introduced by the delegate of Yugoslavia.

Dr HOPKINS (United States of America) welcomed the emergence of the global strategy. In less than three years, WHO had progressed from initial identification of the concept of health for all at Alma-Ata in 1978 to the final formulation of the Strategy in the document now before the Committee. Although there was no doubt that the goal was a worthwhile one, it might be asked whether it was not unduly optimistic in a world in which many still suffered under the burden of disease. However, each country would be applying the Strategy according to its own level of development and within the limits of the resources available to it, and in that sense the goal of health for all would not be unattainable.

His country was pursuing policies aimed at ensuring continued improvements in the health of the population as a whole, while giving special attention to those who were particularly disadvantaged. Control over major health programmes had been decentralized, so that policy formulation and the allocation of resources were now more a state than a federal responsibility. Strong efforts were being made to maintain the level of biomedical and public health research in the face of increasing economic austerity.

His country's view was that the concept of health for all applied equally to developed and developing nations. All countries, as they progressed from one stage of development to another, faced different health problems; as the poorer countries gained control over malaria and malnutrition, they began to encounter cardiovascular disease and cancer, while the more affluent countries, once they had begun to control the latter diseases, were faced with such problems as environmental toxicity, drug abuse, and alcoholism. Thus each country had a double challenge; to provide universal access to primary health care, and to ensure that that care was also relevant to the particular problems facing its population.

The development of indicators of health and health care was essential to national, regional, and global strategies for achieving health for all. Indicators were of three kinds: those that indicated that specific objectives, such as reducing infant mortality, had been set; those that measured or monitored the tasks required to achieve those objectives, such as immunizing a given percentage of children; and finally, those that related to actual results, such as reductions in infant mortality. Such indicators could be used both as a guide in activities and as a means of measuring the progress made towards achieving objectives. What was important was that all countries should develop indicators that were relevant for their particular stage of health development, and use them both for bringing about improvements in the health of the general population and as a guide in relieving the special needs of population subgroups.

Among the indicators suggested in the strategy document for global monitoring and evaluation was the number of developed countries from which at least 0.7% of the health expenditure was transferred to support strategies for health for all in developing countries. He did not think it appropriate to single out an arbitrary figure such as 0.7%, since to do so was to suggest that it was in some way a measure of adequacy. There should be a variety of cooperative efforts, both among developing countries and between less developed and more developed countries, but those efforts should not be judged on the basis of any specific percentage. The use of such a figure also gave undue emphasis to the role of the donor country, whereas it was the needs of the recipient country which should be stressed. He therefore proposed that paragraph 11(4) should be deleted from section V of the draft Strategy and paragraph 6 (6) from section VII.

Dr PLIANBANGCHANG (Thailand) said the draft Global Strategy was based on national response to the challenge of improved health for all the population and greater development of human resources as key components of overall development. Good results had been achieved in many countries in developing national policies and strategies, based on the results of the Alma-Ata conference on primary health care. However, there was need to translate those strategies into concrete action, and national commitment should be renewed and intensified if health for all was to materialize. He expressed his full support for the draft Strategy as set out in document A34/5.

Dr HATA (Japan) also supported the draft Strategy, and particularly the approach proposed in section VII for monitoring and evaluating progress. However, the twelve indicators proposed did not take into account the need for information on trends in major diseases which affected large numbers of the world's population, such as infectious and parasitic diseases, nutritional disorders, cardiovascular diseases and cancer. Such factors should be included.

Some of the indicators proposed might not be universally appropriate; for example, the adult literacy rate was no longer relevant as a measure of social development in most indus-
trialized countries. What was more important in such countries was the level of health awareness as a means of preventing or reducing disease and disability. Other relevant indicators were the aging of the population, and the environment.

While indicators provided a convenient summary of certain aspects of the health and socioeconomic situation of a country, they were not the only tools to be used in monitoring and evaluating health progress. More detailed statistics, including those showing frequency distributions, needed to be taken into account. In her country, there was a publication entitled "Trends in the Health of the Nation" which provided an analysis of social and economic trends in the health status of the population, and of the organization and functioning of health services; it was widely used by health personnel. Another useful publication was the "Compendium of Health and Welfare Statistics". Such publications provided information that was important in assessing health trends in addition to indicators.

Finally, reliable indicators could not be obtained without an adequate mechanism for collecting and analysing statistics. Greater stress should be laid in the draft Strategy on the importance of developing and maintaining a statistical system, and more discussion on the problems involved in improving such systems was urgently needed at international level. Those Member countries in which medical personnel were scarce should pay particular attention to new approaches, such as the lay reporting of health information.

Dr PATEL (United Nations Conference on Trade and Development), speaking at the invitation of the CHAIRMAN, said that UNCTAD had been pleased to respond to the Director-General's invitation to participate in the preparation of the draft Global Strategy. The Strategy recognized health as a fundamental right, and defined the action that was called for to ensure the health of all mankind. It focused particularly upon ways of reducing the inequalities that had long prevailed between the health facilities enjoyed by the developed world on the one hand and the developing world on the other.

UNCTAD also concerned itself with remediating inequalities, and had taken various initiatives to transform the structure of relationships between developed and developing countries, particularly in the economic sphere. The Strategy would add a further dimension to the efforts being made to change those relationships with a view to bringing about the New International Economic Order.

The Third World suffered an even greater disadvantage in the health sphere than in the economic sphere. Of the more than US$ 600 billion spent in 1980 on health care in the world as a whole - a sum greater than that for military expenditures - over 90% was devoted to the care of the populations of developed countries. Their per capita health expenditure amounted to more than US$ 500, in contrast to a mere $ 15 in the Third World. Such a huge gap could not be bridged simply by an increase in per capita health expenditure in the developing countries, and it was for that reason that the new approach proposed in the Global Strategy was so welcome.

The need to rationalize health expenditure was nowhere more pressing than in the developing world, and there had been a most fruitful cooperation between UNCTAD and WHO in forming new policies on pharmaceuticals. He hoped that cooperation would continue.

The new steps proposed in the draft Strategy for delivering health for all called for innovations in social technology. UNCTAD was closely involved in formulating technology policies and in planning for the development of countries of the Third World, and it looked forward to collaborating closely with WHO in the task of translating the dream of health for all into reality.

Mr BERWAERTS (Belgium) said that his delegation believed that industrialized countries had a responsibility towards developing countries, and that a common effort was needed to counteract growing inequalities. The Belgian delegation was also convinced that only by developing primary health care facilities could health for all by the year 2000 be achieved. He appealed to the industrialized countries to make a greater contribution to the developing countries through WHO, and to the developing countries to identify their needs for external funds for the implementation of national strategies; the World Health Organization should assist the developing countries in identifying those needs.

Dr WROBLEWSKI (Poland) repeated the sentiments expressed by the Polish Minister of Health and Social Welfare in his address in plenary session to the effect that the Declaration of Alma-Ata marked a turning-point in the work of the World Health Organization. It was clear that every governmental programme must recognize health, and especially primary health care, as one of the most important social and economic priorities of the State. The overwhelming prob-
problems faced by the developing countries - very high infant mortality rates, malnutrition, diarrheal diseases, vectorborne diseases, and so on - showed that health for all by the year 2000 could not be achieved by the health sector alone.

The Polish Government had recognized that technical and economic cooperation between countries was crucial to the attainment of health for all, and that a country could not be totally self-sufficient but should strive to become self-reliant.

He stated that in Poland there was no illiteracy, no malnutrition, no malaria or schistosomiasis, and an infant mortality rate of about 20 per 1000 live births. However, the prevalence of cardiovascular disease, cancer, and environmental health problems was increasing every year. All these problems had convinced him that international solidarity was needed to overcome obstacles to health for all.

In Poland the national health services covered approximately 99% of the population and included a system of primary health care with a comprehensive structure of supporting and referral services. A system of continuing postgraduate medical education was regarded as part of the strategy for health for all by the year 2000 and had operated for the last 30 years. As their contribution to international cooperation, the Polish health services could offer seminars and training courses on the methodology and organization of postgraduate education for health service staff, in order to share their expertise with other Member States of WHO.

Dr BRITO GOMES (Cape Verde) stressed that it should not be forgotten that health care necessitated a comprehensive development system. All countries should ensure that their health care systems were consistent with the Declaration of Alma-Ata and should promote primary health care. The excellent Global Strategy document gave important guidelines but must be adapted to the situation in each particular Member State. Cooperation with international organizations and with other countries would be very important in this respect.

Dr MPITABAKANA (Burundi) said that Burundi entirely agreed with the aim of health for all by the year 2000 and had opted in December 1976 for a system of integrated medicine with particular emphasis on preventive medicine and health education. A national strategy had been elaborated and was being implemented, and Burundi was a signatory to the Charter for Health Development of the African Region. The Burundi delegation also wished to reiterate its support for the Global Strategy.

Dr FERREIRA (Mozambique) said that the success of the excellent Strategy for the achievement of health for all by the year 2000 that had been so rapidly drafted depended on national factors, since no programme could succeed if individual countries did not create the necessary conditions.

The health programme in Mozambique was an integral part of the overall strategy for socioeconomic development. The present struggle was against poverty, hunger, illiteracy and disease; the country had the will and discipline to overcome them. Community participation through the Mozambique Women's Association, youth organizations and production councils also formed part of the national effort. Although national factors were fundamental, the overall international situation was also important and world peace and security were essential for the achievement of health for all. A new economic order was also needed, including the transfer of resources, as proposed by the General Assembly of the United Nations. Developed countries should remember that they derived much of their wealth from impoverished countries. WHO and other organizations in the United Nations system should ensure that resource transfers did not involve the subjection of the receiving country. Finally, she emphasized that health for all needed national commitment as well as peace and détente throughout the world and would require both the transfer of resources and continuing evaluation of the situation.

Dr CHRISTIANSEN (Norway), on behalf of the five Nordic countries, thanked the Director-General and his staff for the support they had given to Member States, regional committees, the Executive Board and the Health Assembly in the formulation of a strategy for health for all. He hoped that the Global Strategy based on primary health care would prove to be a milestone in social history. Although primary health care had evolved gradually, it constituted a completely new approach to health services and implied a reordering of priorities. The Strategy for health for all should embrace all areas of community development and could not confine itself to the health sector. That health was an integral part of development had been confirmed by the United Nations General Assembly in November 1977, and it was not important to implement the Strategy at national, regional, and global levels. Health for all required
political commitment and a broad attack on poverty and on prevailing socioeconomic structures. WHO should be prepared for conflict over scarce resources, or confrontation with commercial and professional interests that did not serve health for all.

The Nordic countries believed that the health field offered a unique opportunity for international cooperation between Member States and between international organizations, and that the Global Strategy should be used to give an impetus to health development, and thus to social and economic development. Therefore, they supported the proposal that the Health Assembly should request the Executive Board to prepare a plan of action without delay in order to overcome obstacles and ensure the success of the Global Strategy. The plan should seek to support national governments in implementing their strategy, to involve all relevant bodies of the United Nations system and other international organizations in concerted action for health for all, and to mobilize and transfer the resources required. The plan of action should also include concrete measures aimed at attaining global targets such as safe drinking-water and sanitation, adequate nutrition, immunization against the major infectious diseases of childhood, and provision of essential drugs.

The action required to achieve those aims would be intersectoral in nature and the plan of action was needed to provide an overall unifying pattern. The plan should include measures for monitoring the flow of resources.

Paragraph 13 of section V of document A34/5 mentioned a target for the level of transfer of resources to developing countries of 0.7% of the health expenditure of developed countries; although the Nordic countries supported international development and, in fact, already exceeded the target percentage, they had reservations about linking the level of resource transfer to health expenditure, since such a link would be contrary to the country programming principles most often applied in development cooperation. It might also create a precedent which, if applied to other sectors, might have unforeseen consequences.

Finally, on behalf of the delegations of Denmark, Finland, Iceland, Sweden and Norway, he welcomed and supported the call for implementation and action made by the representative of the Executive Board.

The meeting rose at 18h05.
1. FIFTH REPORT OF COMMITTEE B (Document A34/41)

The CHAIRMAN invited the Committee to adopt its draft fifth report, contained in document A34/41.

The report was adopted (see document WHA34/1981/REC/2).

2. HEALTH FOR ALL BY THE YEAR 2000: Item 21 of the Agenda (continued)

Global Strategy: Item 21.1 of the Agenda (Resolution WHA32.30, para. 9 (1); Document WHA32/1979/REC/1, Annex 2, para. 134; Document A34/5 and Add. 1) (continued)

Dr XU Shouren (China) supported the draft resolution on the Global Strategy proposed by the representative of the Executive Board, as well as document A34/5. That document was extremely important; WHO must continue relentlessly to achieve its goal, adopting all further necessary measures and creating all the required conditions.

He had some comments on the document. First, he thought in general that elements favouring the Strategy should be reviewed together with the difficulties that might be encountered. Reviewing the positive elements would further the achievement of the goal, and recognizing the difficulties would make it possible to mobilize in order to overcome them. The efforts by the peoples and governments of the Member countries should also be reviewed; it was necessary to analyse the positive elements to enable all concerned to work with greater confidence.

Second, he referred to the establishment of health structures, particularly the basic health structure. Judging by China's experience, the strengthening of health structures was just as important as the actual training of health personnel. If there were no sound health structure it would be impossible to obtain health for all by the year 2000.

Third, he believed that the strengthening of education and training of health manpower at the medium and higher levels, the improvement of the quality of teaching material and the training of specialists were undoubtedly necessary and important; but at the same time facilities had to be provided for continuing the training of serving personnel so that they could improve their technical and professional level.

As to traditional medicine, there were more than 200,000 traditional physicians in China, and activities in that area had always been promoted. Traditional medicine was an important tool in the prevention and control of disease. Many countries had similar experience in that area, and the training of traditional physicians needed to be considered with more care by WHO. With regard to the education and training of personnel working in rural areas at the basic level, China had more than 1.5 million barefoot doctors, who were an important group in the implementation of primary health care. The training of such personnel was considered in China as an important duty, and it was being fulfilled. The education and training of health manpower should include all the various types of health personnel, in order to mobilize all existing possibilities within a given country and to use all existing specialities. He believed that the achievement of health for all by the year 2000 and the success of the Strategy being formulated for it would largely depend on the factors he had mentioned.
Dr BROYELLE (France) welcomed document A34/5, which she fully supported. She particularly appreciated the paragraph on the analysis of health problems within a global framework and the broad outlines that had been fixed for the development of health systems, both for the principles they embodied and their topicality. She also welcomed the stress on the value of evaluations and the inclusion of global indicators which, although imperfect at present, were essential to ensure that the strategy was followed seriously.

As regards the transfer of resources, her delegation approved the principle of such transfers, which would accord greater justice to the developing countries. However, the criteria on which the suggested figure of 0.7% of health expenditure was based might be questioned, and the percentage might be assessed in many ways depending on the interpretation of "health expenditure". Finally, the document contained suggestions, not obligations, and she interpreted the use of the future tense less as an imperative than as a stimulus.

Dr BOOTH (Australia) reaffirmed his country’s support for health for all through the medium of primary health care. Australia would pursue that goal domestically by improving health education towards preventive or positive health, with less emphasis on a purely curative approach. Health services would continue to be evaluated and extended to those groups in the community that were in most need, and that, for one reason or another, were the most difficult to reach.

Turning to the Global Strategy as presented in the report, he praised the efforts being made in the Western Pacific Region to identify appropriate indicators by which progress could be measured, and the emphasis being placed on the attainment of practical targets. He was also pleased to see the stress on technology that was appropriate to the country concerned, and that was sound, adaptable, acceptable and, above all, maintainable by those who used it.

Australia recognized the need to coordinate donor efforts to help countries build their capacities to develop effective plans and implementation mechanisms. He therefore urged WHO to continue its consultative role with other agencies and organizations in the field, particularly those of the United Nations, the World Bank and nongovernmental agencies interested in the health sector. His delegation supported and had co-sponsored a draft resolution on resources for strategies for health for all by the year 2000 which was now before the Committee.

The draft resolution, which was sponsored by the delegations of Algeria, Australia, Belgium, Burundi, China, Colombia, Egypt, Greece, Malta, Mexico, Netherlands, Perú, Portugal, Rwanda, Spain, Swaziland, Turkey and Zaire, read as follows:

The Thirty-fourth World Health Assembly,

Recalling resolution WHA30.43, which defined the goal of health for all by the year 2000, resolutions WHA32.30 and WHA33.24, which endorsed the Declaration of Alma-Ata and urged Member States to formulate national strategies for attaining health for all through primary health care as part of a comprehensive national health system, and resolution 34/58 of the United Nations General Assembly concerning health as an integral part of development;

Also recalling resolutions WHA27.29 and WHA29.32, which requested the Director-General to strengthen WHO's mechanisms for attracting and coordinating an increasing volume of bilateral and multilateral aid for health;

1. WELCOMES the efforts being made by Member States to prepare and implement national strategies for health for all through the development of health systems based on primary health care;

2. URGES all Member States to allocate adequate resources for health and in particular for primary health care and the supporting levels of the health system;

3. URGES those Member States that, for the implementation of their strategies for health for all, require external sources of funds in addition to their own resources, to identify those needs and report thereon to their regional committees;

4. URGES Member States that are in a position to do so to increase substantially their voluntary contributions to WHO for activities in developing countries that form part of a well-defined strategy for health for all;

5. INVITES the regional committees to review regularly the needs of Member States in the Region for external resources in support of well-defined strategies for health for all and report thereon to the Executive Board;
6. **REQUESTS** the Executive Board to review regularly the international flow of resources in support of the strategy for health for all, to ensure that such resources are effectively and efficiently used for that purpose, and to report thereon to the Health Assembly;

7. **DECIDES** that the World Health Assembly will review from time to time the international flow of resources for health and will encourage those Member States that are in a position to do so to ensure an adequate level of transfer;

8. **REQUESTS** the Director-General:

   (1) to support developing countries at their request in preparing proposals for external funding for health;
   (2) to strengthen WHO's mechanisms for identifying external resource requirements in support of well-defined strategies for health for all, for matching available resources to such needs, for rationalizing the use of such resources, and for mobilizing additional resources if necessary;
   (3) to report regularly to the Executive Board on the measures taken to rationalize and increase as necessary the international flow of resources for the Strategy for health for all.

The Australian delegation had co-sponsored the draft resolution on the understanding that it would contain a reference to the role of the Health Resources Group. It therefore also wished to co-sponsor the amendments proposed by the Netherlands delegation and circulated to the Committee to the effect that a new final preambular paragraph be added, reading: "Noting with satisfaction the initiative taken by the Director-General to convene a Health Resources Group, which will discuss how, with minimum duplication, the necessary resources can be made available and most effectively used to meet country needs in the priority areas defined by the Health Assembly", and that the phrase "including the activities of the Health Resources Group" be added at the end of operative paragraph 8 (3).

Like other delegations, his delegation was concerned about paragraph 11 (4) in section V on page 55 of document A34/5, which stated that resource transfers from developed countries should aim at reaching a level of 0.7% of their own health expenditure. Australia maintained its commitment of 0.7% of its gross domestic product on overseas development assistance, but was unable to accept the report's suggestion that 0.7% of domestic health expenditure be allocated to assist health projects in developing countries. He acknowledged, however, that an insufficient proportion of Australia's overseas development assistance was allotted to health projects. To remedy that situation, it intended to allocate a higher proportion of its overseas development assistance to health projects, and more specifically to those aimed at the development of primary health care.

Miss BETTON (Jamaica) congratulated WHO on the appropriate thrust it had given in document A34/5 to the development of the Global Strategy for health for all by the year 2000 in response to the mandate from the United Nations General Assembly in 1979, the Health Assembly and the earlier Alma-Ata report and Declaration. Jamaica reaffirmed its support for that strategy, as well as for the regional strategies contained in document A34/5 Add.1. However, the adoption of the Global Strategy would not alone bring about a change in the health status of the people of Member countries. It was only by the implementation of specific programmes of activities at the national level that the desired goal could be achieved. Each Member country had the responsibility to ensure that the mandate given was carried out.

To that end, WHO had to continue to improve its organizational structure in the light of its evolving functions, especially with regard to strengthening the regional committees and national coordinators' offices, to ensure that their effectiveness increased and that they became able to respond more readily to the needs of countries within the regions. The cost-effectiveness of programmes was of prime importance, especially in the developing countries where resources were limited. WHO had a specific role to play in promoting the necessary operational research to assist countries to develop the most appropriate national programmes in relation to their local priorities and resources.

She endorsed the priority given to the development of the health system at the primary health care level; however, she cautioned against any thought that health services at the primary health care level could alone bring about health for all by the year 2000. There was also a need for a comprehensive health care system that allowed continuity of care for high-risk patients at the secondary level. Health workers at all levels, as well as policy-makers, needed to understand the respective roles and the priority of primary care in relation to
secondary care. Secondary care was supportive to primary health care and had to form a part of the comprehensive health system. Without that understanding, the existing conflicts and misunderstandings would continue and would negate the efforts being made towards achieving health for all by the year 2000.

She urged delegates to give closer attention to the problem of the brain drain, particularly with regard to medical personnel, as it affected many developing countries: the receiving countries, which were mainly the industrialized ones, should take measures to facilitate a transfer of human resources to the developing countries. Her delegation supported the draft resolutions before the Committee on the Global Strategy for health for all and on encouraging cooperation to support countries in developing and implementing their national strategies for health for all; she hoped that, with regard to the former, the Health Assembly would mandate the Board to proceed with the early preparation of a plan of action for implementation of the Strategy. She considered that the latter draft resolution would also greatly assist efforts to achieve WHO's goals, and she hoped that both draft resolutions would receive the full support of the Health Assembly.

Mrs MAIR (United Nations Children's Fund) said that UNICEF's presence and participation were manifestations of its commitment to the objectives of the Health Assembly, and to the partnership between WHO and UNICEF, which stemmed from their shared concern for an effective global strategy for achieving health for all by the year 2000.

UNICEF's Executive Board was at present holding its annual meeting at United Nations headquarters in New York. The Executive Director of UNICEF had just reaffirmed the Fund's commitment to the goal of health for all by the year 2000. Within that goal the focus for UNICEF was on reducing infant mortality in developing countries to 50 per 1000 live births or less. For many countries that would represent at least a 50% reduction in the existing infant mortality rate. The achievement of such an ambitious goal within a period of 20 years had no historical precedent. At a time in history characterized by economic and political insecurity and by severe budgetary constraints, it might be asked whether such a dramatic goal was realistic.

UNICEF was convinced that the goal was not only realistic but essential; that the world had the technical and economic potential to affect a revolution in health within the next two decades. As the Director-General had eloquently proclaimed, what was first required was the political commitment to health for all, a political commitment of sovereign governments extending not only to national policy but also to the relationships between countries and all that was implied in the New International Economic Order.

UNICEF was pleased to have been associated with WHO in the formulation and advocacy of the primary health care approach as the key to achieving health for all. The endorsement of that approach at the highest political level in the United Nations General Assembly and its incorporation into the new International Development Strategy represented a real political breakthrough. However, the countries with which UNICEF and WHO cooperated had entered the difficult phase of implementing primary health care. They were encountering problems of a new dimension, many of which arose from two cardinal principles of the primary health care approach: namely, that health was a political and social responsibility of governments as such and not simply of their health ministries, and also that the people must be active partners in the improvement of health. Those principles could be put into effect when a government was fully convinced of their validity. Without them the attainment of health for all by the year 2000 was an illusion. The experience of countries in implementing primary health care had therefore become the central concern of the UNICEF/WHO Joint Committee on Health Policy, reflecting the common interests of the Health Assembly and the UNICEF Executive Board.

The Joint Committee had wisely recognized that the conventional forms of UNICEF and WHO cooperation were quite inadequate to meet the new challenge. At its session in February 1981 the Joint Committee had asked UNICEF and WHO to undertake a new kind of study, on how they might jointly provide more effective support to countries implementing primary health care. In that study the countries themselves would be the principal actors.

She was gratified to note that the UNICEF/WHO joint support to several critical components of primary health care had been strengthened during the past year, particularly through the leadership orientation workshops held in many regions and the collaboration in such areas as maternal, infant and young child nutrition, essential drugs, the control of diarrhoeal diseases, and water supply and environmental sanitation. It was evident that the impact of each of those efforts would be much greater if they were planned and executed in a coordinated way within the primary health care framework. UNICEF and WHO therefore had to ensure that their own assistance to countries was also well coordinated so as to support coordination within countries.
The WHO/UNICEF study which was the basis for the primary health care approach had been derived from the experience of several countries. Thus the formulation of the primary health care idea was already a form of technical cooperation among developing countries. In their continuing efforts to put primary health care into practice, countries were encountering many new operational problems and working out practical solutions as they proceeded. UNICEF placed a high priority on helping countries to analyse and document those valuable new experiences so that they might be fed into a continuing TCDC sharing process.

The primary health care approach aimed at national self-reliance with a much more effective use of the resources available within each country. Although the approach was clearly much more cost-effective than conventional health systems, its nationwide extension would require a very substantial increase in the national resources devoted to health. At the same time, it would have important international repercussions: a greater volume of external support for health would be required, and, just as important, support directed to the policy objectives of primary health care. Although some of the external resources would flow through WHO and UNICEF, the bulk of external aid would continue to be administered by major financial institutions and by bilateral organizations. It was therefore vitally important for UNICEF and WHO to remind those organizations of their endorsement of primary health care and to work with them and with developing countries to ensure that the necessary external aid was supplied.

The Joint Committee on Health Policy had commended the executive heads of WHO and UNICEF for having recently developed a joint plan of work and for the excellent collaboration to which that testified. At the same time it had expressed concern over the need to strengthen a joint presence of WHO and UNICEF at the country level, obviously the critical level for their joint support of country action. She hoped that serious efforts would be made to ensure the strong presence of both organizations where they were both needed.

Infant and young child feeding, which was an important component of primary health care, was one of UNICEF's high priority concerns and also one in which UNICEF's cooperation with WHO had been particularly productive. UNICEF and WHO had developed a joint action programme on maternal, infant and child nutrition, including the promotion and protection of breast-feeding within the framework of primary health care. Essential areas of that programme included the nutritional needs of pregnant and lactating mothers, the prevalence and duration of breast-feeding, the development of appropriate weaning foods, changes in the training curricula of health personnel, changes in hospital practices, social support for women, and so on. She had been especially gratified to hear in the debate many statements by governments attaching importance to that programme. She was also pleased that Committee A had approved the International Code on the Marketing of Breast-milk Substitutes, which would greatly assist efforts to promote breast-feeding and thereby further the cause of infant and child health. UNICEF looked forward to assisting governments in the achievement of those objectives.

Finally, she expressed UNICEF's deep appreciation not only for the technical support which WHO had provided so consistently over the years but also the inspired leadership of WHO in the field of health. WHO's vision of health as an attainable goal for all had brought a new dynamism to the long and close partnership with UNICEF.

Professor SHEHU (Nigeria) noted that the Organization's goal of health for all by the year 2000 had generated enormous interest among Member States, although the level of their commitment varied. Document A34/5 was well planned, comprehensive, and thought-provoking, but he welcomed above all its evolution from the country level. WHO terminology was sometimes difficult to comprehend and on occasion generated controversy as to its precise meaning. No such lack of clarity existed concerning health for all by the year 2000 and primary health care. However, health for all was not a finite target but a process leading to progressive improvement in the health of people; similarly, primary health care was a dynamic and evolving practice.

The success of the Global Strategy would largely depend on the success of national strategies. In that connexion, Nigeria's new Constitution and local government reforms had led to devolution of responsibility to the state and local levels, with a resultant impact on all facets of socioeconomic development. By virtue of their proximity to the people, local governments' actions tended to be more relevant to the community's needs; thus, financing received directly from the Federal Government was being channelled into programmes related to primary health care. The structure for the managerial process, which was intended to facilitate intersectoral links at the policy-making and delivery levels, would include development committees at the village and peripheral levels as well as cabinet subcommittees at the state and federal levels.
In the international field, Nigeria would continue to give strong support to OAU, the Economic Community of West African States and the West African Health Community, as well as WHO, UNICEF and other United Nations organizations. Believing that the development of regional and subregional self-reliance would accelerate the development of national self-reliance, Nigeria also strongly supported TCDC. Within Nigeria itself the Ministry of Health was encouraging multisectoral cooperation by highlighting the association between health and other sectors; for example, there was a multisectoral committee for the International Drinking Water Supply and Sanitation Decade, though primary responsibility for the Decade lay with the Ministry of Water Resources.

Nigeria believed that better use could be made of the inadequate resources now available, particularly if those provided by developed countries were no longer consumed by the salaries of their nationals or by inappropriate expensive technology. Much attention had been devoted to intersectoral cooperation between ministries but there was, as yet, little progress towards closer interaction between the Ministry of Health and medical training establishments. Compartmentalization in public service did not serve socioeconomic development or primary health care. Prior consultation with the users might help to counter the tendency of policymakers in developing countries to favour inappropriate and expensive technology. In many such countries, the technology was imported first, then personnel were sought to match it.

A research unit was a necessary component of a Ministry of Health and should be utilized to provide information for rational planning, implementation and evaluation, thereby helping to avoid wastage of scarce resources. Confusion over the roles and responsibilities of the three tiers of government (federal, state and local) and the community had been defined as a major cause of poor implementation of socioeconomic plans in Nigeria. The recent reforms had done much to alleviate the situation.

He drew attention to the different programme budget cycles and resource mechanisms existing within the United Nations system and asked whether steps were being taken to overcome that problem.

In conclusion, he expressed his Government's full support for the global targets set out in document A34/5, on which he hoped socioeconomic goals would now be based. It was inconceivable that the countries should aim at anything less, and Nigeria would strive to bring the dates for the realization of the targets significantly forward.

Consequently, he supported both the spirit and substance of the draft resolution proposed by the representative of the Executive Board.

Dr CHAMOV (Bulgaria) said that document A34/5 was a basic document that defined WHO's future activities. Great efforts had been made to draw up basic approaches to achieve health for all, and collective efforts in that direction should continue. He wished to make four points regarding the document.

First, interesting as the report was, it could not yet be approved as a programme guide. It failed to provide a definition of the concept of health for all. If it meant a level of health that would enable all citizens of the world to lead economically and socially productive lives, it was more a political slogan than an attainable global target. Secondly, such a definition should be derived from the term "public health" which had been commonly employed in the medical literature for some decades. Since WHO's activities were primarily geared to health for all, such a definition was now particularly necessary.

Thirdly, insufficient differentiation had been made in the document between countries and regions, as if the socioeconomic situation and the level of development of health care in the world, including the developing countries, could not alter by the year 2000. The laws of historical development could not be ignored.

Fourthly, the document purported to be a Global Strategy, but it gave much more attention to the developing than the developed countries, and that could well be reflected in the title. While the developing countries had to eliminate communicable and parasitic diseases in the next 20 years, they also still had to face cardiovascular diseases, cancer, occupational and environmental hazards, and other health problems prevalent in the industrialized countries.

His delegation would vote for the adoption of the Global Strategy, but suggested the creation of a working group, with broad geographical representation, to consider all the recommendations made so far.

Mr WHITE (New Zealand) considered the item to be the most important on the agenda from a functional point of view. He welcomed document WHA34/5, which would rank as one of the Organization's major achievements. His only concern related to paragraph 6(6) of section VII on "Monitoring and evaluation". He recognized that the section was in no way mandatory.
Nevertheless, he had reservations concerning the recommended resource transfer target of 0.7% of the health expenditure of developed countries. The allocation of a set percentage for use in a particular sector could not only impinge on the developing countries' right to determine their priority sectors, but could also prove too rigid for donors, whose cooperation, in order to be effective, required both forward planning and a degree of flexibility. His country, which took account of developing countries' priorities in its technical cooperation programmes, believed that operational rather than percentage terms would be more appropriate as an indicator.

He expressed support for the draft resolution proposed by the representative of the Executive Board, and for that referred to by the Australian delegation as amended by the Netherlands delegation.

Dr ZIESE (Federal Republic of Germany) expressed appreciation of the document and full support for many of the objectives it contained. However, he believed the proposed resource transfer target of 0.7% to be an arbitrary figure, with no logical relation to the basic needs of developing countries. It was, on the contrary, related to donor countries. No explanation was provided concerning calculation of the figure, nor was the "total health expenditure" defined. Did it, for example, include the social sector? His delegation was unable to accept that target as an indicator in any recommendation.

Professor LISICYN (Union of Soviet Socialist Republics) congratulated the Executive Board, the Director-General and all who had worked on the strategy and related documents. The Committee could concentrate on certain aspects with reference to the current state of health development in various countries and particularly to primary health care. As participants at the Alma-Ata Conference had seen, the USSR had a widely developed and comprehensive health care system which incorporated primary health care as a major link. His Government had therefore acquired considerable experience in devising strategies, plans and programmes for health care.

Since 1977, when the concept had first been elaborated and goals set, many adjustments had been made, and the Technical Discussions at the current Health Assembly had contributed to a clearer picture of the objectives of the Strategy and how it should be implemented. However, a fair amount of work still remained to be done particularly, as had been observed, on the development of simple, practical indicators; as the stage of research had not yet been reached it was felt that there was a danger of narrowing the scope of the Strategy and getting it into technical difficulties, or of setting such a broad spectrum of requirements that they were difficult to fulfil. As the delegate of Bulgaria had said, further clarification of the concept of public health was necessary since the objective of the Strategy was to ensure an optimum level of health for the entire population through primary health care. An approach using as indicators the organization of primary health care services and health infrastructure and the establishment of a comprehensive health system, important as those were, would not provide a definition of the goal of the Global Strategy that would be both clear-cut and flexible. His delegation would therefore support the amendments to the draft resolution submitted by the representative of the Executive Board that were being proposed by the delegation of the German Democratic Republic in a document circulated to the Committee and which would be introduced in due course by the delegate of that country. The aim of those amendments was to facilitate the further refinement of the Strategy.

As the Director-General had pointed out, it was most important to determine plans for implementation of strategies in countries before elaborating regional strategies. Preliminary successes were not sufficiently clearly related to technical cooperation plans. In that connexion he referred to the draft resolution on encouraging cooperation to support countries in developing their strategies; it was essential to find resources. He believed, however, that the figure suggested in document A34/5 for resource transfers from developed countries to developing countries was intended to be merely indicative and not mandatory.

In view of the need for further clarification and preparation, was a decision on the Global Strategy premature? Time was passing and it was necessary to avoid becoming bogged down in bureaucratic complications. His delegation could support some of the basic provisions of the Strategy provided they were further developed, and he referred, in that connexion, not only to objectives but also to specific plans and programmes. The overall goal was well stated in the draft resolution proposed by the representative of the Executive Board, and his delegation would support it, although he felt that it could be improved by redrafting. It might be supplemented by a definition of the objectives and the arrangements for implementing them. The preamble should be expanded to give a clearer statement of the policy considerations behind the Strategy, and of implementation measures, particularly for the provision of primary health care at optimum levels depending on the social and economic possibilities of each
country. The draft resolution should also give a clear statement of the need for countries to assume definite obligations for implementation of the Strategy. So far as language was concerned, his delegation had some slight difficulty with the word "contract", which in Russian was generally understood in a narrower context implying a financial obligation, but if it was understood in the literary sense of Rousseau's social contract, to which the Director-General had referred, it might be suitable.

Dr VARGAS (Nicaragua) said that his delegation was taking the opportunity to confirm its support for resolution XX of the Regional Committee for the Americas, adopted at the twenty-seventh session of the Directing Council of PAHO, which defined primary health care and its components as basic strategies for the achievement of health for all by the year 2000.

He did so in the spirit of the undertaking given by the Sandinist Revolution to the Nicaraguan people to achieve basic health care for the people through a single national health system. The aims of the system were: to provide health coverage throughout the national territory; to concentrate not only on treatment but more particularly on the preventive measures so necessary in his country, through improvements in environmental hygiene, and mass immunization; to give equal medical care opportunities to the population; and to involve the population in an active and advisory capacity in health measures.

His delegation, while confirming its support in the Health Assembly, felt obliged to draw attention to the way in which the implementation of plans of action might be hindered by the political, economic, scientific and technical factors prevailing in many Third World countries as a result of their former colonial status. Achievement of health for all by the year 2000 implied a decision to plan, implement and monitor health plans, it implied the adoption of realistic attitudes by both government and people, and finally it implied the need for changes in each country's productive structure and the limitation of expenditure to the real wealth produced by the country. He further drew attention to the problem of the scientific and technical dependence of Third World countries on developed countries, and the limitations deriving from monopolies in drugs, biologicals, and equipment.

In conclusion he congratulated the Director-General and the working group which had drawn up the report on the Global Strategy, which he considered a most important working document.

Mr ARSLAN (Mongolia) said that, as a result of discussions in the Executive Board and the Health Assembly, there was an awareness of the need for basic health care at the international level and for the definition of a global strategy. The global strategy for health care was to some extent related to the overall efforts to achieve a New International Economic Order. He was glad to note that WHO was taking the initiative in that area and he strongly approved of developing strategies starting at the country level rather than at global level. However, the integration of national strategies at regional and global levels in accordance with the principles developed at the Alma-Ata Conference and by the WHO Executive Board had not proved simple. The Global Strategy was not merely a conglomeration of regional and national strategies, but rather a synthesis of the general thrust of action that had to be effected at all levels and in all sectors. It was, in particular, incumbent on Member States themselves to carry out the measures endorsed by the International Conference on Primary Health Care, and governments would have to assume specific political commitments in order to implement the objectives of the Strategy. One such commitment might be a regional charter such as that already adopted by many States. He hoped that many more governments would adopt such commitments and that each government on its own initiative would fulfil its responsibility for ensuring health care for the people of its country.

His delegation supported the draft resolution proposed by the representative of the Executive Board, together with the amendments submitted by the delegation of the German Democratic Republic, and the draft resolution proposed by the delegation of Afghanistan and other delegations on encouraging cooperation to support countries in developing their strategies.

Professor SPIES (German Democratic Republic) agreed with the view of the representative of the Executive Board concerning the draft resolution on the Global Strategy; it was time to start on the plan of action. This was not to disagree with proposals to refine and develop the proposed Strategy, which, however, was already being done. While the programme was being implemented, its strong and weak points could be ascertained. The effects of the programme would certainly go beyond the year 2000.

The German Democratic Republic had submitted the following amendments to the draft resolution in an attempt at clarification:

Two new preambular paragraphs should be added, reading:
April 1971

"Appreciating the work the Secretariat so far has done in developing indicators for monitoring progress to health for all on all levels of the Organization;

Acknowledging the important role such indicators play in formulating global, regional and national strategies as well as enabling Member States to define their own state of development of health and health care in internationally comparable terms;"

In operative paragraph 5, a new sub-paragraph (3) should be added, reading:

"(3) to urge Member States to select and additionally elaborate indicators in regard to their specific objectives and health problems including their preference subjects of technical cooperation;"

In operative paragraph 6, two new sub-paragraphs (4) and (5) should be added, reading:

"(4) to continue the study of Member States' experiences in the field of evaluation and monitoring the status of health and of the health care system and to stimulate respective research work aiming at further improving and completing WHO's set of scientifically based and approved indicators with particular regard to those applicable to developing countries' conditions;

(5) to include progress in this area in the annual report to the Executive Board."

Indicators were important in that they could help the Organization not only to evaluate its work but to distinguish the more urgent problems from those less so. Even in this most interesting element of Strategy there was room for improvement; a number of features peculiar to certain States had not been suitable for inclusion, but, for the sake of accuracy, considerations such as differences in social, economic and political systems must be included. It had been useful to select only 12 criteria. Those 12 criteria had been met and even surpassed in the area of health care in the German Democratic Republic. This was not to say that there was no room for improvement, however. His country could draw on experience going back to the beginnings of health care in a socialist society, when at the end of the Second World War the whole health system had been destroyed.

The German Democratic Republic rejected as distasteful the activities of certain of the Western news media during the Thirty-fourth World Health Assembly with respect to the goal of health for all by the year 2000. Such defamation and spreading of alarm and despondency were shameful. The German Democratic Republic shared the opinion that health for all by the year 2000 was attainable if a joint effort was made. The present discussion and the three weeks of talks had been most useful and gave grounds for optimism. Many countries previously at a low stage of development had started to develop their own primary health care systems. The road was rough, but the determination, intelligence and will to succeed were there. His delegation was not blind to the obstacles, but problems were not confined to newly developing countries. The developed nations had their own difficulties: unemployment, alcoholism, drug addiction, racial discrimination. Such countries might be pessimistic about their ability to solve these problems by the year 2000. But the will was essential. The experience of the world family of nations could also be of help. The danger of war, the arms race, the nuclear threat were problems facing all nations, which could be overcome only by cooperation, not only in WHO but elsewhere.

The German Democratic Republic endorsed the opinions expressed in the draft resolution submitted by the delegation of Afghanistan and other delegations on the role of physicians and other health workers in the preservation and promotion of peace, feeling that it was one's duty to encourage doctors and scientists to cooperate to benefit mankind. Much had been said about the politically expressed will of nations, but the responsibility of the politicians must also be made clear. The best way to act was by a combination of clearly outlined political requests and concrete suggestions in the health sector. If this were not done, only scattered elements would remain, successful perhaps for a time, but essentially of only limited effectiveness. The Member States would remain prisoners of a one-sided view. Governments might have the will, but the people also had their responsibilities; they too must help themselves, each other, their neighbours. Cooperation was vital.

His delegation felt that the criteria should be more precisely developed. They should not give rise to competition between nations. Many studies of social hygiene and of health

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1 See summary record of the seventeenth meeting, section 3.
statistics existed, but his delegation believed that the very wide variety of historical and actual situations in different countries was a proof of the most urgent need to develop precise indicators for forecasting national trends until the year 2000. The German Democratic Republic was always ready to help developing nations in attaining this objective.

Dr HYZLER (United Kingdom of Great Britain and Northern Ireland) reiterated the United Kingdom's support for the WHO goal of health for all by the year 2000. The draft Global Strategy provided guidelines for its achievement, and his delegation endorsed the general tenor of the document. If the Strategy were to succeed, it must have inspiration, flexibility and realism. All these had been achieved in the draft document. Much of the credit for this was due to the Director-General, the Executive Board and its Chairman and their assistants in the Secretariat.

As a whole, the Strategy was well structured and well balanced. It was soundly based on the principle of the development of countrywide health systems based on primary health care, community involvement, intersectoral cooperation and the use of appropriate technology. Application of the proposed measures should ensure a sound foundation for health systems responding to the real needs of communities.

Some points in Section III of the document presupposed a strong central direction of health care delivery. This was no doubt a suitable method for many countries, but alternatives also existed. For instance, the United Kingdom had a decentralized, though coordinated system. The document also envisaged a relationship between health workers and authorities different from that in force in the United Kingdom, where doctors had independent contractual status within the National Health Service. These two examples show the importance of flexibility in planning.

The United Kingdom had doubts about the appropriateness of some of the proposed global indices, at least at the present time. His delegation suggested that it might be better to concentrate initially on national and regional indices. This would give experience which could subsequently be used in making a more pragmatic selection of global indicators. Another area of possible confusion was in terminology; he offered one example. The term "community health council" corresponded to an entity which existed within the United Kingdom National Health Service. Such councils however were essentially consumer groups, and not political decision-making bodies, as conceived in the strategy paper. It had been suggested that a glossary be appended, giving definitions of various terms. His delegation approved of such a suggestion.

At its January meeting one member of the Executive Board had thought inappropriate a figure of 0.7% of health expenditure as a resource transfer target on the basis of an analogy with the international target of total development assistance agreed on in the United Nations General Assembly in conjunction with international development strategy. The member had questioned how the health budget was to be defined. The United Kingdom shared these misgivings; its view on the figure of 0.7% had been recorded at the adoption of the international development strategy for the Third United Nations Development Decade. The United Kingdom saw no obvious reason to link the level of resources available in any single sector with the overall level of resources available as resource transfers for development. For these reasons and for those adduced by the delegations of the United States of America, Norway, France, New Zealand, and the Federal Republic of Germany, his delegation thought the proposal on page 55 of the document, section V, paragraph 11 (4), to be inappropriate. His delegation was consequently unable to accept the related indicator in section VII, paragraph 6 (6).

The United Kingdom's record of technical cooperation was well known. The Government intended to maintain a programme of assistance to developing countries as far as its circumstances allowed. In general, his delegation endorsed the strategy and reaffirmed its commitment to respond to it to the best of its ability, and its support for the draft resolution on the Global Strategy.

Professor ARAUJO (Cuba) said that, after studying all the relevant documents, his delegation was in general agreement with the criteria set forth in them. Document A34/5 was of the utmost importance for directing the action of countries in planning and implementing their national health plans and the Global Strategy for health for all by the year 2000. The Director-General and the Secretariat should be commended for having produced a document of extraordinary depth and scope. While it might be amended to take account of delegations' comments, the document was a fundamental one for enabling countries to initiate and follow up the difficult task before them. His delegation approved that task and was ready to join all other developing countries in achieving it.
Referring to the draft resolution on encouraging cooperation to support countries in developing strategies, proposed by the delegations of Afghanistan, Angola, Cape Verde, Cuba, Cyprus, the Democratic People's Republic of Korea, Guinea-Bissau, Iraq, Libyan Arab Jamahiriya, Mozambique, Nicaragua, Sao Tome and Principe, Sri Lanka, United Republic of Tanzania and Yugoslavia, which was a composite of three resolutions adopted by the health ministers and representatives of Members of the Non-aligned Movement and of other developing countries, he said that, at their fifth meeting, ministers and representatives had analysed the possible difficulties that developing countries might face in implementing their strategies for health for all by the year 2000. Those difficulties were related to the planning process and financing. In considering their collaboration with WHO with a view to obtaining the necessary financial and technical support funds for countries requiring them, the health ministers and representatives had decided to add their weight to that of the Director-General in his approaches to United Nations bodies and other possible sources of funds.

For lack of time, it had not been possible to obtain signatures for all countries participating in the meeting just mentioned. He appealed to delegations to support the composite draft resolution.

Dr Jiménez De Bethancourt (Panama) said that her delegation also wished to support that draft resolution. On 15 January 1979, Panama had established a Ministry of Health whose motto was "equal health for all". Ever since its establishment, it had made tremendous efforts to reach every corner of the country, in order not merely to raise hopes but to apply adequate technical criteria for improving the health of the people. Her delegation could not but support the commitment entered into at Alma-Ata. She nevertheless wished to make a few comments.

Her delegation was aware that the contribution that would have to be made from the health budgets of the more powerful countries would be a very heavy burden on them. Nevertheless, if those countries thought about the reasons for the present state of health in the Third World countries, many of them would probably feel some responsibility. It was important to realize that the attitudes or economic policies of the economically powerful countries were the direct cause of that situation. In the circumstances the world might not achieve the desired objective by the year 2000. For example, the high cost of oil made it impossible to reach some of the remote areas of her country; it was difficult to provide drugs for the Indian population at the present phenomenal cost. Despite all its austerity measures, the Government could not afford the necessary measures to deal with the situation. It wished to ensure that every citizen enjoyed the health to which he was entitled, but that was impossible as long as the powerful countries continued to maintain the arms race and to force up living costs. The Third World countries must protest against that inexorable evil. In investing their funds, developed countries should consider what they could do for more needy countries. The latter were not asking for charity, but, as a human right, for support in reaching the same level as others.

Members of the Health Assembly must act as instruments for peace, and for health for all by the year 2000. Mankind was now conquering outer space, but had to ensure that human beings could continue to exist on earth. The delegation of Panama respected the opinions and ideologies of other countries, but the Health Assembly should ensure that the necessary action would be taken to see that powerful countries contributed to the health protection of the populations of the smaller countries.

Dr Mwamba (Zambia) said that his delegation was happy to note that other organizations had appreciated what had been done by WHO in the health sector and recognized the importance of health for development. Other organizations were no doubt delighted that those in the health sector had embarked on a redirection that involved interpreting and formulating development-oriented health policies. Development was a key word and a solution. Its importance was such that it was now used to distinguish between countries. His country, which viewed its health efforts as directly aimed at development, supported the strategy for health for all.

Referring to the indicator in section VII, paragraph 6 (3) of document A34/5, he asked for a definition of health as used in that context. His delegation believed that such a definition should determine the level of percentage of gross national product (GNP) rather than the other way round. On what basis had the level of 0.7% as the indicator in paragraph 6 (6) been arrived at, and how was that level related to the year 2000 in terms of the needs of the intended recipients? What was the relationship between the indicator given in paragraph 6 (12) and the year 2000 in real terms?

Finally, he asked for clarification of operative paragraph 4 (1) and operative paragraph 5 (2) of the draft resolution proposed by the representative of the Executive Board.
Mr CAREAU (Canada) said that his delegation wished to become a co-sponsor of the draft resolution on resources for strategies proposed by the delegations of Algeria, Australia, Belgium, Burundi, China, Colombia, Egypt, Greece, Malta, Mexico, Netherlands, Peru, Portugal, Rwanda, Spain, Swaziland, Turkey and Zaire.

Dr BELCHIOR (Brazil) said that his delegation wished to congratulate the Director-General and to join the many delegations that had commended document A34/5, which was a final and complete version of the initial health strategy documents arising out of the historic Alma-Ata Conference and the Thirty-second and Thirty-third World Health Assemblies.

In line with resolution WHA32.30, his Government had decided that primary health care should be the pillar of its national health policy. The accomplishment of that objective was closely related to the country's national development and was being conducted despite the present unfavourable economic situation. Brazil was making all possible efforts to extend health services to the whole country. To that end, all organizations acting in the health field were making combined efforts at the community level in the firm resolve to enable the people to reach the state of wellbeing they deserved.

As far as priorities were concerned, his country was determined to offer primary health care particularly to the small rural communities, to the periphery of urban areas and to areas with unsatisfactory living conditions. In order to deal with its many health problems, it was devoting special attention to endemic diseases, to diseases susceptible to immunization, to malnutrition and to basic sanitation.

Improvement of maternal and child health services to 70% of the population, which was to receive the highest priority, would represent the main effort of his country's overall health programme.

In its global strategy, Brazil was giving special attention to human resources through the joint efforts of the Ministries of Health, Education and Social Security, with collaboration from the universities and departments of health and education of the different states. Only through primary health care and ample social and economic development would it be possible for Brazil to attain the goal of health for all by the year 2000.

Mr VAN KESTEREN (Netherlands) said that document A34/5 rightly stressed the importance of an intersectoral approach to health problems and to efforts to improve health. Attention should also be paid to development in other sectors, such as education, housing, agriculture, water supply and sanitary provisions. The Netherlands awaited with great interest the plan of action that was to follow the strategy. The extensive list of indicators for monitoring and evaluation formed a promising start in that respect.

Explaining his delegation's proposed amendments to the draft resolution on resources for strategies for health for all, he said that, when it had been asked to co-sponsor the resolution, it had been glad to do so, but it had felt that, in a draft resolution on that particular subject, mention should be made of the Health Resources Group. It had been too late to include such a reference in the draft resolution and his delegation had therefore decided to submit a formal amendment. He welcomed the support expressed for the amendment, and hoped it would be possible to include a text on those lines in the final draft resolution.

The CHAIRMAN announced that a working group, composed of the Chairman of the Executive Board and the delegations of Belgium, Zambia, Swaziland, Cuba, France, Netherlands, German Democratic Republic, Mozambique, Union of Soviet Socialist Republics and Democratic People's Republic of Korea, would meet immediately after the closure of the Committee's present meeting to elaborate a text of the draft resolution on the Global Strategy that would incorporate the various amendments proposed.

The meeting rose at 12h55.
1. HEALTH FOR ALL BY THE YEAR 2000: Item 21 of the Agenda (continued)

Global Strategy: Item 21.1 of the Agenda (Resolution WHA32.30, para. 9 (1); Document WHA32/1979/REC/1, Annex 2, para. 134; Document A34/5 and Add.l) (continued)

Dr KLIVAROVA (Czechoslovakia) supported the Global Strategy for health for all by the year 2000. Since the Strategy, as indicated in the Alma-Ata Declaration, was aimed primarily at providing health care for the entire world population, she proposed that the Declaration should be referred to in the preamble of the draft resolution proposed by the representative of the Executive Board on the item. She emphasized the need for the formulation of a plan of action by the Secretariat for submission to the Board and subsequently to the Health Assembly.

With regard to section VII of document A34/5, the global health indicators in paragraphs 6(7) to 6(12), whilst applicable to many developing countries and to other regions, did not apply to the European Region. In her own country, for example, all the indicators outlined had been exceeded long ago. The section should therefore be developed for the European Region so that the indicators led to improvements in health and health services. The countries and the Regional Office should set themselves higher targets, in terms of life expectancy, infant mortality, literacy, etc. She therefore supported the amendments to the draft resolution proposed by the delegation of the German Democratic Republic at the previous meeting.

Dr ADIBO (Ghana) was gratified to note that many delegations shared similar views on the item under consideration. He drew attention to three areas of particular importance which were closely interlinked: the establishment of a health information system; the development of appropriate indicators; and financing. First, a health information system was needed for the future development not only of primary health care but of the health care system as a whole. The complex problems of gathering, storing, retrieving, processing and interpreting information at the various levels of planning and decision-making required close attention in order to avoid wasting resources, especially in relation to supplies, and WHO could play a leading part in the establishment of such an information system. Secondly, sensitive indicators must be developed in order to measure progress towards socioeconomic goals and there again WHO had an important role to play. Thirdly, after looking very carefully at the various health and health-related activities, including the International Drinking Water and Sanitation Decade and the International Year of Disabled Persons, he was becoming increasingly convinced that financing was the most serious single obstacle in the way of attaining health for all by the year 2000. Successful, effective primary health care in the developing countries meant establishing the necessary infrastructure for rural development, which was very expensive. However, the current uncertain state of the world economy, coupled with inefficient use of resources, had made the flow of assistance from the industrialized countries to the developing countries more difficult. He therefore supported the Director-General's efforts to establish a health resources group.

His delegation supported the draft resolution and proposed amendment on resources for strategies for health for all by the year 2000 and the draft resolution proposed by the representative of the Executive Board, and suggested that it might be possible to combine the two so that there was one single resolution on the all-important topic of health for all by the year 2000.

Mr BENAVIDES (Peru) strongly supported the Global Strategy, which was a synthesis of the measures necessary to achieve a satisfactory level of health for all by the year 2000. In pursuing that aim, the international community was engaged in a race against time. Some countries had already achieved the goals outlined; for others, however, "health for all" was
the great hope and a question of life or death. Those societies that had already achieved the goals could either remain spectators of this 20-year race or do all in their power to assist and encourage the participants. The Health Assembly could do little to tackle all the horrors facing mankind. Nevertheless, he appealed to all Members to work towards the elimination of one of the most shocking diseases. Accordingly, his country was a co-sponsor of the draft resolution on resources for strategies for health for all. It also supported the draft resolution on encouraging cooperation to support countries in developing and implementing their national strategies, and would vote in favour of the draft resolution proposed by the representative of the Board.

Dr MKANDAWIRE (Malawi) said that his Government, in endorsing the primary health care approach as the most appropriate method of attaining the goal of health for all by the year 2000, had formulated national strategies involving the promotion of the active participation of the community in order to meet the country's needs. He therefore welcomed the Global Strategy proposed in document A34/5, which he believed would be instrumental in promoting international solidarity in health matters and in translating WHO objectives into action. However, countries would need not only to adopt national strategies but also to attain self-reliance in their execution. That would entail an assurance from WHO and other agencies of continued assistance in improving national capabilities.

His delegation supported the draft resolution proposed by the representative of the Executive Board, together with the proposed amendments.

Mr TEKA (Ethiopia) said that his delegation fully supported the Global Strategy presented in document A34/5 and A34/5 Add.1 as well as the draft resolution proposed by the representative of the Executive Board. He believed that the slogan "Health for all by the year 2000" would have a significant place as a landmark in the history of mankind, and merited the support of all, particularly the developed countries.

Referring to the proposal to transfer at least 0.7% of the health expenditure of the developed countries to the developing countries (section V, paragraph 11(4) of the document), he appealed to those delegations from developed countries that had expressed reservations or refused to make any commitment in that connexion to reconsider their position so that health for all became a reality for mankind within the time-limit set.

Professor HALEEM (Bangladesh) supported the draft resolution on encouraging cooperation to support countries in developing and implementing their national strategies for health for all by the year 2000. He emphasized the importance of developing national strategies in line with the requirements and situations of the individual countries. At the same time, countries must believe in the nine basic principles on which the WHO Constitution was based, and in particular the principle of enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being. Moreover, unless countries thought in terms of peace, health as it had been defined by WHO could never be realized. He drew attention to the differences in the problems faced by the developed and the developing countries and the seriousness of such problems as communicable diseases, malnutrition, lack of housing, inadequate educational opportunities and unemployment in the latter, which would render the goal of health for all by the year 2000 unattainable without the collaboration of the developed countries and without a multisectoral approach to health.

Miss GARRIDO-RÚÍZ (Mexico) welcomed document A34/5. Her delegation was a co-sponsor of the draft resolution on resources for strategies for health for all. It also supported the draft resolution proposed by the representative of the Executive Board and the draft resolution on encouraging cooperation to support countries in developing and implementing their national strategies. However, it wished to record a reservation in relation to the draft resolution proposed by the representative of the Board. It had difficulty in accepting the term "contract" because of its legal connotations and would prefer an alternative expression, such as "moral commitment" or "commitment".

Dr MARQUES DE LIMA (Sao Tome and Principe) expressed his delegation's support of the Global Strategy and urged all nations to pursue their efforts to attain the goal of health for all by the year 2000, bearing in mind the fundamental importance of mutual cooperation.

Mr SAWI (Sierra Leone) congratulated the Director-General and the Secretariat on their valuable contribution to the formulation of the Global Strategy. His own country was firmly committed to the primary health care approach. The financial and technical requirements,
however, were enormous and the most careful attention must therefore be devoted to the issue of resource procurement for the developing countries. In conclusion, his delegation wholeheartedly supported the draft resolution proposed by the representative of the Executive Board.

Dr AL-SARRAG (Sudan) considered that the draft Global Strategy was realistic and practical. He fully endorsed the draft resolution on encouraging cooperation to support countries in developing and implementing their national strategies for health for all by the year 2000, which corresponded closely to the activities being carried out by Sudan. With the help of WHO, Sudan had initiated a national health programme in 1974 which outlined solutions to the country's health problems. A primary health care programme had been introduced in 1976, which devoted due attention to preventive and social medicine. In 1980, a seminar had been organized to establish a national strategy for achieving the goal of health for all. The same year, a health development conference had been held in Khartoum with the participation of all levels of the population. The President of Sudan had issued a national proclamation containing the country's health strategy on 7 April 1980, World Health Day. His delegation welcomed the draft resolution proposed by the representative of the Executive Board and urged its adoption.

Dr BARAKAMFITIE (representative of the Executive Board) congratulated the Committee on its interesting discussion of what was perhaps the most important item on the agenda of the Thirty-fourth World Health Assembly. The adoption of the Global Strategy would no doubt be a historic decision. In preparing the document, the principle objective had been to provide the Organization with one of the most important instruments in the service of health to have been devised over the past 10 years - one which would be equally useful for the developed and the developing countries. It had been prepared by the Executive Board on the basis of national and - through the regional committees - regional strategies and could be said to reflect the bulk, if not all, of the national and regional aspirations of the Member States of WHO.

Twelve indicators, representing a kind of common denominator, had been selected by the Board as being accessible to virtually all Member States, which could apply them as appropriate to their national circumstances. The Board had also requested the Director-General to publish a detailed document on indicators (document EB67/13 Add.1, Annex) which would no doubt be of assistance to industrialized and developing countries alike. As to the indicator of the number of developed countries from which at least 0.7% of the health expenditure was transferred to support strategies for health for all in developing countries, that was an illustration of the kind of solidarity that was necessary to implement the Strategy. Once the Strategy had been adopted, most of the work still lay ahead. Realistic plans must be drawn up, a certain number of priorities established and the administrative machinery created without which progress was impossible.

In conclusion, he thanked the members of the Committee for their expressions of appreciation of the efforts which had gone into the preparation of the Global Strategy; their observations would be very useful to the Board in drawing up the plan of action for its implementation.

The DIRECTOR-GENERAL, speaking on behalf of the entire Secretariat, expressed satisfaction that the Committee had found its contribution to the preparation of the Global Strategy useful. As it stood, the document was not yet a refined or highly polished text but was already an adequate basis for action, and could, of course, be progressively improved as any shortcomings became apparent. In the light of the discussion that had been held on the subject, the Secretariat was in a position to make a certain number of editorial and even slight substantive modifications to the draft in areas regarding which certain delegates had expressed concern. The references to the indicators, for example, could be altered so as to reflect better their relevance to both the developed and the developing countries. Specifically, it might be advisable to change the wording of the indicator relating to resource transfers so as to render it both more operational in tone and acceptable to all: that could be done by having it refer directly to developing countries that were receiving external support on a sustained basis. In that way, the text would relate precisely to the very purpose of the Health Resources Group, which was to enable developing countries to challenge the more affluent countries with well defined strategies for health for all. Such an indicator, moreover, would illustrate the shortfall in developing countries with a genuine health for all strategy which were not receiving the minimal external support they required in order to move forward. He hoped that, with certain improvements, the Global Strategy would come to be looked upon as a most useful strategy.
The CHAIRMAN said that a working group had produced draft resolutions on the Global Strategy and on resources for strategies for health for all which would be considered by the Committee at its next meeting.

(For continuation, see summary record of the seventeenth meeting, section 3.)

2. PERIODICITY AND DURATION OF HEALTH ASSEMBLIES: Item 36 of the Agenda (Resolution WHA33.19; Document EB67/1981/REC/1, decision EB67(6) and Annex 13; Document EB67/1981/REC/2, pages 284-295) (continued from the thirteenth meeting, section 2)

The CHAIRMAN invited the Committee to consider the following draft resolution proposed by a working group:

The Thirty-fourth World Health Assembly,
Having considered the reports and recommendations of the Executive Board and the Director-General on the periodicity and duration of Health Assemblies;
Recalling resolution WHA33.19 which expressed the belief that Health Assemblies in even-numbered years should be limited to not more than two weeks' duration;
1. DECIDES that commencing in 1982 the duration of the Health Assembly shall be limited to not more than two weeks in even-numbered years, when there is not a proposed programme budget to consider;
2. REQUESTS the Executive Board to elaborate the necessary methods of work for implementation on a trial basis at the Thirty-fifth World Health Assembly;
3. REQUESTS the Director-General and the Executive Board to submit a report to the Thirty-sixth World Health Assembly on the results of the trials in respect of both the methods of work and the duration of the Health Assembly for its consideration.

Mr GILBERT (United Kingdom of Great Britain and Northern Ireland) strongly supported the draft resolution proposed by the working group. Unless the go-ahead were given for a Health Assembly of two weeks' duration, the Secretariat might have difficulty in making suitable arrangements for the next Assembly and the delegates in adjusting to new methods of work and new timetables. There seemed to be widespread approval of any measures which might speed up the despatch of the Assembly's business. Shortening the duration of the Assembly by one week, moreover, would save about three-quarters of a million dollars in administrative costs. He therefore urged the Committee to approve the draft resolution by consensus, on the understanding that the Director-General and Executive Board would have sufficient flexibility to try out various alternatives. The Thirty-sixth World Health Assembly in 1983 would then be able to judge for itself which changes could be deemed a success.

The draft resolution was approved. ¹

3. COLLABORATION WITH THE UNITED NATIONS SYSTEM: Item 42 of the Agenda (continued)

General matters: Item 42.1 of the Agenda (Document EB67/1981/REC/1, resolution EB67.R21 and Annex 10; Document A34/18) (continued from the twelfth meeting, section 2)

The CHAIRMAN invited the Committee to consider the following draft resolution on health assistance to refugees in Africa, sponsored by the delegations of Algeria, Argentina, Benin, Canada, Central African Republic, China, Egypt, France, Gabon, Ghana, Iran, Kuwait, Morocco, Netherlands, Nigeria, Norway, Oman, Qatar, Saudi Arabia, Sierra Leone, Somalia, Sudan, Tunisia, United Arab Emirates, United Republic of Tanzania, United States of America and Upper Volta:

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA34.29.
The Thirty-fourth World Health Assembly,

Taking note of resolution CM/Res.814 (XXXV) adopted by the Assembly of the Heads of State and Government of the Organization of African Unity at its 17th Session held at Freetown, Sierra Leone, from 1 to 4 July 1980 and the United Nations General Assembly resolution 35/42, on the International Conference on Assistance to Refugees in Africa (ICARA);

Deeply concerned about the plight of refugees in Africa and their ever increasing numbers which now constitute over half the population of the refugees in the world;
Noting with appreciation that the Secretary-General of the United Nations convened a successful International Conference on Assistance to Refugees in Africa, in Geneva on 9 and 10 April, 1981;
Appreciating the assistance given to refugees in Africa by those who participated in the Conference and by international and voluntary organizations;
Mindful of the essential principle contained in the WHO Constitution which provides that the health of all peoples is fundamental to the attainment of peace and security;

1. DECIDES to give high priority to the assistance provided to refugees in Africa in the area of competence of WHO;
2. REQUESTS the Director-General:
   (1) to continue and intensify his cooperation, within his fields of competence, with the UNHCR and other concerned organizations in implementation and follow-up of the conclusions of ICARA;
   (2) to report to the sixty-ninth session of the Executive Board and Thirty-fifth World Health Assembly on the measures taken by the Organization to assist the African refugees.

Mr TEKA (Ethiopia) proposed that, wherever refugees were referred to in the draft resolution, the phrase "and displaced persons in Africa" should be added.

Dr AL-SARRAG (Sudan) said that, although he had sympathy for the plight of displaced persons and agreed that they should be given assistance, the resolution had been carefully drafted to reflect the two resolutions mentioned in the first preambular paragraph, namely resolution CM/Res.814 (XXXV) adopted by OAU and General Assembly resolution 35/42. Neither of those original resolutions made any reference to displaced persons. The issue had been debated at length in the United Nations Economic and Social Council, the Office of the High Commissioner for Refugees, and the General Assembly, and it had been agreed that such a reference was not appropriate. He would be ready to support any separate resolution that the delegate of Ethiopia might wish to make expressing his concern for the plight of displaced persons, but the resolution now under consideration was not the place to express that concern.

Mrs ENO-HASSAN (Somalia) supported that view. The draft resolution had its origins in the coordinated efforts of the United Nations and OAU, culminating in the International Conference on Assistance to Refugees in Africa (ICARA). The resolution simply sought to implement the recommendations of that conference. It was not wise to try at this stage to combine two issues which hitherto had not been considered to have anything in common, and she therefore did not think that the Ethiopian proposal could be accepted.

Mr TEKA (Ethiopia) said that if the sponsors of the resolution did not find his proposed amendment acceptable, he would like consideration of it to be deferred in accordance with Rule 52 of the Rules of Procedure of the Assembly, which provided that resolutions should be circulated 24 hours before they were to be considered.

Dr FERNANDES (Angola) thought that, since the problem of refugees and the problem of displaced persons were closely linked, the Ethiopian proposal to mention the two together should be welcomed. He agreed that more time should be allowed to study the problem.

Dr AL-SARRAG (Sudan) recalled that the Ethiopian delegation had joined in supporting both OAU resolution (CM/Res.814) (XXXV) and General Assembly resolution 35/42. It was for the Ethiopian delegate to judge whether it was right for him to take a different position from that taken by his Government on previous occasions.
He agreed with the Somali delegate that the draft resolution was not the right place to include a reference to displaced persons, since the two resolutions on which it was based dealt specifically with the problem of refugees. Even if the question were to be deferred, the same situation would still prevail.

Mr TEKA (Ethiopia) stressed that his delegation's stand was basically in support of the draft resolution; he had only suggested a minor amendment. He did not think his position was different from that taken by his Government on previous occasions.

Mr VOHRA (India), Dr BOOTH (Australia), Professor VON MANGER-KOENIG (Federal Republic of Germany), Dr MARQUES DE LIMA (Sao Tome and Principe) and Mr BENAVIDES (Peru) said that their delegations wished to be included among the co-sponsors of the draft resolution.

It was so agreed.

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

International Year of Disabled Persons, 1981: WHO's cooperative activities within the United Nations system for disability prevention and rehabilitation: Item 42.3 of the Agenda (Document EB67/1981/REC/1, decision EB67/12 and Annex 14) (continued from the thirteenth meeting, section 3)

The CHAIRMAN invited the Committee to consider the following draft resolution on the item, proposed by a working group:

The Thirty-fourth World Health Assembly,

Recalling resolution 31/123 of the United Nations General Assembly proclaiming the year 1981 as "International Year of Disabled Persons";

Recalling resolution WHA31.39 requesting the Director-General to contribute extensively to the success of the International Year;

Considering that the disabled, rather than being a load on society and nations, should benefit from the effort of prevention, treatment, readaptation and rehabilitation to enable them to effectively share in the normal activities of society;

Noting that in addition to malnutrition, communicable diseases, poor quality of care, and traffic and work accidents, wars, armed aggressions, torture and the suppression of fundamental human rights constitute a factor in the considerably increasing number of physically, psycho-traumatically and mentally disabled persons;

Noting the efforts deployed by the Director-General in favour of the disabled;

1. CONGRATULATES the Director-General for his report and on the action already taken;

2. RECOMMENDS that Member States:

(1) continue and increase their efforts to ensure the success of the International Year of Disabled Persons;

(2) build on these efforts and develop permanent programmes that would benefit the disabled, as an integral part of activities towards the goal of health for all by the year 2000;

3. REQUESTS the Director-General:

(1) to collaborate with Member States in support of programmes of disability prevention and rehabilitation within the primary health care context, especially in developing countries;

(2) to enhance cooperation with other United Nations agencies, regional intergovernmental organizations and international nongovernmental organizations in the planning and implementation of the above programmes;

(3) to contribute to the evaluation of the above programmes, particularly in view of their adequacy and effectiveness;

(4) to report periodically to the World Health Assembly on the progress of the programmes.

The draft resolution was approved. 1

1 Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA34.30.
Committee B: Sixteenth Meeting

Cooperation with newly independent and emerging States in Africa: liberation struggles in Southern Africa - assistance to front-line States: Item 42.6 of the Agenda (Document EB67/1981/REC/1, resolutions EB67.R7, EB67.R8 and EB67.R9; Document A34/21) (continued from the fourteenth meeting, section I)

The CHAIRMAN invited the Committee to consider the following revised draft resolution on the item sponsored by Algeria, Angola, Benin, Botswana, Cape Verde, Cuba, Equatorial Guinea, Ethiopia, Guinea-Bissau, India, Jamaica, Lesotho, Mozambique, Swaziland, United Republic of Tanzania, Yugoslavia, Zaire, Zambia and Zimbabwe:

The Thirty-fourth World Health Assembly;
Recalling resolutions WHO29.23, WHA30.24, WHA31.52, and WHA32.20;
Referring to resolution AFR/RC30/R14 of the Regional Committee for Africa adopted in conformity with operative paragraph 3.1 of resolution WHO33.17 on the study of the Organization's structures in the light of its functions;
Recalling resolutions WHA33.33 and WHA33.34 and further recalling the relevant resolutions of the United Nations General Assembly and Security Council concerning the liberation movements in Southern Africa recognized by the OAU;
Noting the escalation of aggression perpetrated by the racist minority regime of South Africa against the People's Republic of Angola, the People's Republic of Mozambique and the Republic of Zambia;
Considering the effects of the attacks and bombings of the civilian population and the destruction of the health infrastructure in front-line States, coupled with economic blackmail of the above States and Lesotho and Swaziland;
Considering that the persistent refusal of the racist South Africa regime to negotiate with the legitimate representatives of the people of Namibia poses an additional threat to security and welfare of the peoples of the front-line States and Lesotho and Swaziland;
Reaffirming the right of the people of Namibia and South Africa to determine their own health policies and to participate in the global strategy of health for all by the year 2000;
Bearing in mind that the deterioration in the situation in Namibia and South Africa leads to an increase in the number of refugees in the front-line States, Lesotho and Swaziland;
Bearing in mind that despite action taken pursuant to resolution WHO33.34 concerning the Republic of Zimbabwe, the health situation in this newly independent country still remains serious;

1. EXPRESSES once again its satisfaction at the concerted efforts made by WHO and other United Nations agencies and the international community for their technical cooperation with the above-mentioned Member States;
2. THANKS the Director-General for his commitment to technical cooperation with the above-mentioned Member States;
3. GIVES its full and entire support to the front-line States, Lesotho and Swaziland for the assistance given to refugees from South Africa and Namibia;
4. REQUESTS the Director-General to:
   (1) intensify cooperation in the field of health with the front-line States, victims of repeated aggressions by the South African regime, as well as with Lesotho and Swaziland which have also suffered provocations and economic blackmail;
   (2) give special priority, in the health assistance programmes within the WHO African Region, to the front-line States, Lesotho and Swaziland;
   (3) continue the collaboration with the United Nations agencies and the international community in order to obtain the necessary support in the health sector of national liberation movements recognized by the OAU;
   (4) accelerate the implementation of the special action programmes for support to Zimbabwe, in collaboration with other United Nations agencies;
   (5) submit a detailed report to the Thirty-fifth World Health Assembly of the progress made in the implementation of this resolution.
Mr BOND (United States of America) proposed that a vote be taken on the draft resolution.

The draft resolution was approved by 78 votes to none, with 7 abstentions.1

Mr BOND (United States of America), speaking in explanation of vote, said that his delegation strongly supported the provision of health assistance to the States mentioned in the draft resolution, and indeed to any States that needed it. He would have preferred to join in a consensus on the draft resolution, and would have been willing to do so if it had not included wording with political implications that were not relevant to health. It was unfortunate that resolutions such as the present one, which were aimed at meeting health needs, were frequently burdened with political rhetoric which some Members found impossible to support. Such practices only tended to distract attention from the humanitarian aims of the Organization. He hoped that in future efforts would be made to present resolutions which were likely to achieve consensus, since it was only through consensus that results could be achieved.

Mr VARGAS (Colombia) explained that his delegation had abstained from voting on the draft resolution because it contained elements that were alien to the objectives of the Committee and of WHO as a whole. Although his Government shared the concern of other Members that assistance should be provided where needed for humanitarian reasons, there were other bodies whose task it was to deal with the problems touched on in the draft resolution.

Mr McKINNON (Canada) said that a number of delegations had made sincere efforts the previous day with a view to reaching consensus on the draft resolution that had just been approved. It was their belief that such a resolution had much greater value when it was supported by all members of the Health Assembly. Such resolutions on Southern Africa and the front-line States had always in the past been accepted or approved by consensus. Unfortunately, after a text had been agreed which might have been approved by consensus, the co-sponsors had seen fit to add a new preambular paragraph which contained wording that could not be accepted; the co-sponsors had been aware of that fact and it was for that reason that the delegation of Canada had abstained in the vote.

Dr LUBANI (Jordan) said that health, as the Alma-Ata Declaration reaffirmed, was not merely the absence of disease, but was a state of complete physical, mental and social wellbeing. WHO had an important part to play in enabling man to achieve that state. The resolution on assistance to front-line States which the Committee had approved related to the issue of health in general. Collaboration with the newly independent and emerging States in Africa was part of the Organization's task.

Mr ISHIMOTO (Japan) said that his delegation had had some difficulty with the preamble of the draft resolution but had nevertheless voted in its favour because it was in entire agreement with the objectives of the resolution as a whole.

The CHAIRMAN reminded the Committee that the resolution on assistance to front-line States which it had just approved had replaced the draft resolution recommended by the Executive Board in resolution EB67.R7.

He invited the Committee to consider the draft resolution proposed by the Board in resolution EB67.R8, concerning the special programme of cooperation with the Republic of Equatorial Guinea.

The draft resolution was approved.2

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Board in resolution EB67.R9, which related to the special programme of cooperation with the Republic of Chad.

The draft resolution was approved.3

1 Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA34.31.
2 Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA34.32.
3 Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA34.33.
The CHAIRMAN invited the Committee to consider the draft resolution on assistance to Namibia introduced at the thirteenth meeting, and which was sponsored by the delegations of Angola, Benin, Botswana, Cape Verde, Cuba, Equatorial Guinea, Ethiopia, Gambia, Guinea-Bissau, India, Jamaica, Lesotho, Mozambique, Sao Tome and Principe, Swaziland, Tunisia, United Republic of Tanzania, Yugoslavia, Zaire, Zambia and Zimbabwe.

Mr GILBERT (United Kingdom of Great Britain and Northern Ireland) requested that a vote be taken on the draft resolution.

The draft resolution was approved by 73 votes to 4, with 9 abstentions.1

Mr BOND (United States of America), speaking on behalf of the delegations of Canada, France, Federal Republic of Germany, the United Kingdom and the United States, expressed regret at the introduction into the Health Assembly of a resolution containing elements which went beyond the competence of WHO. The five governments could not accept the South West Africa People's Organization (SWAPO) as the true representative of the Namibian people. Nor could they accept some of the essentially political language contained in the preambular paragraphs. For those reasons they had been unable to vote in favour of the draft resolution. At the same time, he wished to reiterate the commitment of the five governments to an internationally acceptable settlement of the Namibian issue; they were committed to vigorous action in an effort to bring Namibia to independence at an early date. That position had been made clear in a statement issued by their foreign ministers in Rome on 3 May 1981.

Dr THOMSON (Australia) said that his delegation had voted for the two draft resolutions dealing respectively with assistance to front-line States and to Namibia, as it had felt able to support the general thrust of the resolutions. It was unfortunate that it had not been possible for both resolutions to be approved by consensus and his delegation believed that a stronger search for consensus could have brought about the removal of language introducing political issues which his delegation considered to be out of keeping with the traditions and competence of WHO. His delegation had not, however, withheld its general support for the draft resolutions.

The designation of SWAPO in operative paragraph 2(1) of the resolution on assistance to Namibia did not invalidate his delegation's view that, while it considered SWAPO to be an important protagonist in the resolution of the problem of Namibia, SWAPO's status must be left to the Namibian people themselves to determine in free and fair elections in accordance with Security Council resolution 435.

Mr HOWADT (Austria) associated himself with the delegate of Australia in regretting that the search for consensus had not been pursued further. His delegation's support for the draft resolution on assistance to Namibia was on the clear understanding that it would not prejudice the necessary democratic process in Namibia.

Mr DE JONG (Netherlands) wished to record the views of the 10 Member States of the European Community on the resolutions which had been approved by the Committee under item 42.6 of its Agenda and, in particular, on the resolutions on assistance to front-line States and to Namibia.

The delegates of those States had welcomed the consensus which had seemingly been reached on the draft resolution on assistance to front-line States during the consultations which had taken place the previous day. It was unfortunate however that, in the revised draft resolution, a new preambular paragraph had been introduced which referred to resolution AFR/RC30/R14 of the Regional Committee for Africa. That insertion had reintroduced elements which had made consensus on the resolution impossible and had forced some of the 10 States to abstain. Even if a majority of the 10 had been able to vote in favour of the resolution, all their delegations regretted that, in a number of paragraphs of the resolution, language had been used which reflected unnecessary political overtones. Such language was not consistent with the traditions and working atmosphere of WHO.

1 Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA34.34.
Even although some of the 10 States had voted in favour of the two draft resolutions, notwithstanding the reference to national liberation movements recognized by OAU, that did not imply any change in the position of the 10 in relation to the recognition of national liberation movements or to the status of SWAPO. The 10 States considered that the Namibian people themselves should as soon as possible elect their own representatives in free general elections under the supervision of the United Nations in accordance with Security Council resolution 435.

Dr FERNANDES (Angola), deploring the positions adopted by those delegates who had voted against or had abstained in the vote on the two resolutions, said that their delegations had been requested the previous day to identify clearly the principles with which they disagreed. Those delegations had replied that they agreed with the principles contained in the two resolutions but not with the wording. During the consultations it had become clear that those delegations had wished to raise issues of substance and had even questioned the representative character of SWAPO, which was the only body recognized by the United Nations, OAU and different international institutions.

Mr PINTO DE LEMOS (Portugal) said that his delegation had voted for both draft resolutions and had thus shown its support for the strengthening of cooperation with newly independent and emerging States in Southern Africa. He nevertheless deplored the language used in certain paragraphs in so far as it was of a political nature. His delegation's vote did not imply any change in Portugal's stand on the question of Namibia.

Dr MWAMBAZI (Zambia) said that the preambular paragraph which had been added to the draft resolution on assistance to front-line States had referred to resolution AFR/RC30/R14 of the Regional Committee for Africa, which was the highest WHO organ for the African Region. That resolution had been transmitted to the Executive Board which in turn had recognized it and mentioned it to the Health Assembly in its resolution EB67.R7.

The meeting rose at 17h25.
1. SIXTH REPORT OF COMMITTEE B (document A34/44)

At the invitation of the CHAIRMAN, Dr ASHLEY (Jamaica), Rapporteur, read out the report (document A34/44).

The report was adopted (see document WHA34/1981/REC/2).

2. COLLABORATION WITH THE UNITED NATIONS SYSTEM: Item 42 of the Agenda (continued)

General matters: Item 42.1 of the Agenda (Document EB67/1981/REC/1, resolution EB67.R21 and Annex 10; Document A34/18) (continued from the sixteenth meeting, section 3)

The CHAIRMAN invited the Committee to consider the draft resolution on health assistance to refugees in Africa, which had been presented at the preceding meeting.

Mr TEKA (Ethiopia), recalling that his delegation had proposed the addition of the words "and displaced persons" after the word "refugees" in the draft resolution because the health needs of the two groups were interrelated, withdrew his proposal.

The draft resolution was approved.¹

3. HEALTH FOR ALL BY THE YEAR 2000: Item 21 of the Agenda (continued)

Global Strategy: Item 21.1 of the Agenda (Resolution WHA32.30, para. 9(1); Document WHA32/1979/REC/1, Annex 2, para. 134; Document A34/5 and Add.l) (continued from the sixteenth meeting, section 1)

The CHAIRMAN invited the Committee to consider the following draft resolution proposed by a working group:

The Thirty-fourth World Health Assembly,
Recalling resolution WHA30.43, which defined the goal of health for all by the year 2000, resolutions WHA32.30 and WHA33.24, which endorsed the Declaration of Alma-Ata and urged Member States to formulate national strategies for attaining health for all through primary health care as part of a comprehensive national health system, and resolution 34/58 of the United Nations General Assembly concerning health as an integral part of development;
Also recalling resolutions WHA27.29 and WHA29.32, which requested the Director-General to strengthen WHO's mechanisms for attracting and coordinating an increasing volume of bilateral and multilateral aid for health;
Noting with satisfaction the decision taken by the Executive Board at its sixty-seventh session concerning the establishment of a Health Resources Group;

¹ Transmitted to the Health Assembly in the Committee's seventh report and adopted as resolution WHA34.35.
AWARE that some countries have encountered difficulties in developing and implementing their national strategies for health for all, and convinced that these countries urgently require special support to enable them to overcome their difficulties;

1. WELCOMES the efforts being made by Member States to prepare and implement national strategies for health for all through the development of health systems based on primary health care;

2. URGES all Member States to allocate adequate resources for health and in particular for primary health care and the supporting levels of the health system;

3. URGES Member States that are in a position to do so to increase substantially their voluntary contributions, whether to WHO or through all other appropriate channels, for activities in developing countries that form part of a well-defined strategy for health for all, and to cooperate with these countries and support them in overcoming the obstacles impeding the development of their strategies for health for all;

4. INVITES the relevant agencies, programmes and funds of the United Nations system, as well as other bodies concerned, to provide financial and other support to developing countries for the implementation of national strategies to achieve health for all by the year 2000;

5. URGES those Member States that, for the implementation of their strategies for health for all, require external sources of funds in addition to their own resources, to identify those needs and report thereon to their regional committees;

6. INVITES the regional committees to review regularly the needs of Member States in the Region for external resources in support of well-defined strategies for health for all and report thereon to the Executive Board;

7. REQUESTS the Executive Board to review regularly the international flow of resources in support of the Strategy for health for all, to ensure that such resources are effectively and efficiently used for that purpose, and to report thereon to the Health Assembly;

8. DECIDES that the World Health Assembly will review from time to time the international flow of resources for health and will encourage those Member States that are in a position to do so to ensure an adequate level of transfer;

9. REQUESTS the Director-General:
   (1) to support developing countries as required in preparing proposals for external funding for health;
   (2) to take appropriate measures for identifying external resource requirements in support of well-defined strategies for health for all, for matching available resources to such needs, for rationalizing the use of such resources, and for mobilizing additional resources if necessary;
   (3) to report regularly to the Executive Board on the measures he has taken and the results he has obtained.

Mr SOKOLOV (Union of Soviet Socialist Republics) queried the meaning of the third preambular paragraph of the draft resolution since he understood that in accordance with decision EB67(5) of the sixty-seventh session of the Executive Board the Director-General was still continuing his consultations on the setting-up of the Health Resources Group. He did not understand why the draft resolution referred to the Health Resources Group as having been established.

The DIRECTOR-GENERAL said that the idea of a Health Resources Group had been mooted at the Thirty-third World Health Assembly and had been discussed at the sixty-seventh session of the Executive Board. He thought that the English text of the third preambular paragraph constituted no contradiction and was quite compatible with the Executive Board's decision EB67(5). There was possibly some misunderstanding in the Russian text of the draft resolution, which would be corrected.

The draft resolution was approved.\(^1\)

\(^1\) Transmitted to the Assembly in the Committee's seventh report and adopted as resolution WHA34.37.
The CHAIRMAN invited the Committee to consider the following draft resolution proposed by a working group:

The Thirty-fourth World Health Assembly,
Recalling WHO's constitutional objective of the attainment by all peoples of the highest possible level of health, the Declaration of Alma-Ata, and resolutions WHA30.43, WHA32.30, and WHA33.24 concerning health for all by the year 2000 and the formulation of strategies for attaining that goal, as well as resolution 34/58 of the United Nations General Assembly concerning health as an integral part of development;
Having reviewed the Strategy submitted to it by the Executive Board in the document entitled "Global Strategy for health for all by the year 2000";
Considering this Strategy to be an invaluable basis for attaining the goal of health for all by the year 2000 through the solemnly agreed, combined efforts of governments, people and WHO;
1. ADOPTS the Global Strategy for health for all by the year 2000;
2. PLEDGES WHO's total commitment to the fulfilment of its part in this solemn agreement for health;
3. DECIDES that the Health Assembly will monitor the progress and evaluate the effectiveness of the Strategy at regular intervals;
4. INVITES Member States:
   (1) to enter into this solemn agreement for health of their own volition, to formulate or strengthen, and implement, their strategies for health for all accordingly, and to monitor their progress and evaluate their effectiveness, using appropriate indicators to this end;
   (2) to enlist the involvement of people in all walks of life, including individuals, families, communities, all categories of health workers, nongovernmental organizations and other associations of people concerned;
5. REQUESTS the Executive Board:
   (1) to prepare without delay a plan of action for the immediate implementation, monitoring and evaluation of the Strategy, and submit it, in the light of the observations of the regional committees, to the Thirty-fifth World Health Assembly;
   (2) to monitor and evaluate the Strategy at regular intervals;
   (3) to formulate the Seventh and subsequent General Programmes of Work as WHO's support to the Strategy;
6. REQUESTS the regional committees:
   (1) to review their regional strategies, update them as necessary in the light of the Global Strategy, and monitor and evaluate them at regular intervals;
   (2) to review the Executive Board's draft plan of action for implementing the Strategy and submit their comments to the Board in time for it to consider them at its sixty-ninth session in January 1982;
7. REQUESTS the Director-General:
   (1) to ensure that the Secretariat at all operational levels provides the necessary support to Member States for the implementation, monitoring and evaluation of the Strategy;
   (2) to follow up all aspects of the implementation of the Strategy on behalf of the Organization's governing bodies, and to report annually to the Executive Board on progress made and problems encountered;
   (3) to present the Strategy to the United Nations Economic and Social Council and General Assembly in 1981, and report to them subsequently at regular intervals on progress made in implementing it as well as United Nations General Assembly resolution 34/58.

The draft resolution was approved. 1

1 Transmitted to the Health Assembly in the Committee's seventh report and adopted as resolution WHA34.36.
The contribution of health to socioeconomic development and peace - implementation of resolution 34/58 of the United Nations General Assembly and of resolutions WHA32.24 and WHA33.24 (Item 21.2 of the Agenda) (Resolutions WHA32.24 and WHA33.24, para. 4(4); Document A34/6)

Dr KILGOUR (Director, Division of Coordination), introducing the item, said that resolutions WHA32.24 and WHA33.24 had asked the Director-General to study the question of how health contributed to socioeconomic development and thereby to conditions essential for peace. He recalled that resolution WHA32.24 had been adopted following consideration of the item on collaboration within the United Nations system, whereas resolution WHA33.24 had been adopted in the light of the Technical Discussions held in 1980 on the contribution of health to the New International Economic Order.

The report in document A34/6 was self-explanatory, but he drew particular attention to paragraph 4.4 of the document.

The CHAIRMAN drew attention to the following draft resolution on the role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all, sponsored by the delegations of Afghanistan, Angola, Botswana, Bulgaria, Cuba, Czechoslovakia, Ethiopia, German Democratic Republic, Hungary, India, Kuwait, Libyan Arab Jamahiriya, Mongolia, Mozambique, Poland, Saudi Arabia, Union of Soviet Socialist Republics, and Viet Nam:

The Thirty-fourth World Health Assembly,
Having considered the reports of the Executive Board and of the Director-General on the Global Strategy for the attainment of health for all by the year 2000 and the contribution of the public health sector to socioeconomic development, especially in developing countries, as well as for maintenance and promotion of peace being the most significant factor for the protection of peoples' life and health;
Taking into consideration the provisions of the WHO Constitution that attainment of the highest possible standard of health of peoples on the basis of full cooperation of individuals and States is one of the fundamental factors for peace and security, and recalling resolution 34/58 of the United Nations General Assembly stating that peace and security, in their turn, are of the utmost importance for preservation and improvement of health of all people and that cooperation between States on the vital problems of public health can to a great extent contribute to the cause of peace;
Recalling the provision of the Alma-Ata Declaration emphasizing that an 'acceptable level of health can be attained for all the people of the world by the year 2000 through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts';
Recalling resolutions WHA13.56, WHA13.67, WHA15.51, WHA17.45, WHA20.54, WHA22.58, WHA23.53, WHA32.24, WHA33.30, WHA33.24 and others concerning the role of physicians for preservation and promotion of peace, protection of mankind against nuclear radiation, reduction of military expenditures and allocation of released resources to socioeconomic development including public health, especially in developing countries;
Considering the aggravation of the international situation at present and the growing danger of thermonuclear conflict, whose unleashing in any form and on any scale will inevitably lead to irreversible destruction of the environment, death of hundreds of millions of people, carrying also grave consequences for the life and health of population of all countries of the world without exception and future generations of mankind, which will undermine the efforts of the States and WHO to achieve health for all by the year 2000.
Noting further the growing concern of physicians and other health workers in many countries at the mounting danger of thermonuclear war as the most serious threat to the life and health of all populations and their desire to prevent thermonuclear disaster which is an indication of the increased awareness among physicians and other health workers of their moral, professional and social duties and responsibilities to safeguard life and to improve human health, and to apply every means and resources to attaining health for all;
1. REASSERTS most strongly its appeal to Member States to multiply their efforts for the purpose of consolidating peace in the world, reinforcing détente and achieving disarmament in order to so create conditions for release of resources for the development of world public health;
2. REQUESTS the Director-General:
(a) to expedite and intensify the study of the contribution that WHO as a United Nations specialized agency could and should make to economic and social development in order to facilitate the implementation of the United Nations resolutions on strengthening of peace, détente and disarmament and prevention of thermonuclear conflict and for this purpose, invites him to create an international committee composed of prominent experts of medical science and public health;
(b) to continue collaboration with the United Nations Secretary General, other governmental and non-governmental organizations, to the extent required, in establishing a large and competent international committee of scientists and experts for comprehensive study and elucidation of the threat of thermonuclear war and its potentially fatal consequences for the life and health of peoples of the world.

Professor LISICYN (Union of Soviet Socialist Republics) welcomed the inclusion of the item on the agenda and the report on it by the Director-General. The preservation of peace, the averting of a thermonuclear war and the lessening of tension were of vital importance since the very future of mankind depended upon them. In that connexion, a great responsibility was borne by the medical men of the world and they must deploy their humanitarian efforts to the fullest extent possible.

The Organization had always undertaken action in accordance with its responsibilities for the protection of mankind against the hazards of radiation and bacteriological and biological warfare, and the United Nations General Assembly had dealt with the reduction of military expenditure and the transfer of the relevant resources to social and health activities.

The Director-General had referred during the discussion on the programme budget to the necessary conditions for the preservation of peace and security in the world, the betterment of health and the development of international cooperation. Numerous resolutions had been adopted on the subject, of which he would mention in particular General Assembly resolution 34/58 referring to health as an integral part of development, and resolutions 35/7 and 35/8, adopted by the thirty-fifth session of the United Nations General Assembly, on preservation of nature. He also mentioned resolution AFR/RC27/R9, adopted by the Regional Committee for Africa at its Twenty-seventh session, in which it had stated that atmospheric or underground tests of nuclear weapons were a direct health hazard to the entire African continent and the world as a whole and had recommended the introduction of a ban on such tests.

In view of those precedents, and the noble example set by WHO and the United Nations, it was necessary to undertake regular measures to preserve peace and encourage cooperation among States. WHO and Member States had an ongoing responsibility in view of the continuing arms race, particularly the nuclear arms race, and the mortal danger which that represented for mankind. It was easier for physicians than for anyone else to imagine the horrors of a nuclear holocaust. At the recent first International Congress of World Physicians against Nuclear War the horrific consequences of thermonuclear war had been considered. All areas of the world, even the most remote, would be involved, hundreds of millions of people would die and most of those who survived would be condemned to death from burns and radiation. Under such conditions, the provision of medical treatment to the population at large would be virtually impossible.

Every possible step must be taken to avert such a dread possibility and he therefore appealed to all delegates to endorse the provisions of the draft resolution before the Committee.

Dr ABDULHADI (Libyan Arab Jamahiriya) stated that his delegation regarded the question under discussion as most important. WHO must affirm its role in the area of socioeconomic development and the preservation of peace. After many years the Organization had finally realized that it could not function if it ignored the context in which its work was carried out. Therefore, it must take account of a number of factors, including the fact that its efforts might be hampered by war, the degradation of the environment and the introduction of toxic substances into the environment. Resolution 34/58 of the United Nations General Assembly was of importance in defining the role of WHO in this field. Doctors and medical workers could not hope to attain health and wellbeing for all men unless they took such factors into account. All medical workers must work for peace and must mobilize their communities to do the same. The public must be made aware of the threats which existed to human health.
Quite apart from questions of politics and ideology, doctors and medical workers must be considered as a team working for human betterment and thus aware of the threats to man’s survival. The Libyan delegation was a co-sponsor of the draft resolution under consideration, being convinced of the importance of the role of WHO and of health personnel in the promotion of peace, both global and regional. It believed that WHO represented a moral human force which must protect human rights, health and wellbeing and resist any threat to them.

Mr BAATH (Syrian Arab Republic) said that physicians and health workers were in general most acutely aware of the scourge of war, since they tended its victims. The Constitution of WHO stressed the importance of peace as a prerequisite of health, and it was also a prerequisite for the attainment of health for all by the year 2000; peace based on justice, freedom (including freedom from colonialism) and independence was essential.

Dr FERREIRA (Mozambique) said that the relationship between health and peace was of prime importance. The Director-General’s report and the Global Strategy bore out this view. The resources which could be made available if disarmament became a reality were such that all means must be employed to encourage it. The Committee should consider how favourably better provision of water, food, drugs, transport and training of medical staff compared in cost with modern weaponry. Mozambique stood for peace, but she was beset by colonialism. The States bordering on the Indian Ocean desired that the area should be demilitarized, but imperialist powers continued to increase their military potential there and the Southern African racist regime threatened Mozambique, more particularly since it had developed a nuclear weapon through close links with its imperialist allies. The attainment of health for all by the year 2000 was impossible unless there was peace as a prerequisite. It was these factors which had prompted the delegation of Mozambique to become a co-sponsor of the draft resolution.

Mrs LUETTGEN (Cuba) stated that her delegation was also one of the co-sponsors of the draft resolution, believing that it corresponded to the wish of the Cuban people to contribute to the attainment of health for all by the year 2000. That wish was endorsed by Cuba’s own achievements in the area of health. Cuba was also convinced of the relationship between health and economic development, not only on theoretical grounds, but also on grounds of experience. It was correct to affirm that health for all entailed a willingness to struggle for peace, so that the money spent on weapons might be spent on the furtherance of socioeconomic development and health for the peoples of the world.

Dr RINCHINDORJ (Mongolia) said that his delegation had studied the documents on that most important item with care, and believed that important steps were being taken. A stable political climate and international peace were a guarantee for the successful economic development of States and for the achievement of health for all by the year 2000. Of importance in this context were the efforts of the international community to avoid war, especially thermonuclear war. It should be noted that the international situation had in recent years become more complex, and the potential for war could nullify all efforts made by WHO including the attainment of health for all by the year 2000. For this reason the Mongolian delegation co-sponsored the draft resolution and hoped that the Committee would support it.

His delegation also hoped that document A34/INF.DOC./5, entitled "The contribution of health to socioeconomic development and peace", containing a memorandum from the Soviet delegation on "The preservation of peace and the prevention of a thermonuclear catastrophe", would be of assistance to delegates in considering the item under discussion.

Mr WOHRA (India) said that, if the spirit of earlier Health Assembly and United Nations General Assembly resolutions was examined, it would be seen that the basic urge of all countries had been to bring about a climate in which divisive forces were reduced or eliminated and energies were used for more fruitful purposes, notably health. It was easy to speak of peace and health but not so easy to interrelate them in operational terms.

Document A34/6 provided a brief, clearly enunciated review of the efforts made by WHO in various spheres to implement the recent ideas on the New International Economic Order, the International Development Strategy and the Third United Nations Development Decade. He noted the statements made by other delegations and expressed appreciation to WHO for its systematic efforts.

The representative of UNCTAD had stated that the world spent a little over US$ 600 000 million on health in 1980, 90% of such expenditure being incurred in developed countries, whose per capita expenditure on health was about US$ 500. The remaining 10% was spent in the
developing world, reflecting a per capita expenditure on health of not more than US$ 15 per annum. It had been suggested that if the developed world were to divert 10% of its current expenditure to the developing world, that part of the world could double its health investments. While that was statistically interesting, it was not so easy to accomplish. When it came to specific terms, there was a tendency to shy away, references even to 0.7% being resented.

In the developed and developing world alike, 40-50% of all health expenditure was on drugs. It was indicated in document A34/6 that the Organization was continuing to urge the United Nations bodies concerned to secure more favourable terms for drug purchase, to ensure the transfer of the relevant resources and technology and to strengthen national capacities in basic drug formulation, medicine manufacture, etc. Several years earlier, the Director-General had launched various initiatives to see how greater help could be secured from the more powerful elements in the pharmaceutical world for the procurement and distribution of essential lifesaving drugs and medicines. Much more might be done in that well-defined operational area, both nationally and regionally and through WHO headquarters, since there was a vast opportunity not only for fostering technical cooperation in that field among countries but also for helping to reduce expenditure on imports of drugs, vaccines, etc. He therefore urged the Director-General to consider more specific initiatives for a time-limited programme of action through UNDP and other agencies concerned, under which specific countries in various regions could be enabled to develop their capacity for self-sufficiency and reduce their current expenditure.

It was not only the moral influence of the physician, the medical scientist and the medical researcher that was needed for bringing about peace. The willing support and assistance of all scientists, political leaders, governments, and people in positions of responsibility was required in order to usher in a more peaceful era.

Dr KLIVAROVÁ (Czechoslovakia) said that the questions raised in document A34/6 with respect to the contribution of health to socioeconomic development and peace were extremely important. The present item was one of the most important on the Health Assembly's agenda. Referring to the adoption of the Global Strategy for the achievement of health for all by the year 2000, she asked how health was to be envisaged in the event of a thermonuclear catastrophe. Not only would life in the countries directly involved be destroyed but living and health conditions in other countries would deteriorate.

With a view to safeguarding life on earth and achieving health for all by the year 2000, an international advisory committee should be established to make a comprehensive study on the threat of thermonuclear war and its possible consequences. The Organization could thus contribute to the implementation of United Nations General Assembly resolution 34/58, operative paragraph 1 of which stressed the issues referred to by the Director-General during the discussion on the programme budget, namely, that States must endeavour to strengthen world peace, to promote the relaxation of international tension, and to bring about disarmament so as to free resources for public health development, particularly in the developing countries. Her delegation therefore appealed to other delegations to vote in favour of the draft resolution before the Committee.

Dr HASSOUN (Iraq), supporting the comments made by previous speakers, said that his delegation wished to become a co-sponsor of the draft resolution, being firmly convinced of the important part to be played by doctors, nurses and middle-level health personnel in preserving peace through the promotion of health, and in averting mass destruction. That should be the joint objective of all concerned.

Professor HALEEM (Bangladesh) strongly supported the implementation of United Nations General Assembly resolution 34/58 and of resolutions WHA32.24 and WHA33.24. He had appealed on a number of occasions for determination on the part of all Member States to achieve health as defined in the Constitution. If countries really believed in that goal there should be no problem, but it was the genuine determination of the peoples of the world that would really ensure peace, health and overall socioeconomic development. The peoples of the developed countries in particular should assist in achieving the goal set forth in the relevant resolutions.

Unless nuclear power was used for peaceful purposes, and not for destruction, health for all could not be achieved. It was essential to discover ways and means of averting nuclear war. Even if the nuclear deterrent could not be dispensed with, it could at least be limited to some extent. He therefore strongly urged the countries concerned to reduce their nuclear
budgets as far as possible and to make voluntary contributions to the goal of health for all by the year 2000. He thanked the Director-General for having given so much thought to the implementation of WHO’s programme.

Dr SEBINA (Botswana) congratulated the Director-General on all the Secretariat had done to encourage various United Nations conferences and agencies to recognize the important role of health in socioeconomic development. He thought it was true, as the report contained in document A34/6 mentioned, that health was an important development objective and that the whole purpose of development was to serve mankind. Any development which did not meet the needs of the people was meaningless.

Dr Kilgour had drawn attention to paragraph 4.4 of the report, inviting countries to discuss ways of improving the links between peace and socioeconomic development in Member States. Paragraph 2.6 of the report clearly stated that socioeconomic development could not occur without a minimum amount of security. He thought that statement was of critical importance. It was important for Member countries to note that, without internal peace and security, without people feeling that they were personally safe and that their property was protected, it was impossible to talk about socioeconomic development, a state of complete social and physical well-being, or health for all by the year 2000. Therefore, peace and security were important both internally and internationally; the world was so interdependent that no country could be safe when another country was without peace. Also, as developed countries needed raw materials from developing countries, if there were no peace and security in a remote African country producing such materials it would affect the more developed countries which bought them. If developed countries spent all their resources and funds on the arms race, on manufacturing weapons of destruction, it would also affect those countries producing raw materials, because they needed finished goods, perhaps machinery for agricultural development, for water supply and for other development activities which would receive lower priority.

That was the context in which his delegation wished to see the world made safer, and it therefore fully supported resolution 34/38 of the United Nations General Assembly and the efforts of the Organization for peace and security. He referred particularly to the consideration expressed in the preamble of that resolution "that peace and security are important for the preservation and improvement of the health of all people and that co-operation among nations on vital health issues can contribute importantly to peace".

Mr FEIN (Netherlands), speaking on behalf of the 10 Members of the EEC and the delegation of Canada, which wished to associate itself with his statement, stressed that they were fully aware of the grave consequences for mankind of a nuclear war and therefore attached great importance to dealing with the problems of arms control, disarmament and the reduction of international tension. However, although it could of course be said that there was a link between health and peace, as there was also a link between peace and many other things in the world, he did not think that the World Health Assembly was the proper forum for discussion of disarmament questions. He highly valued the expertise of physicians and other health workers in their own fields of activity but did not believe that their expertise extended to complex problems of arms control and disarmament. Consequently he saw no merit at all in establishing special bodies or committees in the framework of WHO for those problems. Discussions and negotiations on disarmament should and did in fact take place elsewhere, multilaterally and bilaterally, in the United Nations system and other forums, for example, in the Committee on Disarmament in Geneva, the United Nations General Assembly, the United Nations Disarmament Conference and many other bodies, but not in WHO.

In that connexion he pointed to a study by the United Nations Secretary General, contained in United Nations document A/35/392, which already covered the questions raised in the draft resolution before the Committee. If such political questions were introduced into the Health Assembly it would certainly divert attention, time and resources from the primary goal of WHO: health for all by the year 2000. Such a course would serve no one, least of all those countries most in need of international assistance in the field of health care.

He did not doubt that many among the co-sponsors of the draft resolution were moved by honest concern for the preservation of international peace. But he was surprised to find among the co-sponsors certain States which had only recently aggravated international tensions considerably by their military intervention and occupation of neighbouring countries. He did not want to elaborate on the effects of those military actions on the health situation of the populations concerned, including the plight of countless refugees; however, he advised those
States to withdraw their forces and spend the resources thus saved on health services. All wished that at least part of the resources now being spent for military purposes could be used for the attainment, amongst other things, of higher levels of health. He therefore urged the co-sponsors to whom he had just referred to set a good example by rearranging their national budgets in the spirit of the Alma-Ata Declaration, as quoted in the third preambular paragraph of the proposed draft resolution. In the EEC countries the per capita expenditure for health was equal to or even considerably larger than that for defence.

The delegations for whom he spoke completely rejected the draft resolution before the Committee and refused to cooperate in reducing the World Health Assembly to a platform for political purposes that were extraneous to the mandate and work of the Organization.

Dr OWEIS (Jordan) stressed his country's support of the draft resolution and reaffirmed that the noble objective of health for all and of social and economic development could not be obtained unless there was a world community where peace based on justice prevailed, where there was real détente and where freedom was granted to all mankind: a community without domination, aggression and all the instruments of destruction and warfare. What benefits could be obtained if one nuclear explosion was capable within a few seconds of nullifying all the efforts exerted for decades for man's welfare? To realize that disease and suffering in the world were attributable to colonialism, racism and domination was the key to achieving WHO's objectives. Without such a realization only symptoms would be treated. Continued use of a mere sedative would lead to a sad outcome which no human being could accept.

Dr BRYANT (United States of America) said that his delegation fully supported the statement made by the delegate of the Netherlands and associated itself with that statement, including the grave concern it expressed over the consequences for mankind of a nuclear war. His delegation, however, regretted that the World Health Assembly, which was concluding another fruitful session, had been called upon to consider the resolution, which was essentially a disarmament resolution and should be referred to other forums competent to discuss such matters. As the delegation of the Soviet Union well knew, the Committee on Disarmament met in the Palais des Nations for almost six months of the year. A special session of the United Nations General Assembly on disarmament was being prepared. Those were the forums competent to discuss the present draft resolution.

He was also surprised to see among the co-sponsors of the resolution several delegations that had not only advocated more stringent budgetary discipline in WHO, but had actually refused to support the budget in a vote earlier in the week. They had also urged the Secretariat to identify marginal programmes that could be cut down or eliminated. Yet the Committee was now asked to consider programmes, and additional expenses, in a field that was of the most marginal relevance to the Organization.

He urged the co-sponsors of the resolution to consider withdrawing it from the Health Assembly and introducing it elsewhere. If that were not possible, his delegation would have to vote against it.

Mr MUSIELAK (Poland) said that his delegation had explained at the Thirty-second and Thirty-third World Health Assemblies what it considered to be the important aspects of socioeconomic development and the related role of health. It had been trying to place WHO's adopted strategies in the wider context of the implementation of the United Nations Declaration on Social Progress and Development, according to which health for entire populations was one of the main objectives of economic growth. The contribution of the health sector to economic development and social progress was known. The Technical Discussions at the Thirty-third World Health Assembly had brought a number of new ideas and a better understanding of the Alma-Ata Declaration as a source of guidance. In short, WHO was trying with some degree of success to tackle those problems bound to arise when such important strategies were formulated as the one for health for all by the year 2000. Since the Alma-Ata Conference it seemed that the partnership had been strengthened.

Two salient points emerged from an analysis of the progress made so far. First, the attainment of WHO's goals required institutionalized, intensive action by governments and organizations of people having the will to obtain harmonious social development. Second, there appeared to be a new approach to the question of social development and a growing awareness of its role in health. The Director-General's report in document A34/6 not only summarized but also refined the points made and agreed upon when WHO had discussed and adopted its strategies. The summary in paragraph 4.2 of the report stated: "The goals of socio-economic development and peace are interdependent." There could be no more substantial and important statement. Resolution WHA33.24 elaborated very appropriately on that point.
A growing feeling of security was a prerequisite for social and economic development, not only in the political but also in the material sense. A lack of international security was bound to draw resources from social sectors, including the health sector. During the general debate the Minister of Health of Poland had stated that his country was implementing its programmes under conditions unforeseen at the Alma-Ata Conference. Tension was growing in the world, or, at least, détente had been adversely affected. Yet what was needed was détente and not confrontation, peaceful dialogue rather than the threat of conflict. Reason and security must prevail. People were alarmed at the enormous cost of the armaments race; he asked what cost was further being paid in terms of the health of individuals and populations. Among efforts to improve the situation, many countries, including socialist countries, whether separately or in concert, were reviewing their commitment to peace, disarmament and the growing need for international cooperation. That helped to create conditions conducive to the fulfilment of WHO’s mission. Poland approved strongly of such an approach and intended to contribute to peace. The Polish people knew from experience that the effects of war could endure for a generation. For example, with regard to tuberculosis it was estimated that three generations had been, still were, or would be affected by the Second World War. The Polish delegation associated itself with all moves in the Health Assembly which aimed to impress upon Member States the urgency of the situation and the necessity to appeal and to act for peace. Poland would support with its experience and expertise specific actions undertaken by WHO.

WHO was part of the United Nations system, which had been created for the specific purpose of maintaining peace and promoting peaceful cooperation among States. No dichotomy existed between the whole, which was the United Nations, and WHO as a valuable part of it. The delegates were assembled because of peace. He called upon them to work for it; better than anyone the Health Assembly knew the human value of life.

In the memorandum which the Soviet delegation had circulated there was a very significant suggestion concerning the role of scientists in demonstrating once again how monstrous nuclear war would be. Since the first experiments with nuclear weapons, the images of nuclear war might have faded. Well-known scientists in the Pugwash movement and other prominent personalities were also making a valuable contribution to measures to build confidence and lessen tensions. The right initiative on WHO’s part and a scientific examination of facts could only be helpful to the negotiating process inside or outside the United Nations system.

He appealed for strong support for peace from the Thirty-fourth World Health Assembly. The Polish delegation was a co-sponsor of the draft resolution, which fully reflected its views. It would also support the draft resolution on material war remnants.

Professor SPIES (German Democratic Republic) said that the question of the relationship between health, on the one hand, and peace, including disarmament, on the other, had been central to the entire discussion and did not represent a marginal problem as one delegate had implied.

The issue was that of the role of medical doctors and workers in the field of health. Certain delegations had however gone beyond that framework and had attempted to use the Health Assembly as a platform for political discrimination by claiming that they could not understand the relationship between the objectives of WHO and the worldwide objectives of peace and disarmament. In preparing the draft resolution on the role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all, the sponsors had made every effort to avoid political inferences.

In all the discussions, whether on budgetary or technical matters or the state of health in different areas of the world, it had emerged clearly that one of the alternatives for the development and implementation of a programme and strategy was to release funds from disarmament which could be used for worldwide enhancement of health and social conditions. There was a clear interrelationship between the arms race on the one hand and inflation and international financial crises on the other. He did not doubt that the draft resolution was fully in line with the sentiment of the Health Assembly.

Traditionally, doctors and others working in the health field had felt free to raise questions and influence every level of political activity in the interests of the health of the people in their care; there had been times, in particular in his own region, when doctors had been persecuted because they had tried to do their duty. He trusted that such a fate did not await doctors who, when speaking out in defence of the health of the people in their care, opposed death by nuclear weapons.
He appealed to all responsible persons in the field of health and science to share the concern of dedicated doctors and others who had raised their voices against the deadly threat of thermonuclear war. As a co-sponsor of the draft resolution, he asked that all Members join in approving it.

Mrs OLASZ (Hungary) expressed the hope that all delegations which had undertaken to accept the objectives of the strategy of health for all by the year 2000 were aware that such a strategy could only be realized in conditions of peace. Health authorities had an important role to play as well as a heavy responsibility for the preservation of peace and the protection of humanity against thermonuclear war.

Her delegation had co-sponsored the draft resolution on the role of physicians and other health workers in the preservation and promotion of peace as the most significant factor for the attainment of health for all. She appealed to all Members to vote in its favour.

The draft resolution was approved by 46 votes to 43, with 11 abstentions.1

Dr THOMSON (Australia) said that his country was an active member of the Committee on Disarmament and did not underestimate the importance of disarmament issues. However, a great deal of machinery already existed for their negotiation and discussion and, if little progress had so far been made, it was not for lack of expertise or ignorance of the nature of thermonuclear war. Since the problems raised were outside the scope of WHO's mandate, discussion of the broad principles and characteristics of disarmament was therefore best left to the United Nations Disarmament Commission. For that reason, his delegation had been unable to support the resolution.

Mr KELTENBORN (Switzerland) said that his delegation agreed with the views expressed by the delegate of the Netherlands and had voted against the resolution on the grounds that other forums existed for the discussion of disarmament issues and that WHO should not deal with matters outside its sphere of competence.

Dr FRITZ (Austria) said that the resolution went far beyond the framework of WHO and should be taken up in the United Nations General Assembly and related bodies. Her delegation had therefore voted against the resolution.

Dr ALSÈN (Sweden) said that, although Sweden fully shared the concern expressed in the draft resolution and was very active in arms control and disarmament negotiations, it attached great importance to discussion of the subject taking place in the appropriate forums, such as the United Nations General Assembly and the Committee on Disarmament. WHO did not constitute a proper forum for disarmament issues. Furthermore, the matters referred to in the resolution were already largely covered by a study of nuclear weapons undertaken by the United Nations Secretary-General. Sweden believed that the resources of WHO should be devoted primarily to the global strategy for health for all by the year 2000 rather than to purposes which, to a large extent, were outside its scope. His delegation had therefore been obliged to vote against the resolution.

Mr PUURUNEN (Finland) said that Finland had consistently and actively supported efforts made in the appropriate forums to promote disarmament and peace. As one of the sponsoring countries of United Nations resolution 34/58 which endorsed the declaration of Alma-Ata, it fully endorsed the view that health was a powerful instrument in favour of socioeconomic development and peace. It was the view of his delegation, however, that questions relating to disarmament were not within the competence of WHO and should be dealt with in the appropriate forums. While sharing the views expressed in the resolution, therefore, his delegation had felt obliged to abstain in the vote.

The CHAIRMAN drew attention to the following draft resolution on material war remnants, sponsored by the delegations of India, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya and Union of Soviet Socialist Republics:

1 Transmitted to the Health Assembly in the Committee's seventh report and adopted as resolution WHA34.38.
The Thirty-fourth World Health Assembly,
Recalling the principles contained in the preamble of the Constitution of WHO that "health is a state of complete physical, mental and social well-being", that "the health of all peoples is fundamental to the attainment of peace and security", and that "the achievement of any State in the promotion and protection of health is of value to all"; Noting that material World War remnants, especially mines, are still present in some countries;
Deeply concerned by the resulting losses of lives and the mutilation and disfiguration of civilians and the other dramatic effects on agriculture, transportation, housing, oil and mineral resources, development planning and development itself;
Recalling WHO's function to promote the prevention of accidental injuries and, in general, to take all necessary action to attain its objective;
Recalling that this year 1981 is declared by the United Nations as the International Year of Disabled Persons, and that the role of WHO in preventing disabilities due to such injuries is of paramount significance;
Recalling resolution 34/38 of the United Nations General Assembly and resolutions WHA32.24 and WHA33.24 concerning the contribution of health to socioeconomic development and peace;
Emphasizing the urgency not only of preventing war but also of alleviating the dramatic health conditions resulting therefrom;
Recalling the United Nations General Assembly resolution 3435 (XXX) of 9 December 1975 calling upon the Member States responsible to carry out their obligations by removing those remnants and redressing the damage caused by their existence;
1. CALLS upon and urges the States that laid these mines to clear the material war remnants, especially mines, immediately;
2. REQUESTS the Executive Board to take immediate action regarding:
   (a) calling upon the States that laid these mines to provide information regarding the types and exact location of the mines and other explosives, and regarding other relevant questions;
   (b) making a study of the situation regarding the effect on health and submitting a report to this Assembly at its Thirty-fifth session in 1982.

He further drew attention to the following amendments proposed by the delegation of Austria:

A new last preambular paragraph should be added, reading:

"Bearing in mind that this matter will be further considered by the United Nations General Assembly at its thirty-sixth session;"

Operative paragraphs 1 and 2 should read as follows:

"1. REQUESTS States to clear the material war remnants, especially mines;

2. REQUESTS the States that laid these mines to cooperate in this process as far as possible by providing appropriate assistance and information regarding the types and exact location of the mines and other explosives, and regarding other relevant questions;"

A new operative paragraph 3 should be added, reading:

"3. REQUESTS the Director-General to report to the Thirty-sixth World Health Assembly on the situation related to health and the progress achieved."

Dr ABDULHADI (Libyan Arab Jamahiriya) said that his country was still suffering the adverse effects of mines laid during the Second World War. The areas affected represented 33% of the country and although efforts had been made to clear them they had been hampered by lack of precise information on the location of mines and insufficient technical expertise. Thousands of persons, including children, had been killed or maimed by exploding mines, and the inhabitants of the areas affected were continually exposed to mental perturbation. As a result there was a move away from the areas, with consequent adverse effects on the socioeconomic
development of the country. He therefore appealed to WHO to give urgent consideration to the matter and to draw the attention of the countries responsible to the continuing effects of the existence of mines on public health in general and in relation to rehabilitation and pollution of the human environment in particular.

In the light of the situation outlined, his delegation had co-sponsored the draft resolution and supported the proposed amendments. It hoped that the Health Assembly would be able unanimously to adopt the draft resolution with the proposed amendments, particularly since it concerned a matter which was purely humanitarian.

Mr HOWADT (Austria) recalled that his country had suffered greatly from material remnants of the world wars; many Austrians had been wounded or had lost their lives because of them. His delegation believed that the draft resolution should be seen from the standpoint of civilians throughout the world who were suffering the effects of events which people tended to believe were concluded. It therefore welcomed the opportunity for the World Health Assembly to adopt a purely humanitarian resolution. While the causes and responsibilities with regard to war remnants were political matters, their very existence constituted a danger to health and should concern WHO.

It was a deplorable fact that most mines had been laid without plans, and were therefore difficult to remove, but no effort of cooperation in the process of mine-clearing should be spared. Bearing in mind that the legal and political aspects of the issue were not suitable for consideration by the World Health Assembly, his delegation suggested that it concentrate on the immediate humanitarian aspects within its mandate. The Austrian delegation's amendments were designed to give the draft resolution the maximum practical and humanitarian value, and were the result of discussions with the sponsors of the original text. He hoped the draft resolution would be adopted by consensus.

Mr BOYER (United States of America) said that in the view of his delegation the subject matter of the draft resolution on material war remnants was not appropriate for consideration by the World Health Assembly. The issue had already been discussed in other United Nations forums. Moreover, asking the Director-General to study and report on the subject had inevitable financial implications. It was ironic that the majority of the co-sponsors of the original text had refused to vote in support of the budget that had been adopted in the course of the present Assembly. He hoped that those co-sponsors would take note of the lack of support for their initiative, and requested that, before a vote was taken, the views of the Secretariat be heard on the appropriateness of the provisions of the draft resolution, both as originally presented and as amended by the delegation of Austria.

Mr JAAFAR (Kuwait) said he could accept the amendments proposed by the Austrian delegation.

Dr KILGOUR (Director, Division of Coordination), replying to the question from the United States delegate, said that the Director-General had noted the United Nations General Assembly resolution of 5 December 1980 on the problem of remnants of war, which requested the Secretary-General to consult States concerned to find ways and means of dealing with the problem, and also requested him to report to the General Assembly at its thirty-sixth session.

The resolution before the Committee would require the Director-General to make a report, and that report would of course cover any action which the General Assembly might have asked the specialized agencies, including WHO, to undertake. The Organization was ready to respond to any request made to it by the General Assembly within its sphere of competence.

Mr ONKELINX (Belgium) said his delegation sympathized with the concern of the authors of the resolution; terrible accidents had been caused in many countries by weapons left over from war. He was surprised that the draft resolution did not make any reference to an international conference on the subject which had recently concluded in Geneva; Article 9 of the protocol of that conference, which was to be submitted to the forthcoming session of the General Assembly, in fact dealt with precisely the same questions as were covered by the draft resolution. For reasons of principle, therefore, his delegation would be unable to approve that resolution since it believed it would be wrong to try to deal in an Organization such as WHO with a matter which had already been the subject of successful negotiations at international level. It would be for the General Assembly, after the protocol had been submitted to it, to make any necessary appeals to governments and to specialized agencies.
He feared that even if the amendments proposed by Austria were to be adopted, the draft resolution would still be in contradiction with the terms of the protocol, which had been carefully drafted by military experts. Adoption of the resolution would not only be a mistake from the legal point of view, but also a mistake from the point of view of the methodology of the United Nations system. It would have been greatly preferable for WHO, speaking from the standpoint of health, to make a declaration expressing its concern and to appeal for the situation to be remedied, while not referring specifically to any obligations that States should undertake. His delegation therefore felt itself bound to abstain from voting on the resolution, but would be ready to support any initiative that might be taken by its co-authors at the forthcoming General Assembly within the context of the recent conference.

Mr HOWADT (Austria) said that his delegation was aware of the agreement recently concluded by the conference in Geneva, but that agreement had not yet come into force, and what was needed was immediate relief for the existing situation. Every day in various parts of the world nine incidents involving injury or death took place as a result of remnants of war, and it was not enough to wait until such time as the new agreement came into force.

The amendments proposed by the delegation of Austria were adopted.

The draft resolution, as amended, was approved by 62 votes to none, with 20 abstentions.¹

Professor VON MANGER-KÖNIG (Federal Republic of Germany) said that his delegation sympathized with the problems of countries coping with remnants of war left on their soil, and would continue to cooperate in that regard as far as possible. However, it could not accept any obligation in international law to assist with the removal of remnants of war. It did not consider that WHO was the right forum to deal with the question, which would be better tackled in a bilateral context.

Mr GILBERT (United Kingdom of Great Britain and Northern Ireland) fully supported the view, and expressed the same reservations and the same willingness to continue cooperation.

4. SEVENTH REPORT OF COMMITTEE B (document A34/45)

Dr ASHLEY (Jamaica), Rapporteur, read out the draft seventh report of the Committee (document A34/45).

The report was adopted (see document WHA34/1981/REC/2).

5. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 11h55.

¹ Transmitted to the Health Assembly in the Committee's seventh report and adopted as resolution WHA34.39.
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