THIRTY-SEVENTH
WORLD HEALTH ASSEMBLY

GENEVA, 7-17 MAY 1984

SUMMARY RECORDS OF COMMITTEES
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
ACMR - Advisory Committee on Medical Research
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 (World Bank)
ICAO - International Civil Aviation Organization
IFAD - International Fund for Agricultural Development
ILO - International Labour Organization (Office)
IMO - International Maritime Organization
ITU - International Telecommunication Union
NORAD - Norwegian Agency for International Development

OAU - Organization of African Unity
OECD - Organisation for Economic Co-operation and Development
PAHO - Pan American Health Organization
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
UNSCERAR - United Nations Scientific Committee on the Effects of Atomic Radiation
USAID - United States Agency for International Development
WFP - World Food Programme
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.
CONTENTS

Page

Officers of the Health Assembly and membership of its committees ............. 1
Agenda ........................................................................................................... 3

SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

Page

First meeting ................................................. 5
Second meeting .............................................. 8
Third meeting ................................................ 11
Fourth meeting ............................................. 15
Fifth meeting ................................................. 21

COMMITTEE A

First meeting

1. Election of Vice-Chairmen and Rapporteur ........................................... 23
2. Tribute to Dr E. Braga ........................................................................... 23
3. Organization of work ............................................................................ 23

Second meeting

Global Strategy for Health for All by the Year 2000: Report on monitoring of progress in implementing strategies for health for all (continued) ........... 28

Third meeting

Global Strategy for Health for All by the Year 2000: Report on monitoring of progress in implementing strategies for health for all (continued) ........... 41

Fourth meeting

Infant and young child nutrition (Progress and evaluation report; and status of implementation of the International Code of Marketing of Breast-milk Substitutes) .......................................................... 55

Fifth meeting

Global Strategy for Health for All by the Year 2000: Report on monitoring of progress in implementing strategies for health for all (continued) ........... 72
Sixth meeting
1. Global Strategy for Health for All by the Year 2000: Report on monitoring of progress in implementing strategies for health for all (continued) .......................... 82
2. Infant and young child nutrition (Progress and evaluation report; and status of implementation of the International Code of Marketing of Breast-milk Substitutes) (continued) .......................................................... 89

Seventh meeting
1. First report of Committee A .................................................................................................................. 94
2. Infant and young child nutrition (Progress and evaluation report; and status of implementation of the International Code of Marketing of Breast-milk Substitutes) (continued) .......................................................... 94
3. Action Programme on Essential Drugs and Vaccines ................................................................. 102

Eighth meeting
Action Programme on Essential Drugs and Vaccines (continued) ................................................. 106

Ninth meeting
1. Second report of Committee A ............................................................................................................ 117
2. Infant and young child nutrition (Progress and evaluation report; and status of implementation of the International Code of Marketing of Breast-milk Substitutes) (continued) .......................................................... 117
3. Action Programme on Essential Drugs and Vaccines (continued) ............................................. 119

Tenth meeting
1. Action Programme on Essential Drugs and Vaccines (continued) .................................................. 126
2. Infant and young child nutrition (Progress and evaluation report; and status of implementation of the International Code of Marketing of Breast-milk Substitutes) (continued) .......................................................... 133
3. Global Strategy for Health for All by the Year 2000: Report on monitoring of progress in implementing strategies for health for all (continued) .......................................................... 135
4. Action Programme on Essential Drugs and Vaccines (resumed) .................................................... 137

Eleventh meeting
1. Third report of Committee A ........................................................................................................... 142
2. Action Programme on Essential Drugs and Vaccines (continued) ................................................. 142
3. Fourth report of Committee A .......................................................................................................... 149
4. Closure ............................................................................................................................................... 149

COMMITTEE B
First meeting
1. Election of Vice-Chairmen and Rapporteur ....................................................................................... 151
2. Organization of work ......................................................................................................................... 151
3. Review of the financial position of the Organization:
   Financial report on the accounts of WHO for the financial period 1982-1983, report of the External Auditor, and comments thereon of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Health Assembly ......................................................................................................................... 152
Second meeting

1. Review of the financial position of the Organization (continued):
   Financial report on the accounts of WHO for the financial period 1982-1983,
   report of the External Auditor, and comments thereon of the Committee
   of the Executive Board to Consider Certain Financial Matters prior to the
   Health Assembly (continued) .................................................. 163
2. Financial Regulations - additional terms of reference governing the external
   audit of the World Health Organization ..................................... 166
3. Review of the financial position of the Organization (continued):
   Status of collection of assessed contributions and status of advances to
   the Working Capital Fund ....................................................... 166
   Members in arrears in the payment of their contributions to an extent which
   may invoke Article 7 of the Constitution .................................... 167
4. Election of Vice-Chairmen and Rapporteur (continued) .......................... 168
5. Assessment of new Members and Associate Members ............................... 168
6. Real Estate Fund and headquarters accommodation .................................. 170

Third meeting

1. Transfer of the Regional Office for the Eastern Mediterranean .................. 174
2. Real Estate Fund and headquarters accommodation (continued) .................... 174
3. First report of Committee B .................................................... 177
4. Restructuring the Technical Discussions ......................................... 177

Fourth meeting

1. Restructuring the Technical Discussions (continued) ............................... 182
2. Collaboration within the United Nations system:
   General matters ................................................................. 184

Fifth meeting

Collaboration within the United Nations system (continued):
   General matters (continued) ................................................. 188
   Health assistance to refugees and displaced persons in Cyprus .................. 190
   Health and medical assistance to Lebanon ..................................... 192
   Assistance to the front-line States, to Namibia and national liberation
   movements in South Africa, and to refugees in Africa .......................... 193
   Emergency health and medical assistance to drought-stricken and famine-
   affected countries in Africa .................................................. 197

Sixth meeting

Health conditions of the Arab population in the occupied Arab territories,
including Palestine ............................................................... 200

Seventh meeting

Health conditions of the Arab population in the occupied Arab territories,
including Palestine (continued) ............................................... 212
### Eighth meeting

1. International standards and reference preparations for biological substances 222
2. Collaboration within the United Nations system (continued):
   - Assistance to the front-line States, to Namibia and national liberation movements in South Africa, and to refugees in Africa (continued) 226
   - Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa (continued) 228

### Ninth meeting

1. Collaboration within the United Nations system (continued):
   - Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa (continued) 232
2. United Nations Joint Staff Pension Fund:
   - Annual report of the United Nations Joint Staff Pension Board for 1982 233
   - Appointment of representatives to the WHO Staff Pension Committee 233
3. Second report of Committee B 234
4. Third report of Committee B 234
5. Closure 234

**Indexes** (names of speakers; countries and organizations) 235
PREFACE

The Thirty-seventh World Health Assembly was held at the Palais des Nations, Geneva, from 7 to 17 May 1984, in accordance with the decision of the Executive Board at its seventy-second session. Its proceedings are published in three volumes, containing, in addition to other relevant material:

- Resolutions and decisions,¹ and list of participants - document WHA37/1984/REC/1
- Verbatim records of plenary meetings, and committee reports - document WHA37/1984/REC/2
- Summary records of committees - document WHA37/1984/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 1982. 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).

- vii -
OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President:
Dr G. SOBERÓN ACEVEDO (Mexico)

Vice-Presidents:
Mr M. P. TO VADEK (Papua New Guinea)
Dr S. H. ALWASH (Iraq)
Dr M. SHAMSUL HAQ (Bangladesh)
Mr P. D. BOUSSOUKOU-BOUMBA (Congo)
Dr A. GRECH (Malta)

Secretary:
Dr H. MAHLER, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Argentina, Egypt, Ghana, Guyana, Iceland, Indonesia, Ireland, Jordan, Malaysia, Poland, Rwanda, Senegal.

Chairman: Mr E. G. TANOH (Ghana)
Vice-Chairman: Mr TAN Koon San (Malaysia)
Rapporteur: Mr A. GRIMSSON (Iceland)
Secretary: Mr D. DEVLIN, Office of the Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Benin, Bulgaria, Burma, China, Costa Rica, Djibouti, Equatorial Guinea, Ethiopia, France, Jamaica, Japan, Mongolia, Nigeria, Peru, Sweden, Syrian Arab Republic, Tunisia, Union of Soviet Socialist Republics, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United States of America, Upper Volta, Venezuela, Zimbabwe.

Chairman: Dr O. S. CHIDEDE (Zimbabwe)
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: Botswana, Cameroon, Chile, China, Cuba, France, India, Kenya, Kuwait, Nigeria, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America, Uruguay, Yemen, Zimbabwe.

Chairman: Dr G. SOBERÓN ACEVEDO (Mexico), 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 K. AL-AJLOUNI (Jordan)
Vice-Chairmen: Mr R. EDWARDS (Canada) and Professor F. Renger (German Democratic Republic)
Rapporteur: Mrs K. M. MAKHWADE (Botswana)
Secretary: Dr D. K. RAY, Scientist, Health Manpower Planning

Committee B

Chairman: Dr N. ROSDAHL (Denmark)
Vice-Chairmen: Dr E. YACOUB (Bahrain) and Dr B. P. KEAN (Australia)
Rapporteur: Dr Sriati DA COSTA (Indonesia)
Secretary: Mr I. CHRISTENSEN, Administrative Officer
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 seventy-second and seventy-third sessions
11. Admission of new Members and Associate Members
   11.1 Application by the Cook Islands for admission to membership
   11.2 Application by Kiribati for admission to membership
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-seventh World Health Assembly

Supplementary agenda item 1: Assignment of Algeria to the African Region

COMMITTEE A

18. Election of Vice-Chairmen and Rapporteur
20. Infant and young child nutrition (Progress and evaluation report; and status of implementation of the International Code of Marketing of Breast-milk Substitutes)

The agenda was adopted at the third plenary meeting.
Item added to the agenda at the ninth plenary meeting.
THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

21. International standards and reference preparations for biological substances
22. Action programme on essential drugs and vaccines

COMMITTEE B

23. Election of Vice-Chairmen and Rapporteur
24. Review of the financial position of the Organization
   24.1 Financial report on the accounts of WHO for the financial period 1982-1983, report of the External Auditor, and comments thereon of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Health Assembly
   24.2 Status of collection of assessed contributions and status of advances to the Working Capital Fund
   24.3 Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution
25. [deleted]
26. Assessment of new Members and Associate Members
27. Financial Regulations - additional terms of reference governing the external audit of the World Health Organization
28. Real Estate Fund and headquarters accommodation
29. [deleted]
30. Transfer of the Regional Office for the Eastern Mediterranean
31. Health conditions of the Arab population in the occupied Arab territories, including Palestine
32. Restructuring the Technical Discussions
33. Collaboration within the United Nations system
   33.1 General matters
   33.2 Health assistance to refugees and displaced persons in Cyprus
   33.3 Health and medical assistance to Lebanon
   33.4 Assistance to the front-line States, to Namibia and national liberation movements in South Africa, and to refugees in Africa
   33.5 Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa
34. United Nations Joint Pension Fund
   34.1 Annual report of the United Nations Joint Staff Pension Board for 1982
   34.2 Appointment of representatives to the WHO Staff Pension Committee

1 Item referred to Committee B.
SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

FIRST MEETING

Monday, 7 May 1984, at 17h05

Chairman: Dr G. SOBERÓN ACEVEDO (Mexico),
President of the Health Assembly

1. ADOPTION OF THE AGENDA AND ALLOCATION OF ITEMS TO THE MAIN COMMITTEES (Document A37/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 33 of the Rules of Procedure of the Health Assembly, its first task was to deal with item 8 of the provisional agenda (Adoption of the agenda and allocation of items to the main committees), in order to be able to transmit that agenda (prepared by the Executive Board and issued as document A37/1) with its recommendations to the Assembly in plenary session.

He also drew the attention of the General Committee to document A37/GC/2 in which the Director-General submitted to it, in accordance with Rule 12 of the Rules of Procedure, a request received by him from a Member State for the inclusion of a supplementary item in the agenda of the Thirty-seventh World Health Assembly. Before asking the General Committee to state an opinion on this request, he also drew its attention to Rule 11 of the Rules of Procedure of the Assembly, which provided, in particular, for the possible referral of a proposal to another organ of the Organization for examination with a view to deciding whether action by the Organization was desirable.

Dr AL-AWADI (Kuwait), noting the wording of the proposed supplementary item in the letter contained in the aforementioned document ("Health aspects of chemical weapons and medical protection"), was of the opinion that the Assembly should not examine a question of such importance in haste, for lack of the time needed to study it thoroughly. Moreover, it would be necessary, in his opinion, were such an examination to be made, for it to be preceded by consultations with other organizations of the United Nations system. For that reason, and having regard to the provisions of Rule 11 of the Rules of Procedure, to which the Chairman had just referred, he thought it would be wise to refer the matter to the Executive Board.

Dr SEKERAMAYI (Zimbabwe) also considered that, by virtue of the complexity of the subject proposed for inclusion in the agenda, it would be preferable for another organ of the Organization to examine it before it came before the Health Assembly.

Dr AL-AJLOUNI (Jordan), Chairman of Committee A, would prefer for his part that such a matter should undergo preliminary examination by a more scientifically oriented committee before the Assembly could discuss it.

Mr BOYER (United States of America), while agreeing with the previous speakers that the question of chemical warfare, since that was the subject, would be more appropriately examined in bodies other than the Health Assembly, thought that even the Executive Board would not be the appropriate body to make such an examination.

Moreover, he was inclined to a narrower interpretation of Rule 11 of the Rules of Procedure, to which the Chairman had referred and on which Dr Al-Awadi had based his suggestion that the matter be referred to the Executive Board. Before making provision for such referral to another organ of the Organization, that rule in fact stipulated that a proposal for new activities to be undertaken by the Organization might be placed upon the supplementary agenda of any session only if such a proposal was received at least six weeks before the date of opening of the session. In the case in point, it would in fact be a new activity, since the question of chemical weapons had not been debated by the Assembly for
some 15 years, and that being so the proposal for inclusion in the agenda should have reached the Organization six weeks before the date of the opening of the session, i.e., by the end of March, and not 24 April (the date of the letter received by the Director-General). In Mr Boyer's opinion, the Assembly ought not therefore to refer the question to the Executive Board but merely to decide not to examine it.

Professor NGU (Cameroon) was of the same opinion. Whether the subject was chemical warfare, bacteriological warfare or other forms of warfare, it was not strictly speaking a health problem, and WHO was not the competent body to examine or to debate it. In his opinion, therefore, the subject was not one for the Health Assembly.

After the CHAIRMAN had briefly summed up the two proposals that had been put forward, Mr VIGNES (Legal Counsel), at the invitation of the Chairman, outlined the alternatives open to the Committee under the provisions of Rule 11 of the Rules of Procedure; the Committee could recommend to the Health Assembly:

- either, should it consider that the request for inclusion in the agenda was concerned with new activities, to have regard to the fact that this request had not been received by the statutory period of six weeks before the date of the opening of the session, and therefore not to take it into consideration;
- or, if it considered that the request constituted a proposal which should be referred to another organ of the Organization, to refer that proposal to the Executive Board with a view to its deciding whether action by the Organization was desirable.

Having regard to the two proposals that had been put forward, it was between those two alternatives that the Committee should be called upon to decide.

The CHAIRMAN therefore invited the Committee to express its opinion, in the first place, on the first alternative: the proposal not to take into consideration the request for inclusion in the agenda.

The General Committee agreed to recommend to the Health Assembly not to include in its agenda the supplementary item proposed in document A37/OC/2.

The CHAIRMAN, observing that the debate on the question was thus concluded, then brought to the Committee's attention the fact that certain items included in the provisional agenda with the mention "if any" had not materialized. They were item 25 (Supplementary budget for 1984-1985) and item 29 (Working Capital Fund), and its two sub-items; he proposed therefore that the General Committee should recommend to the Health Assembly the deletion of those items from its agenda. On the other hand, the words "if any" following item 11 (Admission of new Members and Associate Members) should be deleted: the Director-General had received two requests for admission to membership of the Organization submitted within the statutory period by the Cook Islands and Kiribati; those requests, contained in documents A37/21 and A37/22 respectively, had immediately been transmitted to all Members in accordance with the provisions of Rule 115 of the Rules of Procedure of the Assembly. Those two requests could be submitted to the Assembly as two sub-items of the aforementioned item 11, with the numbers 11.1 and 11.2. Should the General Committee accept the various proposals which he had just made, he would transmit its recommendations to the plenary meeting of the Assembly on the following morning.

The General Committee accepted those proposals and it was so agreed.

As regards the allocation of items between the main committees, the CHAIRMAN next pointed out that the items were shown in the provisional agenda under Committee A and Committee B according to the terms of reference of those committees as laid down by Rule 34 of the Rules of Procedure. He took it that the Committee would wish to recommend to the Assembly that it accept that allocation, which did not rule out the transfer of certain items from one Committee to the other during the session, depending on the volume of work of each Committee.

It was so agreed.

Lastly, recalling the items of the provisional agenda for consideration in plenary meetings, the CHAIRMAN pointed out that the Assembly had already examined items 1 to 7 in the
course of the afternoon, and that the recommendations of the Committee at the end of its current examination of item 8 would be transmitted to the plenary meeting on the following morning. He thought that the Committee would agree to recommend to the Assembly that the remaining items (item 9 to 17) be considered in plenary as planned.

It was so agreed.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The CHAIRMAN reminded the Committee that the provisions of resolution WHA34.29 limited the duration of the Health Assembly to not more than two weeks and, having drawn its attention to the preliminary daily timetable prepared by the Executive Board (document A37/GC/1), he took it that the Committee agreed to approve that timetable in principle, subject to such changes as might subsequently appear necessary.

It was so agreed.

The General Committee then drew up the programme of meetings for Tuesday, 8 May, Wednesday, 9 May, Thursday, 10 May, Friday, 11 May, and Saturday, 12 May, which would, as a general rule, be held from 9h00 to 12h30 and from 14h30 to 17h30, and decided to hold its own next meeting on Thursday, 10 May at 17h30.

The CHAIRMAN also proposed that the General Committee should decide that, in accordance with the procedure followed at previous Assemblies, the order of the list of speakers wishing to take part in the debate on agenda items 9 and 10, a list which already contained 91 names, should be strictly followed and that any additions should be taken in the order in which they were received. The list would appear regularly in the Journal of the Assembly. If the Committee agreed, the Chairman would inform the Assembly of those arrangements at the next plenary meeting.

It was so agreed.

On the subject of speeches in the debate in plenary session, the DIRECTOR-GENERAL wished to inform the General Committee that he had been approached by Central American countries and Panama. As the new health problems arising were the same in that region, those countries wished those problems to be presented by the delegation of only one of them, which would avoid pointless repetition, but they would like, by way of compensation, that delegation to have 20 minutes instead of the regulation 10 minutes to which speakers should keep in principle. He had replied that he had no objection, reserving the position of the General Committee.

The General Committee gave its agreement to that procedure.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) asked that the Chairman should announce those derogations to the Assembly in plenary session.

It was so agreed.

In closing, the CHAIRMAN drew the attention of the Committee to the Technical Discussions which were to be held all day Friday, 11 May, and on the morning of Saturday, 12 May.

The meeting rose at 17h40.
SECOND MEETING
Thursday, 10 May 1984, at 17h40

Chairman: Dr G. SOBERÓN ACEVEDO (Mexico),
President of the Health Assembly

1. REQUEST FOR INCLUSION OF A SUPPLEMENTARY AGENDA ITEM: ASSIGNMENT OF ALGERIA TO THE AFRICAN REGION

The CHAIRMAN drew the attention of the Committee to document A37/GC/3 which contained a request for the inclusion of a supplementary agenda item concerning the assignment of Algeria to the African Region of WHO. That request had been addressed to the Director-General, by the Permanent Representative of Algeria in Geneva, in accordance with the provisions of Rule 12 of the Rules of Procedure and within the time-limit laid down in that Rule.

He therefore assumed that the Committee would agree to recommend the Health Assembly to add that supplementary item to its agenda and to consider it in plenary; if such were the case, the recommendation would be transmitted to the Assembly on the following morning.

It was so agreed.

2. ELECTIONS TO THE EXECUTIVE BOARD: AMENDMENTS TO THE RULES OF PROCEDURE OF THE HEALTH ASSEMBLY

The CHAIRMAN invited the attention of the Committee to a second matter, namely the amendments to the Rules of Procedure of the Assembly made necessary by the entry into force of the amendments to the Constitution increasing to thirty-one the number of Members entitled to designate a person to serve on the Executive Board. Those amendments were clearly explained in document A37/3\(^1\) and the Chairman proposed, if the Committee agreed, to submit to the plenary meeting next morning the draft resolution for the adoption of those amendments, which appeared on pages 4 and 5 of that document.

Asked by the CHAIRMAN to give the necessary explanation to Mr BOYER (United States of America), to whom it was not clear what draft resolution was involved, Mr VIGNES (Legal Counsel) first pointed out that the document to which the Chairman had just referred was document A37/3 (Assembly document) and not the document A37/GC/3 (General Committee document) that had been previously mentioned, the similarity of the two document numbers having apparently been a cause of confusion.

Document A37/3, which was the one under consideration, indicated that because of the coming into force of amendments to Articles 24 and 25 of the Constitution, the number of members of the Executive Board had been raised from thirty to thirty-one. Consequently, that year the Assembly would be called upon, during the following week, to elect 11 Members entitled to designate a person to serve on the Board, and not 10 as previously. So that the Assembly could proceed to that election it would first have to amend certain of its Rules of Procedure that mentioned the election of 10 Members only. The Chairman therefore asked the Committee to recommend the Assembly to adopt the necessary amendments contained in the draft resolution submitted at the end of document A37/3 during its plenary meeting on the following morning, so as to be able to proceed during the following week to the annual election of Members entitled to designate a person to serve on the Executive Board in accordance with the new requirements.

The CHAIRMAN asked the Committee whether, after having heard the explanations just given by the Legal Counsel, it was agreed that the Chairman should submit the draft resolution in question to the Assembly in plenary session on the following morning.

It was so agreed.

3. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

Dr AL-AJLOUNI (Jordan), Chairman of Committee A, reported on the progress of the work of that Committee during the opening days of the session and gave details concerning the

\(^1\) Document WHA37/1984/REC/1, Annex 1.
institution of that work in relation to the Technical Discussions which were to take place on the two following days.

After describing the progress made in the work of Committee B, and announcing what agenda items it would deal with at its next meeting, planned for Monday, 14 May, Dr ROSDAHL (Denmark), Chairman of that Committee, informed the General Committee that the Secretariat had just received that day from a Member State a draft resolution dealing with the subject of chemical weapons, including a request that the draft resolution be considered under agenda item 33 (Collaboration within the United Nations system).

The DIRECTOR-GENERAL took it that the Chairman of Committee B, by drawing the attention of the General Committee to the draft resolution in question, wished to have the opinion of that Committee as to whether or not the draft resolution should be distributed. Certain other Member States, who had knowledge of that draft, had in fact felt that it was not for the Secretariat to distribute a draft resolution dealing with a matter that the Health Assembly, on the recommendation of the General Committee, had refused to include on its agenda at the beginning of the session. The Secretariat would therefore very much like to have the guidance of the General Committee in that respect; like the Chairman of Committee B, he considered that the subject of the draft resolution was very similar to that of the supplementary agenda item proposed by the same Member State and refused by the Assembly on the second day of the session.

Rule 70 of the Rules of Procedure of the Health Assembly stipulated that, when a proposal had been adopted or rejected, it could not be reconsidered at the same session unless the Health Assembly, by a two-thirds majority of the Members present and voting, so decided. He interpreted those procedural provisions as excluding that the Assembly, having once adopted a certain position regarding a given subject, should be induced to reconsider it by means of a fresh proposal. So that the General Committee could decide in full knowledge of the facts, he read out the draft resolution that had been handed to him.

The CHAIRMAN felt that the problem facing the Committee had two aspects: that of the content of the draft resolution which seemed indeed very similar to the content of the supplementary item already considered by the Committee at its first meeting and which the Assembly, on the recommendation of the Committee, had refused to include on its agenda; and that of the procedural question of the possible distribution of the draft; he asked the Legal Counsel to instruct the Committee regarding the latter question.

Mr VIGNES (Legal Counsel) agreed that, as had been stressed by the Director-General, the substance of the operative part of the draft resolution which the Director-General had read out seemed incompatible with the decision previously taken by the Assembly on the recommendation of the Committee, since the substance of the draft resolution was the same as that of the question which the Assembly had refused to include on its agenda. As regards Rule 70 of the Rules of Procedure to which the Director-General had referred, it could be argued that its provisions were not perhaps specifically intended for a case such as that before the Committee, although he felt that in their spirit they were applicable to it.

He reminded the Committee, however, that under Rule 33 of the Rules of Procedure the Committee was the directing body of the Assembly and that, inter alia, it had the duty, under paragraph (h) of that Rule, of facilitating the orderly dispatch of the business of the session. It could therefore be legitimately considered that the Committee could be called upon to give its opinion on whether the Secretariat was entitled to distribute the draft resolution or, on the contrary, whether it should not refuse the request to distribute it in view of the fact that the Committee considered the draft to be incompatible with the decision taken by the Assembly in plenary session on its recommendation.

Mr BOYER (United States of America) pointed out that when a country requested the addition of a new item to the agenda of a conference, it did so with a view to submitting a draft resolution under that item. Should the addition of such an item be refused, and should the country subsequently submit the intended resolution under another item of the agenda already approved, that was obviously in order to circumvent the decision which had already gone against it.

He was therefore of the opinion that the Committee should recommend to the Assembly, by virtue of the decision already taken on the substance, not to consider the draft resolution. Should the question nevertheless be submitted to it, it seemed obvious to him that the two-thirds majority clause provided for in Rule 70 of the Rules of Procedure ought to be applicable in any vote that was taken.

Mr AL-SAKKAF (Yemen), having heard the explanations of the Legal Counsel, was convinced that the Committee ought to keep to its previous position: since it had already declared
itself against examination of the question by the Health Assembly, it should also declare the draft resolution not receivable. The Assembly met to discuss matters of health, and not subjects such as those raised by the draft resolution.

Dr AL-SAIF (Kuwait) was also of the opinion that since the General Committee and the Assembly had refused to examine the substance of the previous request, the Committee ought not to authorize distribution of the draft resolution in question.

Dr AL-AJLOUNI (Jordan), Chairman of Committee A, associated himself with the two previous speakers and asked that the Committee should not authorize distribution of the draft.

Professor ROUX (France) fully shared the view of the delegate of the United States of America. The Committee would be reversing its own decision if it failed to recommend rejection of the request.

The DIRECTOR-GENERAL wondered whether the General Committee ought to refer the matter to the Assembly in plenary session as suggested, or whether it would not rather be more appropriate for the Committee itself to deal with the matter, basing itself on the provisions of Rule 33 of the Rules of Procedure to which the Legal Counsel had referred. If it were concluded that the request before the Committee was not receivable, the Committee could ask its Chairman to inform the Member State that had made the request to that effect.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) supported the Director-General's suggestion that the Chairman of the General Committee be asked to inform the Member State in question of the rejection of its request.

Dr SEBINA (Botswana) wondered what would happen if, having been thus informed by the Chairman, the delegation of the Member State in question, not accepting that decision, again raised the matter in a meeting of the Assembly. What then would be the situation, in particular, regarding the applicability of the provisions of Rule 70 of the Rules of Procedure?

The DIRECTOR-GENERAL saw the situation as follows in that case: if the question were raised in Committee B during examination of agenda item 33 (Collaboration within the United Nations system), and more especially during examination of document A37/14 on general matters under that item, it would be for the Chairman of that Committee to ask that Committee to decide.

Mr VIGNES (Legal Counsel) considered that, following the debate that had just taken place, the General Committee was faced with the following alternative. Should it recommend that the draft resolution be treated as not receivable in order not to be at variance with the previous decision of the Assembly, it could ask the Chairman of Committee B to inform that Committee at its next meeting that the General Committee, consulted on the matter, had been of the opinion that acceptance of the draft by the Secretariat would have run counter to the earlier decision of the Assembly in plenary session; or it could request the President of the Assembly to inform the delegation concerned that the General Committee had been of the opinion that the draft resolution should not be considered, which did not exclude the Chairman of Committee B, for his part, from informing the Committee of that opinion. He added that if the delegation of the Member State concerned were to request the floor under agenda item 33, on document A37/14 and more especially its paragraph 4.26, he did not think that a delegate could be prevented from speaking on a particular point in an official document of the Assembly that had been distributed in a regular manner.

In reply to a further question from Dr SEBINA (Botswana) on how to act should the delegation of the Member State concerned, while accepting the decision of the General Committee not to consider the present draft resolution which the Director-General had read out, submit another draft resolution on the same subject, Mr VIGNES (Legal Counsel) stated that the decision that had been taken regarding not receiving the present draft resolution would, in his opinion, apply not only to that draft, but also to any subsequent draft resolution couched in identical terms.

Dr MEYER-LONG (Uruguay) wished to know whether it would be legally possible for a delegation, following one or two rejections of its request for such a draft resolution to be considered, to submit that draft directly to the Assembly in plenary session.

For the DIRECTOR-GENERAL, the provisions of the Rules of Procedure applicable in the situation under consideration were extremely clear. Whether the delegation concerned
wished to reraise the question or to resubmit the draft resolution which he had read out or any other identical draft, whether it were to be in Committee B or in the Assembly in plenary session, application of Rule 70 could be considered.

Dr MEYER–LONG (Uruguay) recalled that it was for procedural reasons that the General Committee had decided, at its previous meeting, to recommend to the Assembly not to include in its agenda the supplementary item submitted to it. The Committee would recall that what had been at issue, in particular, had been a matter of the time-limit to be respected for the submission of such a request. Summarizing the position of his delegation, which was based on a logical interpretation of the relevant procedural provisions, he stressed that, in its opinion, the Committee ought to take its stand in relation to the procedure to be followed and not on the substance of the problem raised by the draft resolution.

The DIRECTOR–GENERAL, in his turn, recalled that the decision of the General Committee to which Dr Meyer–Long had just referred stemmed from its interpretation of Rule 11 of the Rules of Procedure, which was based not only on the time element in that rule, but also on the fact that the inclusion of a supplementary agenda item, as requested, would oblige WHO to undertake new activities. It would naturally amount to the same thing if the draft resolution in question were to go through, and the Committee, in order to be consistent, should also take that aspect of the problem into consideration in the present case.

Summarizing the debate that had taken place, the CHAIRMAN noted that there was a consensus in the Committee on the position to be adopted: it was of a mind that the draft resolution transmitted to the Secretariat by the delegation of the Member State concerned should not be considered. What remained for the Committee to decide was whether to ask him, as Chairman of the General Committee and President of the Assembly, to inform the delegation of that decision, or whether to ask the Chairman of Committee B to do so.

The General Committee agreed to ask the Chairman of Committee B to inform the delegation of the Member State that had originated the draft resolution that its request for consideration of that draft had been deemed not receivable by the General Committee because of the rejection by the Assembly in plenary session of that delegation’s earlier request for the addition of a supplementary item to the agenda.

The CHAIRMAN having recapitulated the programme of meetings already drawn up for the following day and the day after, the General Committee finally fixed the programme of meetings for Monday 14 May and Tuesday 15 May, and in particular its own next meeting for Monday, 14 May, at 12h30.

The meeting rose at 18h40.

THIRD MEETING

Saturday, 12 May 1984, at 10h50

Chairman: Dr G. SOBERÓN ACEVEDO (Mexico),
President of the Health Assembly

PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The CHAIRMAN stated that he had convened the Committee earlier than envisaged at the request of the Chairman of Committee B, whom he asked to explain the reasons for his request.

Dr ROSDAHL (Denmark), Chairman of Committee B, recalled the opinion expressed by the General Committee at its previous meeting, on Thursday 10 May, as regards the request made by a Member State for consideration of a draft resolution dealing with chemical weapons (opinion appearing in the summary record of that meeting). He announced that the Member State in question had withdrawn the draft resolution of which it had been informed at its previous meeting and replaced that draft by a new one which, unlike its predecessor no longer condemned or even mentioned another Member State.

1 See above.
By virtue of his discretionary powers, the Chairman of Committee B felt that it was for him to apply the relevant provisions of the Rules of Procedure of the Assembly, namely those of Rules 50 and 52. The normal procedure was the one described in Rule 52 which provided inter alia that "proposals and amendments shall normally be introduced in writing and handed to the Director-General, who shall circulate copies to the delegations". As for Rule 50, it stipulated that "formal proposals relating to items of the agenda may be introduced ...", from which it followed that proposals submitted had to deal with an item on the agenda adopted. The new draft resolution did specifically refer to the terms of agenda item 33.1 (Collaboration within the United Nations system - General matters), an item under which document A37/14 was to be considered. That document, as had already been pointed out to the Committee at its previous meeting, contained a paragraph in which the Director-General had deemed it necessary to draw the attention of the Assembly to United Nations General Assembly resolution 38/187 concerning chemical and bacteriological (biological) weapons; that showed the importance he attributed to the matter and enabled the Assembly to discuss it, if it so wished.

While the Chairman of Committee B found that it was for him to decide whether the new draft resolution should be distributed or not, he had deemed it necessary to inform the General Committee of the submission of the new draft and of its nature. To his knowledge the distribution of a draft resolution had never previously been prevented, nor was any mechanism provided for screening draft resolutions before they were submitted to the Assembly. The question might arise whether such a mechanism should be set up, but at the moment none existed. It was therefore for him, in his capacity as Chairman of Committee B, to use his discretionary powers in taking the decision awaited. Obviously, if he decided to have the draft distributed and consequently to allow its consideration, the delegations of the Member States were entitled to raise a point of order in committee, which would enable Committee B take a stand to on the matter in accordance with the relevant provisions of the Rules of Procedure.

He would welcome the informed opinions of the other members of the General Committee on those matters.

The CHAIRMAN asked the members of the Committee to give the Chairman of Committee B the guidance he had requested from them, while stressing the fact that the decision whether or not to distribute the draft resolution was for Dr Rosdahl to make, as he himself had just pointed out.

Dr BORGOÑO (Chile) felt it essential for the General Committee and Committee B to adopt the same approach in the matter. The Chairman of Committee B had been perfectly right to point out that the decision whether or not to have the draft resolution distributed came under his discretionary powers. If certain delegations contested his decision, the Rules of Procedure gave them the possibility of opposing it. Moreover it should not be forgotten that it was always possible to amend a draft resolution in the course of discussion.

He felt that the attitude of the General Committee in the current situation, was very important because it could establish a precedent for the consideration of questions of that type. For his part he supported the view of the Chairman of Committee B as regards the course he intended to take in accordance with the relevant rules of the Rules of Procedure.

Mr AL-SAKKAF (Yemen) recalled that the General Committee had rejected the request for consideration of the previous draft resolution not because another Member State had been accused in the draft, but because the Committee had felt that the subject dealt with in the draft was not related to the agenda of the Assembly. He considered that the Committee had taken a reasonable, wise and practical decision which it should not now reverse by taking a different position. He therefore called on the Committee to stand firm on its previous position and also to decide that the new draft resolution should not be taken into consideration.

Dr AL-AWADI (Kuwait) said he would like, before giving his opinion, to ask the Legal Counsel to explain the legal situation concerning the two following questions:

1. the position of principle as regards the distribution and consideration of the new draft resolution;
2. the practical consequences of the adoption by the General Committee of a position contradicting its previous one.

Mr VIGNES (Legal Counsel) said he would try to reply in detail to the essential questions that had been raised by Dr Al-Awadi, which were those upon which the Chairman of Committee B had felt that he should consult the General Committee.
As regards the first point, the position seemed clear to him from the point of view of principles: pursuant to the relevant provisions of Rules 50 and 52 of the Rules of Procedure, a draft resolution submitted by the delegation of a Member State and relating to an item of the agenda adopted had to be distributed to delegations.

The second point, namely the adoption of two successive and contradictory positions by the General Committee, was more complex. Could it be considered that the Chairman of Committee B, by having the second draft resolution distributed, would be going against the earlier decision of the General Committee that the first draft resolution was not receivable? It should not be forgotten that when the General Committee advised the Chairman of Committee B to declare that first draft not receivable and not to have it distributed, that was because it deemed that the draft did not relate to an item of the agenda adopted but to the supplementary item proposed by the Member State which was the author of both projects, a supplementary item that the Health Assembly had refused to include in its agenda. However, the second draft resolution had been submitted, as mentioned by the Chairman of Committee B, under an item of the agenda adopted, namely item 33.1, the text of which was included in the title of that draft. It might therefore be asked whether the General Committee would really contradict itself by adopting a position with reference to the second draft resolution different from that taken regarding the first one, since the situation had changed.

Nevertheless it was for the General Committee to decide regarding that point and to give the Chairman of Committee B the opinion he had requested, so that he could then decide in full knowledge of the facts, but on his own authority, either not to have the draft resolution distributed or to let the matter take the course provided for in Rule 52 of the Rules of Procedure.

Dr AL-AWADI (Kuwait) agreed, following the explanations given by the Legal Counsel, whom he thanked, that it was doubtless necessary, in order to respect the Rules of Procedure, to accept the request of the Member State concerned that the draft resolution be distributed. Basically, however, the situation had hardly changed: that Member State had raised once more, by procedural means, a question that the Assembly had previously decided not to consider. He therefore suggested that the Chairman of Committee B should use his discretionary powers to prevent the opening of a discussion on the basic issue when the principle of such a discussion had been refused by the Assembly.

Mr MOHAMMAD (Nigeria) said that, having carefully listened to the details given by the Chairman of Committee B and the Legal Counsel, he was definitely of the opinion that the General Committee should be guided by the provisions of the Rules of Procedure and not adopt a position that would deviate from them, which would create a dangerous precedent.

Dr AL-ALJOUNI (Jordan), Chairman of Committee A, also thought that any position adopted in the matter by the General Committee would have future repercussions. It should not be forgotten that the Assembly, in deciding not to add to its agenda the supplementary item proposed at the beginning of the session, had intended to avoid a discussion of the substance of the question raised. The General Committee should therefore, in his opinion, advise the Chairman of Committee B to reject the second draft resolution.

Dr BORGOÑO (Chile), who had not attended the previous meeting of the Committee (Thursday, 10 May), felt that the attitude taken by the Committee on that day and at its first meeting (Monday, 7 May) was perfectly consistent, namely that the rejection of the first draft resolution on Thursday followed from the rejection of the supplementary agenda item on Monday.

In his opinion the Committee was now faced with a very different case, since it involved a request for consideration of a draft resolution under a specific item of the agenda adopted. By a recommendation against distribution of the document, and in so far as that recommendation was followed, the General Committee would create a very dangerous precedent for the future, as had been stressed by the delegate of Nigeria. Naturally Committee B would be able question the decision of its Chairman to have the draft resolution considered and, in that case, it would have to pronounce on the matter by vote. In such a case, however, the General Committee, on which 24 Member States were represented, should not take the place of the Assembly, which had over 160.

He considered that the General Committee would not contradict itself by adopting that day a position different from the one taken at its previous meeting, since the circumstances were different, but that it would act in a manner more inconsistent - and more dangerous for the future - by putting itself at variance with the Chairman of Committee B. It was for the latter to reach his decision in accordance with the relevant provisions of the Rules of Procedure, and he (Dr Borgoño) was in complete agreement with the position that the Chairman of Committee B had stated at the beginning of the meeting.
Returning to his previous argument, Dr AL-AWADI (Kuwait) recalled that it was the Assembly in plenary session - and not the General Committee, which had merely made the recommendation - that had rejected the request for the inclusion on its agenda of the matter which had subsequently been the subject of the two draft resolutions. Because of that decision by the Assembly, a substantive discussion should not be engaged in. It therefore followed, in his opinion, that the Chairman of Committee B should, once the draft resolution had been submitted, declare that discussion of the basic issue was not possible because of the earlier decision of the Assembly which, he felt, should remain consistent in the matter.

The CHAIRMAN stated that, pursuant to the provisions of Rule 32 of the Rules of Procedure, he would give the floor to the delegate of the Islamic Republic of Iran.

Mr ZAHIRNIA (Islamic Republic of Iran) pointed out that the draft resolution submitted by his delegation dealt with technical matters, and more especially with medical protection with which the Health Assembly had dealt at its previous session.

While recognizing that the Committee was perfectly entitled to take the position it had taken regarding the inclusion of a supplementary agenda item, and that it was quite normal for the Chairmen of the main committees to request, as a matter of courtesy, the opinion of the General Committee concerning the conduct of the affairs of their committees, he wished to stress that any delegation had the right to submit a draft resolution on any point of the agenda adopted. If such a draft resolution dealt with a technical matter, such as medical protection, in his opinion the Assembly ought to consider it.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) observed that the Committee was discussing the fate of a draft resolution of which it was almost completely ignorant. Recalling that the Director-General, during the previous meeting of the Committee, had read out the first draft resolution, he requested that the second should also be read out so that the Legal Counsel could then be asked for his views on the relevance of the text with respect to the agenda item, to document A37/14 submitted to the Assembly under that item, and more particularly to its paragraph 4.26 to which reference had already been made several times.

Dr ROSDAHL (Denmark), Chairman of Committee B, read out the new draft resolution that had been handed to him.

At the invitation of the Chairman, Mr VIGNES (Legal Counsel), replying to the request by Dr Harris for a legal opinion, mentioned that he had already explained the position as he saw it following the first intervention by Dr Al-Awadi. In brief, if a draft resolution was found to relate to an item on the agenda adopted it should be distributed for consideration in committee; if, on the contrary, it was considered that it dealt with a matter forming the subject of a supplementary item that had been turned down, then the request for consideration should be rejected. It was precisely regarding that question that the Chairman of Committee B had asked for the opinion of the members of the General Committee. It was for the latter, rather than for the Legal Counsel, to give their views on the subject.

Dr ALWASH (Iraq) supported the comments previously made by Mr Al-Sakkaf and Dr Al-Ajlouni: on the one hand, the first draft resolution had not been refused because that draft implicated a certain country, but for reasons of procedure; on the other, Rule 50 of the Rules of Procedure did not now seem to apply, since the Assembly in plenary session had already refused to include the matter in its agenda. He also shared Dr Al-Awadi's opinion, namely that there was no reason, bearing in mind that decision of the Assembly, to consider the substance of the matter. In actual fact, and despite the arguments advanced by the delegate of the Islamic Republic of Iran who had claimed that the draft resolution dealt with technical and, more specifically, medical questions, the purpose of the draft resolution was precisely to enable a discussion to be opened on the substance, in effect a discussion of a political nature. The importance of precedents had already been repeatedly mentioned during the meeting and, for his part, he felt that it was precisely by going against a previous decision of the Assembly in plenary session - a decision which in his eyes was binding on all the other bodies of the Assembly - that a dangerous precedent would be created. When he took the floor for the first time during the present Assembly he had stressed that WHO had a noble mission to accomplish and should not allow itself to be diverted from that mission, which was precisely the aim of the draft resolution the purpose of which was to launch WHO into a political debate.
In the absence of other comments, the CHAIRMAN stated that the Chairman of Committee B had just received many very well circumstantiated opinions from the members of the General Committee which would enable him to come to a decision in full knowledge of the facts.

In reply to a question by Dr AL-AWADI (Kuwait) on the position he intended to adopt, Dr ROSDAHL (Denmark), Chairman of Committee B, said that he felt he had clearly explained his point of view during his first intervention in that meeting. If the question were raised in Committee B of whether or not the draft resolution should be discussed - naturally after the draft resolution had been introduced - he would follow the line of conduct called for by democratic observance of the provisions of the Rules of Procedure applicable in that case. Moreover, he felt it necessary to mention, in view of the many references made to the Assembly decision not to include the supplementary item submitted to it on its agenda, that that decision was based inter alia on failure to respect the time-limits laid down by the Rules of Procedure for the submission of such requests.

Dr AL-AWADI (Kuwait) felt it was therefore clear that Committee B would be confronted with two tasks: taking cognizance of the draft resolution and deciding on the applicability of the relevant provisions of the Rules of Procedure. The General Committee should not ignore the fact that this procedure might well go against the Health Assembly's earlier decision not to consider the matter that had been submitted to it. As regards the substance, and apart from a few differences, the present draft resolution was very similar to the previous one. In conclusion, he urged the General Committee to recommend the Assembly not to consider the problem dealt with in the draft resolution as regards its substance, for that problem came within the competence of the United Nations and not of WHO, although he feared that the borderline between a procedural debate and a substantive discussion would not be very easy to draw.

Dr ROSDAHL (Denmark), Chairman of Committee B, assured the General Committee that if a point of order were raised on the question of procedure he would strictly apply the relevant provisions of the Rules of Procedure. In conclusion, he wished to say that the fact that the draft resolution would be distributed in no way meant that it would be discussed, for it would be discussed only if Committee B so decided; and if it were discussed, that by no means meant that Committee B would approve it.

The meeting rose at 11h50.

FOURTH MEETING

Monday, 14 May 1984, at 12h35

Chairman: Dr G. SOBERÓN ACEVEDO (Mexico), 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 to the Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and by Rule 102 of the Assembly's Rules of Procedure as amended by resolution WHA37.3 adopted by the Health Assembly on the previous Friday. He also drew the Committee's attention to document A37/3 and especially its paragraphs 2.1, 2.2 and 2.3 which set out the amended procedure that the Assembly had to follow for the election in question.1

Because of the entry into force of amendments to Article 24 of the Constitution, the Assembly was called upon, in the current year to elect eleven Members in order to bring the number of members of the Executive Board to thirty-one; in order subsequently to maintain membership at that level, elections would need to follow the sequence eleven, ten, ten in a three-year cycle. As a transitional measure, however, one of the eleven Members elected in 1984 would be elected for only one year, whereas the other ten would be elected for the usual three-year period, in application of the provisions of Article 25 of the Constitution, which had also been amended. That Article stipulated that at least one Member of each regional

1 Document WHA37/1984/REC/1, Annex 1.
organization must be elected each year. The purpose of the change that had been made was to enable the South-East Asia Region, which so far had had only two Members entitled to designate a person to serve on the Executive Board, to have three, each of the other regions of WHO having at least that number. Consequently, the Assembly had, in the current year to elect two Members belonging to the South-East Asia Region, one of which would be elected for one year only.

To assist the Committee in carrying out its responsibilities, it had been provided with the following documents:

(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-seventh World Health Assembly and who would have to be replaced; for the African Region, Guinea-Bissau, Mozambique, Sao Tome and Principe and the Seychelles; for the Region of the Americas, the United States of America; for the South-East Asia Region, the Maldives; for the European Region, Bulgaria and Spain; for the Eastern Mediterranean Region, the United Arab Emirates; and lastly for the Western Pacific Region, Japan.

The Chairman then suggested that the Committee should adopt the following procedure in drawing up its recommendations to the Assembly. It could, if it so wished, first engage in a discussion during which its members could propose the names of countries other than those that had already been suggested in writing; it could then draw, by secret ballot, a list of candidatures; should the Committee so desire, that list could then be discussed. The Committee would then draw up, on the basis of that list of candidatures, again by secret ballot, a list of not more than 15 Members and not less than the number of Members equal to the number of seats to be filled, in accordance with the provisions of Rule 102 of the Rules of Procedure; in other words, that list should consist this year of not more than 15 and not less than 11 Members. Finally, should that list contain more than 11 names, the Committee would again vote by secret ballot to select the 11 Members which, in its opinion, would provide, if elected, a balanced distribution of the Board as a whole.

Observing that the Committee did not wish to hold a preliminary discussion, the Chairman called upon it to proceed, by secret ballot, to draw up the formal list of candidatures, from which it would then have to select the names that would appear on the list specified in Rule 102 of the Rules of Procedure. He stressed that when taking part in that first vote the members of the Committee must without fail enter on their ballot papers the names of all the candidate countries that they wished to have taken into consideration, because at the time of the vote proper it would be too late to introduce the name of any Member not appearing on the list of candidatures. The ballot papers could include as many names of countries as the members of the Committee wished, whether or not those names had been suggested in advance on the list distributed at the beginning of the meeting (referred to under (c) above).

In reply to a request from Dr BORGOÑO (Chile), who wished to know how a distinction would be drawn between the two countries of the South-East Asia Region to be elected in the current year, but one of whom, as the Chairman had pointed out, would be elected for only one year, the CHAIRMAN said he already had before him a proposal on that subject.

Mr BOYER (United States of America) wished to explain why his country's name appeared both on the list of countries that were candidates for election and on the list of countries whose term was expiring (the lists referred to by the Chairman under (c) and (d)).

Most members of the Committee were undoubtedly aware that, from the earlier days of the Organization, five countries had figured regularly among those which designated a person to serve on the Executive Board; they had been given three-year terms in regular succession, with a gap of only one year between two terms. The United States of America was one of those countries. Since it was the Member State of WHO that made the largest contribution to the Organization's budget, it particularly appreciated the entitlement to designate a person to serve on the Executive Board when the proposed programme budget was considered by the Board. Since the biennial budget cycle had come into force in the Organization, it so happened that, with the current three-year terms, no person designated by his country had been a member of the Board and able to participate in the consideration of the proposed programme budget in 1981, and the same would happen again in 1985. In other words, the United States would find
itself unable to designate a person to serve on the Executive Board for the consideration of
the proposed programme budget in one biennium out of two, which was not the case for the
other four countries concerned. The United States therefore wished the cycle for the
designation of one of its nationals to serve on the Executive Board to be modified in such a
way as to ensure that one of its nationals should be present whenever the biennial proposed
programme budget was examined by the Board.

He therefore requested the members of the Committee to recommend to the Assembly that it
elect his country again in the current year, on the understanding that his Government would
forgo its right to designate a member of the Board after one year. The request by the United
States of America had the de facto objective of prolonging its existing term in order to
enable the person designated by it to participate in January 1985, and in subsequent
odd-numbered years, in the consideration of the programme budget estimates. The United
States would then be absent from the Board - to put matters more simply - from May 1985 to
May 1986, at which time it would begin a new three-year cycle. He thanked the other
countries of the Region of the Americas for agreeing to that change.

Mrs ZHEN Yun (China) informed the Committee that the nomination of the country proposed
for the Western Pacific Region - the Republic of Korea - did not stem from preliminary
consultation at the regional level. She did not know who had proposed the name of that
country.

The CHAIRMAN pointed out that such consultations at the regional level usually enabled
the Member States of a Region to agree on the name, or names, of one or more of their number
to be submitted to the Assembly for election. However, such preliminary agreements did not
prevent members of the Committee from adding the names of as many other countries as they
wished to the list that they had to draw up.

Professor ISAKOV (Union of Soviet Socialist Republics) supported the candidatures of
Hungary and the United Kingdom of Great Britain and Northern Ireland for the European
Region; those candidatures reflected a unanimous decision by the countries of that Region,
as was confirmed by Dr GRECH (Malta).

Mr BOUSSOUKOU-BOUMBA (Congo) said he had believed that the list of proposals submitted
to the Committee was the outcome of preliminary discussions and agreements in the various
regional committees, and that the vote which had to be taken on those candidatures was a mere
formality. Such at least was the case in the African Region from which he came, and he was
surprised that the same practice had not been followed in the Western Pacific Region. Would
it not be desirable, before the Committee proceeded to a vote, for the Member States of the
latter Region to get together in order to reach a consensus?

Dr SEBINA (Botswana) was also of the opinion that the practice of the consensus at the
regional level made things easier, as the experience of previous years had proved. Although
there was no question of preventing members of the Committee from adding names to the list of
proposals submitted to them, it would be desirable in future that all the names of countries
proposed should reflect the consensus arrived at in the regions.

Mr BOYER (United States of America) agreed that the practice of the consensus at the
regional level was both desirable and useful for the smooth running of the Assembly, but
emphasized that it was a customary practice, not something laid down in the Assembly's Rules
of Procedure. Regarding the particular situation of the Western Pacific Region, he
understood that the Republic of Korea was the only country of that Region to have come
forward as a candidate for the Executive Board elections in the current year.

The DIRECTOR-GENERAL, noting the concern shown by several members of the Committee over
the absence of consensus in one of the regions, expressed his intention of bringing that
concern to the attention of the regional committees, so that they could all take it into
consideration in the future when nominating countries from their regions for election to the
Executive Board.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) reminded the Committee
that the previous year it had not had to take a formal vote, as the list of Members submitted
to it had resulted from agreements reached in the various regions following unofficial
consultation. In his opinion it would be desirable if the Committee could proceed in the
same way in the present year.

Mr VIGNES (Legal Counsel) confirmed the way in which the matter had been dealt with the
previous year, but stressed that such a procedural simplification was possible only if there
was unanimous agreement on the list of names proposed. In the absence of such prior agreement, the Committee could not dispense with voting in drawing up, as a first step, the list of candidatures, unless the differences of opinion that had been expressed were resolved and the Committee unanimously agreed to accept the provisional list.

Noting that such was not the case, the CHAIRMAN called upon the Committee to proceed with the first step in the procedure laid down, namely the drawing-up of the formal list of candidatures. He asked Mrs de la Batut (France) and Dr Chidede (Zimbabwe) to act as tellers. He stressed that the vote that was about to take place did not constitute the election proper but was intended merely to draw up the list of candidatures.

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

The CHAIRMAN announced the results of the ballot, in which 19 countries had received votes. It seemed, however, that the distribution of the nominated countries between the various regions was somewhat unbalanced; for two regions the name of only one country had been proposed, whereas for another region no less than eight names had been put forward. The Committee should therefore now draw up a list of Members that would produce a more balanced geographical distribution between the regions. He suggested that, in the following step in the procedure as laid down, the Committee should concentrate its attention on those regions where the large number of candidatures obliged it to make a choice in order to arrive at a list of Members that would provide, if elected, a balanced distribution of the Board as a whole. There were four such regions. In the second step in the procedure the Committee could leave out of consideration those regions for which only one candidature had been put forward consequent upon a consensus at the regional level.

Following a suggestion by the DIRECTOR-GENERAL, supported by Mr BOUSSOUKOU-BOUMBA (Congo), the CHAIRMAN further drew the attention of the Committee to the names of the countries which, in each of the four regions concerned, had been put forward to be voted upon by the Assembly following a consensus reached at the regional level. He added, in reply to a remark by Dr BORGÔÑO (Chile), that when the vote proper was taken the Committee would of course also have to vote for the two countries that were unopposed in their respective regions.

Mr BOUSSOUKOU-BOUMBA (Congo) could not see why the Committee should take a vote concerning regions where several candidatures had been put forward during the establishment of the list of candidatures when a consensus had been reached beforehand in those regions regarding a limited number of countries whose election was necessary to maintain the desired geographical distribution of the Board. He even doubted whether the Committee should be called upon to decide on the candidatures of countries other than those which had been the subject of such a consensus, and felt the Committee should confine itself to dealing with the Western Pacific Region where the candidature of the country proposed had been contested.

Mr BOYER (United States of America) wondered whether the countries whose names had been added when the formal list of candidatures had been drawn up really wished to stand; all the countries on the initial list of names suggested, and read out by the Chairman at the beginning of the meeting, were genuine candidates. In particular, he understood, although he had no brief to speak in their name, that the two countries whose names had been added to the list of candidatures for the Western Pacific Region were not in fact candidates.

Mr TO VADEK (Papua New Guinea) pointed out that the general feeling, in the Region to which his country belonged, was in favour of the candidature of the Republic of Korea.

Dr MEYER-LONG (Uruguay) joined Mr Boyer in wondering what attitude the Committee should take with regard to the candidature of countries when it was not certain that the countries concerned had agreed to stand. As the only region where a real problem arose appeared to be the Western Pacific, could not the Member States of that Region be asked to agree on a single candidature acceptable to all of them?

The CHAIRMAN noted that in the absence of a general consensus the Committee would have to move on to the following step in the procedure so as subsequently to be able to draw up, in a third step, the list of 11 Member States to be transmitted to the Health Assembly. He pointed out that, based on the present list of candidatures which comprised 19 names, the Committee now had to draw up a list of not more than 15 and not less than 11 names. He suggested that, when the Committee voted in order to draw up that list, it should take into consideration the consensus which the Member States had reached in almost all the regions.
Mr VIGNES (Legal Counsel), referring to the suggestion that the Committee should confine itself to deciding between the candidatures in regions for which there were more candidatures than seats to be filled on the Board, felt that from the legal viewpoint the Committee could not avoid voting on all the countries whose candidatures had been put forward. However, when voting to draw up a list of not less than 11 and not more than 15 members, it could be guided both by the known regional consensuses and by the statements made during the meeting. In that connection, he suggested that the Committee might hear the delegate of the Republic of Korea, who wished to explain the views of his country on the matter.

Dr Sung Woo LEE (Republic of Korea), speaking at the invitation of the Chairman under Rule 32 of the Rules of Procedure, stressed that, although there was not perhaps a general consensus among the Member States of the Western Pacific Region regarding the candidature of his country, that candidature had at least been the subject of extensive preliminary consultations between those Member States and was, moreover, the only one put forward by a Member State in that Region. After mentioning the contribution of his country, where the Regional Committee had met in 1981, to the activities of WHO, he also pointed out that the Republic of Korea had so far been able to designate a person to serve on the Board on only one occasion, in the early 1960s. He therefore asked the members of the Committee to support its candidature.

Dr SEBINA (Botswana) stressed that respect for the regulations should take precedence over regional arrangements, and asked the Committee to conform to the procedural provisions applicable in the matter. He observed, moreover, as concerned the situation in the Western Pacific Region, that the Committee was faced with opposite statements by the delegates of China and of Papua New Guinea.

Mr MOHAMMAD (Nigeria) proposed that the lists of candidatures supported by the regional committees be accepted as they had been submitted, without any additional vote, and indicated the names of the countries appearing on the list drawn up by the Regional Committee for Africa.

Mr CAMPBELL (Australia), speaking at the invitation of the Chairman, stated that his country was not a candidate for the election to the Executive Board. If it had been, he would have made the fact known within the prescribed time-limit. To his knowledge only the Republic of Korea had put forward its candidature for the Western Pacific Region.

The CHAIRMAN noted that statement and informed the Committee that, on the basis of the 18 remaining candidatures, it should proceed to draw up the list of not more than 15 and not less than 11 Members in a second secret ballot where the majority needed was a simple majority. He pointed out that any ballot paper bearing less than 11 or more than 15 names, or containing names of countries not appearing in the list of candidatures drawn up previously, would be considered null and void.

Mr BOUSSOUKOU-BOUMBA (Congo) said that, in his capacity as Chairman in office of the Regional Committee for Africa, he wished to support the position taken by the delegate of Nigeria. In his opinion the Committee should not do anything to destroy a consensus that had been reached at the regional level, namely in the Regional Committee in the case of the Region to which his country belonged.

Regarding the problem which arose for the Western Pacific Region, he wondered whether the candidature of the Republic of Korea which, as he understood, had already been able to designate a person to serve on the Board, could not be withdrawn for the benefit of some other country in that Region which had not yet had the opportunity to do so.

The DIRECTOR-GENERAL, who said he was intervening in an effort to assist the Committee in its work, stressed that if the Health Assembly concluded, after consideration of the problem by the Executive Board, that the consensus reached at regional level should be respected during elections to the Board, then the work of the Committee would be facilitated in future.

In the present situation the Committee was faced with a consensus in five of the six regions. If it did not respect that consensus, it might be considered to have violated a well-established practice and would in that way risk creating a precedent which would present awkward problems in the future.

He confirmed, moreover, that in the past the Republic of Korea had already been entitled to designate a person to serve on the Board.
The CHAIRMAN asked the members of the Committee, in the second vote, to bear in mind the consensus in the regions stressed by several of its members.

The General Committee then took a vote by secret ballot to draw up a list of not more than 15 and not less than 11 Members, selected from the list of candidatures, which would be transmitted to the Health Assembly.

2. PROGRAMME OF WORK OF THE HEALTH ASSEMBLY — ALLOCATION OF AGENDA ITEMS TO THE MAIN COMMITTEES: TRANSFER OF AN ITEM

After drawing attention to the programme of meetings already established by the Committee at its meeting on Thursday, 10 May, for Tuesday, 15 May, the CHAIRMAN asked the Chairmen of the main committees to report on the progress of the work of their committees.

Dr ROSDAHL (Denmark), Chairman of Committee B, followed by Dr AL- AJLOUNI (Jordan), Chairman of Committee A, reported on the progress made by those committees since Friday, 11 May.

In the light of those statements the CHAIRMAN considered that it might be necessary to transfer an agenda item from Committee A to Committee B, a decision which it was for the General Committee to take by virtue of Rule 33(d) of the Rules of Procedure. He therefore proposed that the Committee decide at once that, should such a transfer be necessary, it should concern agenda item 21 (International standards and reference preparations for biological substances).

It was so agreed.

The Committee then fixed the programme of meetings for Wednesday, 16 May.

3. DATE OF CLOSURE OF THE HEALTH ASSEMBLY

The CHAIRMAN then reminded the Committee that it was also called upon to fix the date of closure of the session, and asked the members to consider the matter so that the Committee could take its decision at its meeting on the following day, Tuesday, 15 May, at 17h30.

4. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD (resumed)

The CHAIRMAN announced that the votes in the second ballot taken by the Committee had been counted. Only 11 Members had obtained the necessary majority in the second ballot, namely the 11 countries that appeared on the list of Members suggested, and to which he had drawn the attention of the Committee at the beginning of the meeting.

It was therefore unnecessary to proceed to a further ballot and the list of those 11 Members — Egypt, Equatorial Guinea, Guinea, Hungary, Indonesia, Ivory Coast, Kenya, Republic of Korea, Thailand, United Kingdom of Great Britain and Northern Ireland and United States of America — would be transmitted to the Health Assembly with a view to the annual election of Members entitled to designate a person to serve on the Executive Board.

It was so agreed.

The meeting rose at 14h25.
FIFTH MEETING

Tuesday, 15 May 1984, at 17h35

Chairman: Dr G. SOBERÓN ACEVEDO (Mexico),
President of the Health Assembly

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

After hearing reports from Dr AL-AJLOUNI (Jordan), Chairman of Committee A, and Dr ROSDAHL (Denmark), Chairman of Committee B, on the progress of the work of their committees, the General Committee fixed the date of closure of the Health Assembly as Thursday, 17 May and drew up the programme of meetings for the last day of the Assembly. On that day there would be two plenary meetings in the afternoon: the meeting to adopt the last reports of the main committees would be followed, after a short break, by the closing plenary meeting.

2. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the General Committee completed.

The meeting rose at 17h45.
COMMITTEE A

FIRST MEETING

Tuesday, 8 May 1984, at 11h15

Chairman: Dr K. AL-AJLOUNI (Jordan)

1. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 18 of the Agenda (Document A37/27)

The CHAIRMAN expressed gratitude for his election and welcomed those present, particularly the delegates of Antigua and Barbuda, and Saint Vincent and the Grenadines, which had become Members of the Organization since the preceding Health Assembly.

He then drew attention to the third report of the Committee on Nominations (document A37/27),1 in which that Committee had nominated Mr R. Edwards (Canada) and Dr K.-H. Lebentrau (German Democratic Republic) as Vice-Chairmen and Mrs K. M. Makhwade (Botswana) as Rapporteur. The Chairman proposed Professor F. Renger (German Democratic Republic) to replace Dr Lebentrau, who was unable to accept the nomination.

Decision: Committee A elected Mr R. Edwards (Canada) and Professor F. Renger (German Democratic Republic) as Vice-Chairmen, and Mrs K. M. Makhwade (Botswana) as Rapporteur.

2. TRIBUTE TO DR E. BRAGA

The CHAIRMAN communicated to the Committee the sad news of the recent death of Dr Braga of Brazil, who had, three years previously, served as Chairman of Committee A and who had worked tirelessly throughout his career in the cause of public health.

Dr BORGOÑO (Chile), speaking on behalf of delegations from the Americas, paid a warm tribute to the memory of Dr Braga, whose career had been closely linked to that of WHO, where he had served with his countryman, the former Director-General Dr Candau, becoming Director of the Health Manpower Division; later he had been a member of the Executive Board. His interest in training had deeply involved him in the work of other international organizations as well as in his own country, where he had been Director of the School of Public Health in Rio de Janeiro, and in the whole Region of the Americas, as coordinator of schools of medicine. His death would deeply sadden his colleagues, and all efforts made by the Health Assembly towards the goal of health for all by the year 2000 would be in keeping with his achievements.

The CHAIRMAN invited the Committee to stand in silence in memory of Dr Braga.

The Committee stood in silence for one minute.

Dr BONOW (Brazil) expressed appreciation, on behalf of his delegation, for the tribute paid to the memory of Dr Braga, who had throughout his life rendered such immense services to the cause of public health in Brazil as well as to the promotion of wellbeing in other countries.

3. ORGANIZATION OF WORK

The CHAIRMAN, after introducing the background reference documentation to the present session, suggested that the normal working hours should be from 9h00 to 12h30 and from 14h30 to 17h30, though they might have to be adjusted from time to time.

It was so agreed.

1 See document WHA37/1984/REC/2.
4. GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000: REPORT ON MONITORING OF PROGRESS IN IMPLEMENTING STRATEGIES FOR HEALTH FOR ALL: Item 19 of the Agenda (Resolutions WHA34.36, WHA35.23, WHA36.34, EB73.33, and EB73.38; Documents EB73/1984/REC/1, Annex 1, A37/4 and A37/5)

The CHAIRMAN said that, since the Executive Board had considered the item and was presenting its conclusions to the Health Assembly, the representative of the Executive Board would introduce the item.

Professor LAPOINTE (representative of the Executive Board) recalled that the Thirty-Fifth World Health Assembly, in its resolution WHA35.23, had requested the Executive Board to monitor progress in implementing the Global Strategy for Health for All by the Year 2000 and to report to the Assembly on progress made and problems encountered. At its seventy-third session, in January 1984, the Board had reviewed the progress report drawn up on the basis of information received from Member States and considered by the regional committees and the Programme Committee of the Board. The Board had also taken note of the comments by the Director-General on the subject.

The Board had noted that only three-quarters of the Member States had reported on progress in the implementation of their national strategies for health for all in due time. Many of the reports submitted had not been as complete or accurate as they could have been and the progress report had therefore suffered from a lack of detailed and precise information on many of the important aspects which were crucial to the national strategies. The Board had wondered whether that information had not been available in the countries or whether it had not been possible to collect and analyse the data that were actually available, but had recognized that some countries might have experienced difficulties in the interpretation of the selected indicators and in the collection and analysis of relevant data, and had also felt that the information support for the data collection and evaluation mechanisms in the countries required considerable strengthening. The Board had endorsed the comment of the Director-General that the data collection process had to be implemented, in the first place, at the national level where the information was compiled, analysed and used to review progress of national strategies for health for all.

The progress report indicated nevertheless that a high level of political sensitization had taken place and that the political will to attain the goal of health for all existed in a large majority of the countries which had reported. Several countries had taken steps to formulate national policies and strategies aimed at achieving universal coverage of their populations with primary health care. Others were reviewing their national health systems with a view to reorienting them more towards primary health care. The training and retraining of health workers in primary health care had been initiated, as had the involvement of communities in health activities. Moreover, there was a trend towards increased international cooperation in health, especially in sharing information and technical "know-how".

The Board had recognized that while those various signs were encouraging, the implementation of the Strategy had not proceeded as rapidly as was desirable. Since the period remaining to achieve the collectively agreed goal of health for all was less than 17 years, the implementation of the Strategy should be accelerated; and Member States should undertake serious and analytical reviews of their responsibilities and of progress in their countries. The Board was well aware that there were obstacles: it was endeavouring to identify them with the help of the Member States and to make recommendations for surmounting them.

The progress report also showed that many countries had yet to formulate their national strategies, to determine their objectives and to evaluate the means and resources required for achieving them. Implicit in that task was a review of existing resources and an analysis of needs, backed up by plans for the exploitation of both national and external resources: it was a fact that that question had surprised most countries, most of which experienced genuine difficulty in estimating the real expenditure in the health sector. It was also essential for those countries to strengthen considerably their managerial and programming capacity, together with the evaluation and utilization of resources. There were some guiding principles for promoting such a policy, but it was necessary to take into account factors specific to each country and practical conditions. One of the most urgent steps, in the Board's opinion, was to train health personnel for such a policy and prepare them for the change it implied.

Other countries had reported difficulties in reorienting their health care systems towards systems based on primary health care. The Board was aware of the extent of the shortcomings and the size of the task, which also called for appropriate knowledge and sound management practices; nor should it be forgotten that any such reorientation might require interpretations of laws and regulations. Moreover, it would only be achievable if appropriate coordination was established with the existing health care systems so as to make them consistent with primary health care and if all resources that could be used for health were used to the full. Special attention should be paid to training, management and supervisory techniques, particularly for middle-level personnel: the Board believed that the WHO Secretariat ought to take a particular interest in that problem. Moreover, the Board had recognised that States, for their part, should try out new ideas or consider new approaches for speeding up progress, strengthening operational research and applying the conclusions.

As regards the reorientation and training of health manpower, the Board had considered it desirable to intensify efforts to plan training programmes for health personnel in an appropriate manner, to adapt the basic training programmes and to provide retraining for existing personnel. Such efforts called for the mobilization of the universities and research establishments - and he hoped they would enter into it wholeheartedly. In addition, in the effort to achieve social justice as represented by health for all by the year 2000, the "supplément d'âme" referred to by the philosopher Bergson and the preoccupation expressed in resolution EB73.R3 with the spiritual dimension of the Global Strategy for Health for All by the Year 2000 should not be lost sight of.

Finally, the community itself should be won over to the idea that the objective of health for all could be achieved only if each and every person in the population was motivated to look after his own health and that of others, and if there was effective participation by all the structures involved directly or indirectly in health. It was important to define the health element in development strategies and economic policies and to make every effort to prevent microbiological, physical, toxicological and psychological hazards, and to bring about social harmony.

Such collaboration, essential at the national level, was just as necessary at the international level, both within and outside the United Nations system, so that all intergovernmental, nongovernmental and voluntary organizations would take part in activities to achieve the objective of health for all.

The relatively slow progress and the difficulties encountered by Member States over effective community participation in the effort and in implementing intersectoral activities for health, the Board urged Member States to pay very close attention to the problems and to take the appropriate steps to solve them. It was certain that every country would respond to that appeal; that they would do more than draw up a balance sheet of successes and failures without becoming discouraged by temporary difficulties - for efforts must be redoubled so as to record more progress in 1985; and that a creditable score would be achieved if political will was converted into action. Member States would assume their responsibilities in the certainty of receiving active support from the WHO Secretariat while making the best of their resources for the purposes of the established strategies. They must work together to achieve the ideal of health for all in peace and within a fair socioeconomic climate.

It was in that spirit that the Board invited the Assembly to consider the draft resolution contained in resolution EB73.R6.

Dr OLIVER (United Kingdom of Great Britain and Northern Ireland) welcomed the useful analysis of country reports undertaken by the Executive Board and the Secretariat, and the Director-General's comments. Despite the shortcomings of the monitoring process, to which Professor Lafontaine had referred, some satisfaction could be derived from the fact that the process had been initiated, and credit should be given for the efforts and commitment of many Member States, some labouring under considerable handicaps, which had responded with candour and objectivity. An encouraging level of political sensitization had been attained and there were positive signs that the primary health care approach was gaining greater acceptance in the planning of health service development.

Everyone was concerned at the disappointingly low return from many parts of the world; even in a developed region such as Europe, only 60% of Member States had responded. The failure to provide critical information might well be due to a combination of several factors: the complexity of the common framework and format document; the unavailability of the information requested; and a lack of conviction on the part of Member States as to the relevance of the information requested.

For many Member States, the exercise must have appeared daunting, both in terms of the volume and the detail of the information requested. In the United Kingdom, considerable difficulties had been experienced in undertaking the monitoring exercise. An ad hoc
committee had been set up to study the problem and the services of a consultant had been required. The regional offices might provide more support to Member States next time the monitoring exercise was undertaken.

Another problem was the lack of health information systems in many countries. Without the tools to gather relevant and valid information, the gaps that were evident in the present report would remain, resulting in reduced usefulness of the exercise. The need for health information systems was being considered in the United Kingdom, and his Government's Minister of State for Health would probably refer further to that matter in his forthcoming address to the plenary. The lack of health information systems also called into question the ability to adopt a credible managerial process for health development. WHO should give priority to that aspect, and Member States should be helped to develop the skills and expertise required to obtain the necessary data for quantifying and qualifying the key indicators.

The Director-General had drawn attention to another disquieting aspect which undermined the whole concept of the monitoring process - the fact that even when information was available it was not always released. It might be appropriate to take a fresh look at the indicators. The 12 global indicators should not be considered as immutable. He suggested that, given the difficulties experienced by a number of countries in supplying information on some of the indicators, the usefulness of elaborating a sub-group of indicators might be examined, perhaps by the Executive Board. In that way, returns might be improved and the value of the exercise enhanced.

Despite all the shortcomings, he shared the optimism expressed by the Director-General and by Professor Lafontaine. The lessons learned should be used to improve the monitoring process and, as the Director-General had said, as the springboard for future action. The monitoring process could provide a useful tool for assessing progress and for promoting better planning, and thus for shaping the future policies of WHO.

His delegation supported the draft resolution proposed by the Executive Board.

Dr. SADRIZADEH (Islamic Republic of Iran) said that the humanitarian goal of health for all by the year 2000 could only be achieved by the eradication of poverty, injustice, illiteracy and war and through community involvement, the reorientation and equitable distribution of health resources, intercountry cooperation and the mobilization of external resources.

The Constitution of the Islamic Republic of Iran recognized the right of all citizens to health and made it incumbent upon the Government equitably to provide health services for the population. National health policy was in accordance with the long-term objective of health for all.

The first health development plan, covering the first part of the decade, set out general policies, corresponding strategies, operational objectives and specific health development programmes. The plan gave high priority to rural underserved areas as well as to community involvement. The primary health care approach had been accepted as an ideal system for health care delivery, and special attention had been paid to the expansion and development of rural health services and the training of health auxiliaries in order to provide health care to the entire population. Efforts were made to recruit students from the areas and the communities in which they would serve and newly qualified physicians were compelled by law to serve three to five years in the rural health services.

The first monitoring of the national strategy had been carried out in 1983, and the evaluation of programmes based on field reports related to various health activities indicated relatively good progress towards the achievement of the goal of health for all by the year 2000.

Dr. SAVEL'EV (Union of Soviet Socialist Republics)said that the review of global and regional activities in implementation of the health-for-all strategy covered a relatively short period. It was never easy to advance from words to actions, as the Director-General had rightly emphasized, and it was particularly difficult against a background of world tension, warfare and the diversion of resources to a pointless arms race. The achievement of the health-for-all goal was essentially dependent on peace in the world, as set out in United Nations General Assembly resolution 38/188, which attached great importance to the report published by WHO on the effects of nuclear war on health and health services, and called on specialized agencies and other organizations to work in their own fields to promote disarmament. The first results indicated that implementation of the Global Strategy necessitated in many countries the introduction of far-reaching social and economic changes. His delegation shared the Director-General's concern in regard to the serious lack and poor

quality of information on the implementation of national strategies. It was a matter of particular regret that in the European Region, where statistical and information services were most developed, the reply rate had only been 60%. Consistency required that the Organization should systematically monitor implementation of the strategy at the national and regional levels. The first attempt which had been made to use the 12 global indicators had clearly demonstrated the need to simplify and improve them, but he could agree with the Director-General that in spite of its limited scope the monitoring process, even at so early a stage, provided useful information on the efforts made by governments to implement national strategies. He had no comments to make on the draft resolution submitted to the Health Assembly.

The right to health, enshrined in the Soviet Constitution, found its expression in the social, economic and public health legislation both of the Union itself and of the constituent republics. Concrete targets had been set both in the five-year and annual economic development plans and provision had been made for medical and health research. Various other measures affecting health had been taken during the past two years such as the Food Programme to 1990, measures to improve housing and living conditions, environmental protection, culture and recreation. A multisectoral Health Care Commission had been set up under the Ministry of Health by order of the Government to coordinate all aspects of preventive medicine and public health. The increasing emphasis on health care had been reflected in the funds supplied for that purpose in the State budget and by individual industrial establishments and collective and State farms.

No serious changes had been found necessary in the programmes and infrastructure of primary health care proclaimed at the Alma-Ata Conference. All citizens of the Soviet Union were entitled not only to primary health care but also to specialist medical attention. The basic structure for providing primary health care to the population was a system of outpatient centres, staffed by highly qualified medical workers and catering for adults and children separately. Eighty per cent of the persons treated began and completed their treatment in the same centres. Similar facilities were available for factory workers, including centres staffed by certain surgeons and nurses either within or in the vicinity of the industrial installation. The planning of hospital, outpatient and referral services for the rural population had been based on geographical, demographic and other local factors. That system was closely tied in with the 4900 sanitary-epidemiological stations throughout the country.

Planned preventive medicine emphasized the importance of a healthy way of life, and that was reflected in the work in schools, community organizations and the media. The need for active participation by the population itself had also been stressed and community councils, trade unions and other social bodies had all played a very necessary part. The trade unions had made a direct contribution to ensuring healthy and safe working conditions, to planning a healthy dietary regime for the population and to setting up State social security schemes and providing sanitaria and rest homes. The Red Cross and Red Crescent with a coverage of 116 million people had been instrumental in propagating a knowledge of health and hygiene among the population.

In the Soviet Union the health services had been planned and developed on a strictly scientific basis. Research and the study of health in all its aspects (medical, demographic and health planning) were undertaken at more than 100 scientific research centres and departments throughout the country. Steps were being taken all the time at State level to raise the living standards of the population, to protect the environment and to prevent disease. As a result the health indicators of the population were constantly improving.

Those achievements did not mean, however, that health workers at country level in the Soviet Union had found solutions to all the problems of preventive health care. The utilization of human and material resources had to be radically improved and intensified, moving on to the next stage of development, the main emphasis being placed on an increased effectiveness of outpatient facilities and more effective preventive, diagnostic and therapeutic activities in primary health care. Particular attention was paid to the introduction of annual check-ups of the state of health of every citizen, including healthy people and those in especially exposed occupations or otherwise particularly at risk, as well as those suffering from certain specific diseases. Soviet workers in the medical field were prepared to share their experience with other countries as a practical contribution to the achievement of the Global Strategy for Health for All by the Year 2000, so as to enhance cooperation, mutual trust and fellowship between nations and serve the cause of world peace.

The meeting rose at 12h35.
GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000; REPORT ON MONITORING OF PROGRESS IN IMPLEMENTING STRATEGIES FOR HEALTH FOR ALL: Item 19 of the Agenda (Resolutions WHA34.36, WHA35.23, WHA36.34, EB73.R3 and EB73.R6; Documents EB73/1984/REC/1, Annex 1, A37/4 and A37/51) (continued)

Professor ORDÓÑEZ CARCELLER (Cuba) recalled that two years previously the Health Assembly had adopted the plan of action for implementation of the health-for-all Strategy and countries had been urged to undertake collective action on the monitoring and active evaluation of the progress made. The present review would constitute a first assessment which could then serve as point of departure for future systematic evaluations of the progress made towards the goal of enabling all the citizens of the world to reach, by the year 2000, a level of health that would enable them to lead a socially and economically productive life.

He proposed to single out, among the 12 global indicators approved by the Health Assembly, a few of the aspects most relevant to the development of public health in Cuba. Of fundamental importance was the political decision to give priority to primary health care within the framework of socioeconomic development with the establishment of an integrated national health system and active community participation both in decision-making and in the solution of the health problems of the individual, family and the community. An adequate information system was also vital to the monitoring process and great efforts were being made in the Region of the Americas to increase the capacity and accuracy of national information systems. His country was fully committed to the attainment of success of the health-for-all Strategy.

Dr BORGOÑO (Chile) welcomed the fact that less than 25% of all Member States had failed to provide information on the implementation of their health-for-all strategy. It was noticeable that some of the countries best fitted to provide information (in the European Region and the Region of the Americas) had failed to do so, thus indicating a certain lack of commitment to inform on their part. The countries of those two Regions had a responsibility to discharge vis-a-vis all the other countries, through WHO, in the common quest. That was an important matter as current monitoring was to provide the information for the first formal evaluation of the strategies, which was to take place in 1985. Monitoring was not merely collecting and analysing information—it was a basic element in the evaluation process. Coming from a country that had before it the health targets of the Americas, which were even higher than those of WHO, he felt that the important point was that such targets had to be achieved not merely in terms of national averages but in every part of every country. Surveillance alone was not enough; it had to lead to analysis and projection of data for evaluation purposes in a rational use of the monitoring process. The regional offices had a part to play as catalysts in obtaining more and better reports on time and in ensuring that the strategies were directed to the promotion of cooperation between developing countries and indeed between countries in general.

He would like the current first review of the monitoring of progress to achieve some simplification of the frameworks and formats, and an improvement of the tools being used to measure the progress made.

It sometimes appeared that there was a sort of schizophrenic gap between the political will to take decisions and their implementation in practice. Although on paper it might appear that many problems could be solved concurrently, what was important was to make a

1 Document WHA37/1984/REC/1, Annex 3, parts 1 and 2.
start without delay; the real commitment was to act at the national and regional levels. In that connection he agreed with previous speakers on the need for WHO to provide, at the global and regional levels, more support to countries in improving their information systems so that they would provide the reliable data required for the monitoring and evaluation process. Emphasis should also be placed on the continuing education and training of health workers, in order to provide the essential health infrastructures at the national, regional and, especially, rural levels. The Organization also had an obligation to demonstrate, with examples, the connections and intersectoral and multisectoral linkages between the health-for-all strategies and development in other sectors of national life.

His delegation supported the draft resolution submitted by the Executive Board.

Dr MGENI (United Republic of Tanzania) agreed that the incompleteness and inaccuracy of some of the reports submitted by individual countries on the implementation of the health-for-all strategies seemed to have been due in no small measure to the inadequate information systems and lack of statistical skills and experience in many developing countries. Experience of monitoring progress in his own country suggested that the 12 global indicators, although excellent as criteria of overall progress, had not been altogether appropriately designed to meet the requirement at the national level and that they needed further elaboration to include some complementary factors. Basic standard health status indicators appeared to be required covering at least the eight components of primary health care since, in their absence, some countries tended to remain faithful to traditional hospital-based standards which might present a biased picture of community health status. It would be misleading, for example, for a country like his own in which the primary health care workers at the periphery consisted of medical assistants and rural medical aid personnel, to use the doctor/population ratio rather than the appropriate allied personnel/population ratio as an indicator of the provision of health care; that would also perpetuate a demand for highly skilled, and in consequence expensive, hospital-based staffs, which were not really required to meet the vital health needs of the community. The standard basic health status indicators covering at least the eight primary health care components should also clearly state standard targets and objectives and comprise standard supportive indicators relating to resources required for their achievement. In the absence of these primary health care oriented standard indicators, many countries would either revert to the hospital-based, curative health care indicators or over-invest in supportive services without any objective impact assessment. There was a need for a model.

Taking the example of maternal and child health in a community, the health target indicator already adopted would be the achievement of an infant mortality rate not exceeding 50 per 1000 live births annually. The supportive inputs required, i.e., the resources, could then be defined in terms of the number of health personnel required to serve the number of children or number of expectant mothers to be covered, and the number of health worker visits required, and at what intervals, to ensure proper health monitoring at least during the first year of life.

It was also imperative that the indicators that lay within the purview of the health system itself should be identified and clearly defined before an attempt was made to tackle the intersectoral indicators.

His Government would be interested in developing appropriate indicators and would welcome WHO cooperation in so doing, as well as the collaboration of other interested organizations and Member States.

He supported the draft resolution contained in resolution EB73.R6 submitted by the Executive Board.

Professor BENADOUDA (Algeria) agreed that 75% of Member States' having responded to the Organization's request to report on their progress was a factor that made for optimism. The unanimity of political will was also most promising.

The Executive Board's report (document A37/4) was particularly valuable, however, in that it identified some of the obstacles to be overcome. One of the most formidable was the economic recession which tended to intensify the disparity in health standards between countries and within individual countries. That called for the establishment of priorities and the reinforcement of intersectoral cooperation in all fields with an impact on health, both within countries and between WHO and the other international organizations concerned, where necessary to the extent of a real mobilization of United Nations resources. For example, there was no point in organizing vaccination programmes in the Sahel if the children had nothing to eat. The second obstacle which arose at the human level was also important, namely shortcomings in the analysis and handling of information, defective planning and

---

management, on occasion a complete lack of intersectoral cooperation, and inadequate operational research capacity at the national level. A further problem sometimes arose with health professionals, whose hospital-based training prevented them from accepting the concept of primary health care, and with the community itself which was conditioned to accept disease rather than to fight it. Nothing less than a reorientation of national systems was required and a change in the attitude towards primary health care, brought about by educating health personnel to the new approach and the population to assume responsibility for their own lives. That was where the real thrust should be directed. The problems enumerated above could all be solved by medical personnel who were realistically trained and conscious of the needs of society. The alternative solution of the periodical detachment of experts did not work; when the experts left the situation reverted to its original state.

Dr EL BERMANY (Egypt) said that the idea of formulating global indicators was novel and helpful but he wished to comment on some of them.

Global indicator 3 (expenditure on health in terms of GNP) should take into consideration indirect expenditure on projects and activities which might have a more far-reaching effect on health than direct health expenditure, for example environmental health measures, drinking-water supply, sanitation and solid waste disposal. A distinction should be made in global indicator 4 (percentage of national health expenditure devoted to local health care) between coverage and efficiency. It would be wrong, for example, to compare a locality in which a centre of excellence or a university hospital was located with another locality which had only a primary health care unit. When considering global indicator 7 (population coverage with primary health care) where immunization was concerned, a distinction should again be made between reported coverage, real coverage and effectiveness. Global indicator 11 (adult literacy), on the other hand, was closely dependent on the availability of public education and the date on which the policy of literacy for all had been adopted (time had to be allowed for the beneficiaries to reach adult status).

Apart from those specific comments, it would be helpful to quantify global indicators 4, 5, and 7, including its sub-indicators, and to state, for example, the percentage of the population with access to safe water supply and sanitation, the extent of real coverage with immunization and immunization effectiveness, what were the essential drugs and their availability in terms of population served and the availability and distribution of trained personnel for maternal and child health care in terms of categories and rates per population.

He therefore proposed the addition of a further subparagraph to paragraph 4 of the draft resolution contained in resolution EB73.R6, which he supported, requesting the Director-General to attempt to quantify global indicators 4, 5 and 7.

Dr GUNJI (Japan) welcomed the Executive Board's report, which gave a clear picture of the actual health situation in the world. He was pleased to note the steady progress made in the past two years in the implementation of strategies at the global and regional levels. However, the common framework and format for monitoring progress would require some improvement if more accurate information was to be obtained in the future. Some of the more difficult questions and indicators could perhaps be refined and amended. Indicators that were more sensitive to the progress being made in developed countries should also be included. The improvement of health information systems was, of course, important in order to strengthen monitoring and evaluation processes. He hoped that WHO would intensify technical cooperation with Member States in order to strengthen their capabilities in that respect.

In Japan, the rapidly aging population and the change in the pattern of illness, with an increase in chronic diseases compared to communicable diseases, had meant that health care expenditure had continued to soar while the increase in national income had slowed in response to the slowing of economic growth. Ways would have to be found of achieving an appropriate balance of health care costs with economic growth.

In accordance with the national plan of action for implementing the strategy, communities throughout Japan were making efforts to set up their own programmes for health promotion. More community health centres had been established and steps were being taken to increase the number of public health nurses at those centres. A law concerning health and medical services for the elderly had come into force in February 1983 and a new comprehensive health programme for the elderly had been introduced.

He pledged his country's continuing efforts to implement the national strategy of health for all.

Dr KIM Won Ho (Democratic People's Republic of Korea) also welcomed the Executive Board's report. The Global Strategy launched in 1979 had passed through the stages of
formulation of action plans and initial implementation and was now being pushed forward on a full scale. It would be essential to analyse the successes achieved and the experience gained so far, and to evaluate correctly the strong and weak points, taking measures for improvement. The Organization's proposal concerning the evaluation, in 1985, of the Strategy for health for all was a just and realistic one and he supported the draft resolution proposed by the Executive Board in resolution EB73/R6.

In order to establish an accurate evaluation of progress at the global and regional level it was essential that each country should evaluate carefully its own national strategy. In his own country, President Kim Il Sung had stated that efforts should be undertaken to rationalize economic activities by putting them on a scientific basis. To that end, his Government had paid great attention to the setting up of a rational health information system, based on a careful investigation and analysis of the country's health situation, and with due regard for timely measures for its improvement. In the period under review, the Government had undertaken a series of measures to improve public health services in accordance with needs as assessed by such investigation and analysis. In particular, research groups had been mobilized to investigate the differences in the health services available to urban and rural populations in selected regions. It had been confirmed that the inequalities had been considerably reduced and that the ratio of mortality rates in urban and rural areas had been improved from 1.2 to 1.3 in the period 1960–1980. On the basis of such information, primary health care for the rural population would be strengthened further in order to reduce the remaining differences.

Dr MARKIDES (Cyprus) welcomed the Executive Board's comprehensive report. It had been a wise decision, in resolution WHA35.23, to request the Executive Board to undertake monitoring of the progress made in implementing the plan of action through the monitoring and evaluation of the Strategy for health for all. In preparing their responses, countries had had the opportunity of undertaking national evaluation at a high level. In his own country, that exercise had revealed many shortcomings in the implementation of the political decisions made so enthusiastically at Alma-Ata. The slogan "Health for all by the year 2000 through primary health care" had been received with some scepticism as nothing new, and in the belief that his country's policies were already being implemented along such lines. However, it had now been realized that for small and poor countries such as his own proper implementation was by no means easy.

He went on to outline the deficiencies revealed by the evaluation of national strategy undertaken in his own country, deficiencies that had existed for some time but that had only become apparent through the evaluation. There was a lack of leaders with a real enthusiasm for primary health care and it was clearly necessary to persuade people of their real needs as opposed to superficial needs. There was a need for leaders in all the health professions, and among other professions, who were oriented towards community rather than clinical or hospital medicine. Experts in public health were needed and those who were available should be better used. It would also be necessary to bring together the Government and the private medical sector so that they worked together rather than competed. For example, while the Government was currently supporting an essential drugs policy, the private sector was not. Doctors from all sectors would have to be brought closer together and ways would have to be found of giving prestige and status to those working in primary health care. Further, satisfactory links would have to be established between primary health care and secondary and tertiary health care levels.

Although his country had all the necessary elements for a good health service, efforts were needed to combine those elements into a cohesive whole. One means of so doing would be to establish good referral and health information systems – present systems, where they existed, were inadequate. It would also be necessary to strengthen managerial capacity, and to pass new laws and regulations and improve existing ones.

WHO's advice and financial assistance in holding seminars, awarding fellowships, and so on, would be needed in order to solve those problems. However, WHO would have to find the right way of giving such assistance in accordance with each country's needs. To send out experts whose reports could be impractical or, though practical, simply shelved, was likely to be of little use.

His delegation supported the draft resolution contained in resolution EB73/R6.

Dr AL SARRAG (Sudan) welcomed the Executive Board's report and the Director-General's comments, as also those of Professor Lafontaine, representative of the Executive Board to the Health Assembly. He agreed with many of the Director-General's comments (document A37/5).1 The slogan "Health for all" was very attractive from a political viewpoint and

was one that could be welcomed by all countries. However, when translated into strategies and plans, the slogan was proving to be a challenge for activities in all spheres and not just for those related to health. Thus it had been realized that health for all would only be possible if there was active participation of the community and if there was coordination of the activities of all sectors related to health, for example, provision of clear and potable water, food and nutrition, general and public education and housing. Then there were the relatively easier tasks of the health sector itself in the fields of maternal and child health, preventive and precautionary measures against diseases and accidents, as well as curative measures through health centres, clinics and hospitals.

The concept of health for all had met with a great response in his own country. Three years earlier, the President had called for a clear commitment and adherence to the Strategy and had instructed the Ministry of Health to meet with other sectors and to coordinate activities into a single strategy to achieve the goal.

The process of evaluation, starting with the framework and format on the 12 global indicators, had called for a degree of courage on the part of Member States in order to state clearly and frankly the situation in their health services. That some of the replies would be rather weak, inconsistent or lacking in accurate information was only to be expected. A more comprehensive and accurate response might have been obtained if the evaluation had been undertaken within a workshop held in each country, with the support of the regional office, at which all the important aspects could have been emphasized.

Considerable progress had been achieved in implementing the strategy in Sudan. Primary health care programmes had already been laid down prior to the adoption of the Declaration of Alma-Ata, so that the concept was not entirely new. His Government had realized the need to decentralize administration and there were now eight regional administrations which were further decentralized into local administrative units. At all levels, efforts were being made to achieve the target of health for all.

The realization of health for all would require spiritual support. Since 1983, Sudan had adopted Islamic law in all its activities, with considerable consequences in the field of health. For example, two social scourges — alcohol and prostitution — which undermined the lives of individuals, had been prohibited.

Although considerable efforts were being made towards health for all, the influx of many refugees from countries to the east, south and west of Sudan were proving a considerable burden on the country's limited health resources and it was impossible to ignore such problems. In the evaluation of the effectiveness of the Global Strategy, in two years' time it would be essential to take into account questions of stability, security and peace in all countries in order to contribute to the extension of comprehensive health services in the countries affected and in order to enable them to offer assistance to other neighbouring countries or countries with similar problems within the framework of technical cooperation among developing countries.

His delegation supported the draft resolution contained in resolution EB73.R6.

Dr HEDAYETULLAH (Bangladesh) expressed his appreciation for the leadership and sense of direction given by those concerned in WHO to Member States in their arduous task of attaining the goal of health for all by the year 2000.

Bangladesh was one of the least developed countries with many constraints on the implementation of the health-for-all strategy, including overpopulation, high mortality and morbidity, low literacy rates and frequent natural calamities and epidemics, which were accentuated by poor funding, lack of sound planning and programming, and inadequate monitoring, evaluation and accountability. Despite these innumerable economic, social and environmental impediments, his country was trying hard to implement the strategy, keeping in mind the 12 global indicators.

In respect of the endorsement of health for all at the highest official level (global indicator 1), he noted that his country was a signatory to the Declaration of Alma-Ata of 1978 and that his Government had defined an 18-point programme for minimum health care.

A number of measures had been undertaken in Bangladesh for involving people in the implementation of strategies (global indicator 2). Management committees had been formed for most institutions, in order to improve their operational efficiency and accountability. Village health committees had been set up and voluntary health workers trained. A programme for the training of village leaders, imams, traditional healers, teachers and others at the grass-roots level in primary health care was under way. Project committees had been formed with local representatives, for the development of health and family welfare centres covering populations of about 20 000. A restructurering of administration had been introduced with a view to decentralizing power to people's representatives at the upazilla level, who would identify their own problems and undertake planning, programming, budgeting, implementation, monitoring, evaluation and, if necessary, reprogramming in order to determine their own solutions.

THIRTY-SEVENTH WORLD HEALTH ASSEMBLY
With respect to the percentage of GNP spent on the health sector (global indicator 3), he noted that during the financial year 1980-1981, his country's health expenditure had totalled 565 000 million takas, 49.5% in the public sector, the balance in the private sector, including nongovernmental organizations. That sum represented 2.2% of gross domestic product. The United Nations system had contributed 152 million takas during the years 1980-1981. The health sector's share of the total public outlay in the second five-year plan, 1980-1985, was 3.72%.

As regards the global indicator 4 (percentage of national health expenditure devoted to local health care) Bangladesh had increased that percentage from over 50% in 1980-1981 to 69% in 1982-1983.

Global indicator 5 referred to the equitable distribution of resources. Bangladesh was making serious efforts to provide health care facilities for the 90% of its population living in rural areas and had established 354 upazilla health complexes there, each covering a population of 200 000 to 300 000. Each complex had eight doctors, including one physician, one surgeon and one gynaecologist, and one dental surgeon. Each possessed 31 beds for in-patient treatment and maternity and family planning cases and there were also domiciliary staff for domiciliary health and family planning work. About 2000 health and family welfare centres had been established to provide primary health care facilities at grass-roots level and their budget had been recently increased. The medical manpower now available in rural areas amounted to 3500 doctors, 1000 medical assistants, 800 nurses, 3500 female welfare workers, 400 sanitary inspectors, 13 500 male health assistants, 4000 family planning assistants and 30 000 traditional birth attendants.

In regard to global indicator 6 (well-defined strategies, with explicit resource allocation for health for all and external support from more affluent countries) Bangladesh had formulated a well-defined strategy for achieving the health-for-all goal, accompanied by explicit allocation of resources. The strategy was being implemented in a phased manner. External resources, for which his people were most grateful, played an important role in the country's health development efforts. Recently a Health Resources Group/country resource utilization review had been carried out by WHO in Bangladesh, which had revealed that there was still a large resources gap for the effective implementation of the strategy in Bangladesh.

As regards global indicator 7 (availability of primary health care to the whole population), in Bangladesh coverage was as follows: 60% of the rural population had access to safe drinking-water supplies and there was one tube well for every 150 people in rural areas. Three per cent of the people had access to water seal latrines. Thanks were due to UNICEF and WHO for providing support for those two programmes. There was, however, much room for improvement in that sector. Widespread immunization, for instance, had not yet been carried out in his country. Efforts were being made in that direction with the establishment of immunization centres in medical colleges, hospitals and health centres and a crash programme to immunize all expectant mothers with two doses of tetanus toxoid during the last three months of pregnancy would soon bring down the infant mortality rate. The present coverage for the various vaccines was about 3%, but for BCG it was 20%.

The nutritional status of children (global indicator 8) in Bangladesh was poor but, owing to lack of a proper information system, it was impossible to quantify.

The infant mortality rate (global indicator 9) at 120 per 1000 was high, the major causes of death being tetanus, diarrhoeal diseases, and acute respiratory infections. With effective control of those three diseases, it was hoped to bring down the infant mortality rate to 50 per 1000 with a short period.

In Bangladesh, life expectancy at birth (global indicator 10) was 54.8 years. Separate figures for males and females were not available.

The adult literacy rate (global indicator 11) in Bangladesh was 26%, much below the desired 70%.

Finally, the GNP per head in his country was some US$ 120, a far cry from the aim of US$ 500 expressed in global indicator 12.

In conclusion, his delegation endorsed the draft resolution submitted by the Executive Board.

Mr Edwards took the Chair.

Dr TOGBA (Liberia) said that his Government had accepted the principle of health for all by the year 2000 but he, personally, was very pessimistic about the possibility of achieving that goal. In Liberia and other countries like it, there were many isolated villages and enormous financial problems. The population lived in remote areas and was difficult to reach and, moreover, the illiteracy rate was high. It was therefore difficult to get health measures, such as safe water supplies, to the people and then difficult to get the people to accept them.
For instance, his country had received help in recent years from the United States of America in the form of a demonstration project for primary health care. He had himself been a member of the committee which had evaluated the project. Clinics had been established and provided with health educators, and latrines and wells had been installed. The committee had visited some of the villages concerned and had found the latrines locked up and no roads leading to them. On inquiry, the people in charge of the clinics had said that they were kept locked up so as to keep them clean. Certain village chiefs had stated that they kept their latrines only for guests.

The Netherlands Government had also sent a team to Liberia to teach primary health care methods in a project which had lasted from three to five years. Among other things, they had established stores where drugs could be bought cheaply. When the project initiators had left, those stores had not been maintained because the Liberian administration could not afford the "cheap" drugs for people to buy. The Federal Republic of Germany had also provided primary health care assistance and the United States would soon initiate a further programme. Liberia was sending students to advanced industrialized countries to study, but he still wondered what would happen when those helpers left the villages.

The vaccination of children who were hungry had been mentioned. If hungry children were vaccinated, severe reactions were to be expected. Moreover, there were problems in keeping the vaccines cool in a country which had only kerosene-fuelled ice boxes. The villages often ran out of kerosene, and, in any case, found it costly to buy. Liberia was, however, making efforts to train workers for rural areas and to get the villagers themselves involved in their own health care. But he still wondered how they would continue to put into practice what they had been taught, in view of their poverty. Even if health for all was attained by the year 2000, what would happen after that? The ideal was wonderful, but he found the reality depressing to contemplate.

Dr CABRAL (Mozambique) said that the Strategy of Health for All by the Year 2000 had already led to an awareness of the need for changes in many spheres where hitherto unquestioned ideas had maintained inequalities and discrimination in the access to health care.

The report of the Executive Board confirmed the social value of the Alma-Ata Declaration and provided stimulation with the acknowledgement that there was greater commitment among the world health community to solving the basic health problems of the people and that honest attempts were being made. However, some parts of the report, in particular the section on orientation and training of health workers, still confirmed his delegation's concern that in a number of countries primary health care was being translated into rural or second-class health care for the poor and underprivileged.

Mozambique's national health strategy had been prepared on the basis of the directives of the FRELIMO Party and the Prospective Indicative Plan for 1980-1990. In 1983, a medium-term plan (1983-1985) had been approved. His country considered that, in the present political situation, it was neither possible nor advisable to divert resources for the elaboration of a long-term plan, extending up to the year 2000.

Mozambique was making every effort to improve its capacity for planning, organization and management at all levels, but particularly at the district level, which was considered as the basic planning unit. Such organization and management, however, and especially coordination with other sectors, was a difficult and complex task in view of the inadequate degree of training of auxiliary personnel. In order to overcome those difficulties, a guide for planning, organization and evaluation had been prepared for use at the health centre level, containing a set of simple norms for the organization and programming of the main health centre activities, as well as definitions and rules which allowed for the choice of priorities and the evaluation of results. In order to train district level personnel, workshops had been held for the district directors of health throughout the country and it was planned to hold a further workshop on planning and management for provincial and central staff during the present year.

A primary health care project was being implemented in several villages and should provide information for evaluation of primary level activities which would be useful in implementing the strategy of health for all by the year 2000. Thanks were due to WHO for its help in those activities.

During 1982-1983, his country had undertaken studies on the costs and benefits of several activities at different levels of health care with the aim of making the most effective utilization of available resources. Estimated results obtained so far showed that the trend had been consistently in favour of the primary level.

Efforts were also being made to obtain more exact data on which planning and evaluation and possible reformulation of strategies could be based.
Unfortunately, Mozambique's implementation of the strategy had been greatly hampered by the action of armed bandits which had been disastrous in all aspects of life. Personnel training, however, had begun to produce positive results at the primary level.

His delegation agreed with the views expressed in the Executive Board's report and in the comments by the Director-General on the availability and reliability of the data provided by Member States but it was convinced of the need for periodical evaluation. His own country's evaluation had proved a useful tool for tracing gaps in statistical data and for a reflection about the resources allocated to the peripheral level. Mozambique had, however, found it difficult to provide all the information requested. Health coverage only attained 30% to 60% of the total population, the illiteracy rate was still over 80%, difficulties of transportation were enormous and health workers were few and inadequately trained and working under great shortages of materials, drugs and equipment. In such conditions, it was impossible to provide completely reliable data. It was impossible, for instance, to calculate the mortality rates by age and cause, but the newly established health information system should provide data from hospital mortality and morbidity.

He shared the view that WHO should make a particular effort to provide assistance in the field of data collection. In that connection, his delegation supported the Director-General's view that the new managerial methods for the optimal utilization of WHO resources would provide Member States with a better chance of implementing the Strategy and agreed with the content of the managerial framework for optimal use of WHO's resources in direct support of Member States. They regretted that not all the agencies and organizations in the United Nations system appeared to have the same understanding of the problems facing developing countries. Mozambique's experience was that the effectiveness of the support from international organizations was greater if programmes were incorporated more effectively into national plans. External resources should be invested in strengthening the planning and management capacity of the countries themselves and not in imposing isolated projects on them.

In conclusion, his delegation supported the draft resolution submitted by the Executive Board.

Mr SONG Lienzhong (China) expressed his appreciation of the Director-General's comments (document A37/5) on how the strategy for health for all was being applied with encouraging results.

He said that after China's health strategy and policy had been determined it had been important to ensure that the necessary assistance was provided by central or local government financial and planning institutions. China had adopted a decentralized system of financing so that local support provided an important guarantee for implementation.

Since 1980 China had been strengthening the rural, district and communal bases for public health care, and by the end of 1982 some 16.6% of the total budget was being spent at district level. In order to improve the health infrastructure, attempts had been made to increase cooperation with national and international bodies. Training of health manpower was carried out at various levels: at district level there was a district hospital, a vaccination centre and sometimes a health worker training centre and an institute for traditional Chinese medicine, while at the regional level there were clinics. The current rural level of expertise was very low since most medical staffing had had only primary education. Progress was being made in improving the level by recruiting more students of middle and higher educational standard to work in the countryside, as well as by reinforcing the continuing education of existing health personnel.

Difficulties were still being encountered in China in the monitoring and evaluation of the strategy for health for all. That was due partly to the planning and financing system applied and partly to the lack of health management capacity. The intention was to expand the health information capacity by setting up a statistical study for planning purposes.

Professor LUNENFELD (Israel) said he was glad to know that about 75% of Member States had submitted reports on the implementation of their strategies for health for all and he hoped that the documents before the Health Assembly and its deliberations would motivate others to do likewise. Constant monitoring of health strategies was essential, and discussion of the problems involved would make it possible to modify health indicators and adopt sub-groups and reference values specific to national situations and needs. It should also enable many countries to adopt their own upgraded regional reference values for standard indicators. Intercountry cooperation in the sharing of information and transfer of technology through the coordinating role of WHO would be an important factor in the success of the programme.

Systems for the assessment, planning and monitoring of strategy were only useful if they were based on reliable health information, and greater intercountry and WHO collaboration could help to ensure the quantity and quality of health-related data.
He was proud to inform the Health Assembly that Israel’s health system had achieved nearly universal coverage of health insurance (95%) and that health services were provided to all citizens irrespective of sex, religion or ethnic group through organized public agencies. Preventive and curative health services were heavily utilized. Curative services included primary health care centres, including maternal and child health, basic and specialized services at the community level, specialized referral services, hospital services, long-term care and rehabilitation services. The easy availability of such services had in some cases produced over-use (there were 12 visits per capita per annum). Thought must be given to devising a method of preventing over-use, distinguishing it from high effective use and ensuring that the underserved population groups were not deprived.

In Israel, nearly 90% of children had had full immunization by the age of one year, including mumps vaccination since the beginning of 1984. The immunization programme had been strikingly successful throughout the country. Eradication of measles should be achieved by 1989, of rubella in the female population by 1990 and of hepatitis by the year 2000.

Public drinking-water systems provided safe water for domestic use to almost the entire population. Israel’s target for the International Drinking Water Supply and Sanitation Decade included: fluoridation of all public water systems by 1988, continuous monitoring of bacterial and chemical water quality, revision of water standards in accordance with WHO standards, and development of re-use of used water.

Special attention was being given to improved housing, recreation, education, and social and health programmes for poor urban areas, through “project renewal”, which featured a large element of community participation and had been effective in improving life-styles and changing community attitudes. It was an example of projects and expenditures having an indirect positive effect on health but not included directly in the national health budget.

Considerable progress had been made in reorienting health programmes towards emphasis on disease prevention and health promotion, as was shown by the increased commitment of government and public organizations at all levels, by changes in laws regarding health issues, by budgetary trends and programme development. Allocation of resources and health services administration had been modified in response to changes in epidemiology as well as to technological and research advances.

Several preventive initiatives had led to an improvement in prenatal care, with a significant decrease in the number of high-risk pregnancies; a decrease in accidents and injuries; and the full coverage of children with immunization against preventable childhood illnesses. The national infant mortality rate had dropped from 17.8 per 1000 live births in 1979 to 12.8 per 1000 in 1982, and the aim was to achieve an average of 9 per 1000 by the end of the decade, with no region or population group having an infant mortality rate higher than 12 per 1000.

Mortality from strokes had decreased by 21% and that from coronary heart disease by 28% in the past six years, and it was expected that increased attention to diagnosis and management of hypertension, together with expanded health education, would further decrease mortality from the two commonest causes in Israel. A nationwide network of mobile coronary units would be fully operational by 1987, and basic cardio-pulmonary reanimation courses for the public had been initiated.

High priority was being given to meeting the needs of a rapidly aging population in ways, such as home care and assistance, that the State could afford. Careful planning was required to avoid creating an over-supply of other kinds of health facilities.

Programmes to reduce environmentally induced cancer by 50% by the year 2000 were in progress, including a recent one to ban smoking and one to remove carcinogenic substances in food, cosmetics and the environment. Israel was collaborating with many countries in active research programmes for the identification of carcinogens.

In spite of an ample overall supply of physicians, real shortages in specific health fields were hampering the development of services. Intermediate health planning indicated the need to upgrade expertise in specific health-related fields, including highly qualified managers and administrators, nutritionists, etc. The WHO fellowships programme and bilateral agreements continued to have a real impact on Israel’s health manpower development, which was an integral part of its national strategy for health for all.

In conclusion his delegation endorsed the Executive Board’s resolution EB73.R3.

Dr KOOP (United States of America) said that the issues outlined in Executive Board’s report and the Director-General’s comments (documents A37/4 and A37/5) were critical for the achievement of the global and national goals of health for all by the year 2000.

Considerable progress had been made in focusing international and national attention on the policies, strategies and resources necessary to achieve the goal established in 1979.

The United States had supported that goal since its inception and considered it as significant for industrialized as for developing nations. In 1980 the United States had
established a plan of action and health-for-all strategies and in 1983 had submitted its report to WHO on monitoring progress in implementing those strategies, which were based on certain disease prevention and health promotion objectives with specific goals to be achieved by the year 1990.

Progress had been significant. One of the objectives, for example, had been to immunize 95% of school-age children against the seven vaccine-preventable diseases of childhood by the year 1990. Over 95% coverage had already been achieved, and the incidence of the seven diseases had dropped 71% in three years. Indeed, a number of those diseases were on the verge of being eliminated entirely in the United States.

The Director-General in his comments (document A37/5) had outlined some early achievements of Member States and had been candid in acknowledging the problems. He believed it was time for all delegations to speak as frankly as Dr. Mahler and the members of the Executive Board. He agreed with the Director-General that the monitoring process had been started barely in time. It was clear from the documents before the Health Assembly that to a large degree the Secretariat had met its responsibilities. However, it was the Member States which had collectively decided on the Global Strategy and it was the Member States which must shoulder the most important responsibilities for achieving that goal. That would not be done without careful monitoring and evaluation of progress, which would be meaningless if it was not taken seriously at the national level.

The common framework and format for monitoring progress had been a useful tool in facilitating reporting but he agreed, as indicated in paragraph 146 of the Executive Board's report, that in view of the difficulties experienced by some countries it was necessary to improve and refine the monitoring tools. He also fully agreed that an analysis of the problems should be carried out with a view to improving approaches to monitoring strategies and reporting evaluations. The Secretariat should take those concerns fully into account in developing the document for reporting on evaluation.

His delegation was also seriously concerned by the reporting deficiencies that still remained in the monitoring report. Specific technical needs existed in national capacities to manage implementation of the policies and to monitor progress. His delegation commended the Executive Board for its recognition of those needs and urged that Member States fully support WHO's efforts to intensify its technical cooperation with them in strengthening national capabilities for carrying out a suitable managerial process for health development, including information support. Regional offices and Member States must cooperate; the United States would share its information and expertise in contributing to the improvement of national managerial processes for health improvement. In addition it would continue to provide support, through its development assistance programme, for primary health care initiatives and improving monitoring and management.

He also urged the Secretariat to continue to enhance management of WHO's capabilities through strong coordination at all levels and through upgrading of technical abilities in areas relevant to health for all; staff should be encouraged to give more specific support to Member States in pursuit of health for all; new staff should have technical expertise in areas related to primary health care and health management.

Member States clearly recognized the significant benefits that health for all embodied and stood ready to reaffirm their commitment to its achievement. By adopting the Director-General's suggestions and the resolution before the Committee he was confident that they would move ever closer to fulfilling their goal.

Dr. WESTERHOLM (Sweden), speaking on behalf of the Nordic countries, said that health development, like economic development should be analysed continuously since it was one of the most important components of a country's wellbeing. The 12 global indicators established at the Thirty-fourth World Health Assembly provided a nucleus of methodology but WHO should further develop simple methods. It was essential to determine the changes in the health status of the population, the "risk panorama" and the organization and activities of the health care system by evolving progress indicators according to national disease profiles, risk profiles and care profiles.

The disease profile was the obvious foundation on which to follow up health development. The global indicators of average longevity and infant mortality constituted a minimum level. Special efforts should be made to elucidate the distribution of disease between various socioeconomic groups and between population groups in different geographical regions. The essence of the health-for-all strategy was to reduce differences within and between countries in order gradually to realize health equality targets, and WHO should support Member countries in the development of disease statistics facilitating the identification of high and low risk groups in the health sector.

The health policy targets for the European Region gave the Nordic countries a point of departure for analysing changes in the health of various groups of the population. Strategic
importance should be given to a direct follow-up of circumstances favouring or threatening the health of various groups of the population, i.e., monitoring of the risk profile.

The global indicator relating to economic development was one example of that type of progress indicator since most disease was connected with poverty. Other basic factors in the risk profile were the proportion of the population having access to pure water and decent sanitary conditions. In addition to the global WHO indicators, every country should try to elucidate developments in various sectors as they affected health, the most important being agriculture and food production, housing, employment and transport. Health policy in those sectors had a critical bearing on public health, and it was important to elucidate also the differences between men and women and between various socioeconomic groups in avoiding health hazards and opting for a healthier life. National adult literacy rates for men and women should therefore be separate for WHO's purposes, being of direct relevance in view of the effects of education for women on family health.

The follow-up - like the planning - of a country's health development must therefore be intersectoral, and WHO's work to encourage intersectoral action for health should be given even greater priority.

That holistic view of health policy had become increasingly dominant in the Nordic countries; health policy aspects of living and working environments and unemployment, and agricultural policy and food policy had been highlighted in several projects. Parallel to follow-up of health hazards in relation to social development and living conditions it was essential to follow up hazards more directly related to the life-style of the individual, as in the use and abuse of tobacco, alcohol and narcotic drugs.

The health care system constituted a third subject of health development analysis, and the goals of the national primary health care strategy provided an obvious point of departure for it. Special attention should be paid to changes in financial and personnel resources for health and medical care for rich and poor, town and country, large hospitals and local health centres, and prevention and cure. In most countries care was least available to those who most needed it. Indicators of coverage and accessibility must therefore play a prominent part in the follow-up of primary health care strategies.

Primary care strategy and increasing emphasis on preventive measures constituted the corner-stone of health planning in the Nordic countries. However, changes usually took place less rapidly than planned, necessitating follow-up and analysis of factors impeding development. Health development presupposed stimulation of the various decision-making bodies, informal groups, voluntary organizations and individuals to participate more actively in local health promotion. Thus, the follow-up of the strategy for health for all should elucidate as far as possible the extent of present and future participation by the population in the realization of that strategy, both through the political process and through direct local action.

The Nordic countries supported the draft resolution recommended by the Executive Board in its resolution EB73.6.

Dr CHIORI (Nigeria) commended the report and the Director-General's comments. The initiation of the monitoring process should provide the opportunity to learn from deficiencies, and he would therefore support continuous monitoring of progress with the Global Strategy until the goal was achieved.

His country recognized the importance of evolving a national health policy based on equity, and any review of existing policy should take into account the needs of the underserved majority of the population and seek to ensure a shift of resources in their favour.

It was now two years since Nigeria had instituted a mechanism for intersectoral action in favour of health. The requisite perseverance to introduce new measures aimed at improving the existing system was assured, as Nigeria was totally committed to the development of realistic policies at federal and local levels in the discharge of its responsibilities for health care delivery. The consequent reorientation of the health system would need to be based on adequate information at all levels. Accordingly, workshops and seminars had been held with a view to improving the national information system. Another vital component was the development of health manpower, and reorientation of personnel had been initiated with increasing emphasis on the training of new cadres and community-oriented health workers.

His delegation supported the draft resolution recommended by the Executive Board.

Dr BRAMER (German Democratic Republic) commended the comprehensive report by the Executive Board and the Director-General's valuable comments.
His country's experience with its health system over the past 35 years supported the emphasis in the Global Strategy on the fundamental role of primary health care in achieving health for all by the year 2000, and indicated that primary health care should be developed as part of concerted health measures, ensuring a network for quantitative as well as qualitative extension of care. Basic health care should even extend to specialized disciplines; for example, the follow-up of hepatitis patients could be entrusted to primary health care physicians. In the German Democratic Republic, prophylactic care, treatment and rehabilitation were all integral parts of a complex free health care system for all citizens.

Experience had also pointed to the need for caution in decentralization, mentioned in paragraph 45 of the report by the Executive Board; a certain degree of centralization with regard to the responsibility for resources, and to activities to motivate and mobilize the community, was desirable.

His delegation would continue to support WHO in the achievement of its Global Strategy in the spirit of United Nations General Assembly resolution 38/188 concerning initiatives for peace, disarmament, détente and social justice, as it was gravely concerned about the growing danger of nuclear war.

The delegation would support the draft resolution recommended in resolution EB73.R6.

Dr BANKOWSKI (Council for International Organizations of Medical Sciences (CIOMS)), speaking at the invitation of the Chairman, outlined the activities of CIOMS bearing on the moral issues involved in the Global Strategy of Health for all. He recalled that for some years CIOMS had focused on the ethical implications of advances in the biomedical sciences. Although health for all necessarily presupposed the development of tactics and methods adapted to different contexts, the ideal itself was rooted in non-material and moral considerations, such as the universality of human rights, social justice, and the brotherhood of man irrespective of race or creed, and it was those very considerations which provided the main motivation of the Strategy, involving as it did concerted efforts by health workers in vastly different cultural, philosophical and economic circumstances.

Most health decisions had inherent ethical components and, since different national, cultural and religious traditions yielded different ethical value systems, their interactions with health policy-making would consequently vary from country to country. CIOMS would be convening an international conference on health policy, ethics and human values in Athens in October of the current year, which would provide a forum for discussions between health policy-makers and health ethicists, philosophers and sociologists from different cultural and ideological groupings on selected health policy issues and their ethical implications, such as allocation of resources for primary health care, public policy and hereditary disease, care of low-birth-weight infants, health care of the elderly, and organ substitution therapy.

The main objectives of the conference would be: to identify and compare the ethical content of selected health policy issues for different national and cultural settings; to examine the interaction of ethical factors and other determinants of health policy in those different settings; to explore activities and arrangements which could assist interested countries in enhancing their capacities for dealing with the interaction of ethics and health policy-making; and to consider the usefulness of that kind of dialogue, which drew upon the roots of human values in each culture, in promoting better international understanding across cultural, economic and political lines. It was hoped that an international dialogue of that type could contribute to the achievement of the goal of health for all.

Dr NJIE (Gambia) said that the wide range of comments on the common framework and format pointed clearly to the need for reviewing the task WHO had undertaken. In the present state of national information systems, the rate of response was an achievement. But on the basis of the indicators provided, it was difficult to assess exactly the progress actually achieved, in community involvement, for example. His Government had had some difficulty with parts of the common framework and format. It was hard, for instance, to ascertain expenditure as compared with allocations. He was aware that workshops were being arranged to assist in the monitoring process, and he was convinced that simplified indicators could be established to assist in making realistic assessments rather than to reflect declarations of intent.

What WHO had already achieved towards the implementation of its Global Strategy since its initiation was, however, cause for congratulation. Most of the goals of the five-year health plan in his own country had already been achieved at the end of three years.

Experience had shown the need to maintain maximum flexibility.

Improvements in the health system enjoyed high-level backing in the Gambia, but intersectoral cooperation had been disappointing. A review had been made of existing systems, including even such points as whether intersectoral bodies should be called "health coordinating committees"; other countries' experience with those problems would be welcome.
The time was perhaps ripe to call a meeting of Heads of State to review some of the philosophy of the primary health care concept itself, as in developing countries their influence could be decisive in maintaining progress.

While all would agree that health action should go beyond merely curative aspects, the real need, particularly in rural areas, for essential drugs could not be overlooked. Consequently, more attention should be paid to the supply of developing countries since their situation was grave, particularly in view of financial constraints. The efforts being made through the Action Programme on Essential Drugs and Vaccines must be coordinated with primary health care action; otherwise, confidence in that whole system might be undermined.

The results of using the media to publicize action under the expanded programme of immunization in the Gambia had been gratifying. The basic issue in suitting projects to real needs was one of ensuring that the requisite funds, both from national and international sources, were available. The review of country resource utilization provided a useful exercise for possible remodelling of the resource pattern. He appealed to donor agencies to be flexible when certain sudden trends, such as an increase in the price of fuel, for example, affected the development situation. He urged countries to follow the Gambia's example in seeking to ensure that all projects proposed really did conform to the actual needs of the situation.

The meeting rose at 12h40.
THIRD MEETING
Thursday, 10 May 1984, at 9h00

Chairman: Dr K. AL-AJLOUNI (Jordan)
later: Professor F. RENGERT (German Democratic Republic)

GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000: REPORT ON MONITORING OF PROGRESS IN IMPLEMENTING STRATEGIES FOR HEALTH FOR ALL: Item 19 of the Agenda (Resolutions WHA34.36, WHA35.23, WHA36.34, EB73.R3 and EB73.R6; Documents EB73/1984/REC/1, Annex 1, A37/4, A37/5 and A37/INF.DOC./6) (continued)

Mrs BOROTHO (Lesotho) commended the Executive Board on its report and the Director-General on his comments (documents A37/4 and A37/5),1 facilitating the work of the Health Assembly. The assistance provided to Member States by headquarters and the regional offices in their review of progress in implementation of the Global Strategy had been greatly appreciated. Through that exercise, countries had been able to identify areas of weakness that needed urgent attention. She wished to highlight a few such areas that had been found in her own country — indicating that the way ahead was still fraught with difficulties.

Data collection and processing needed considerable strengthening to ensure the reliability of data. National budgets and expenditures were not disaggregated in a manner that permitted the isolation of primary health care expenditure. It was therefore difficult to assess primary health care expenditure accurately when reporting on progress.

The evaluation exercise had also revealed that many of the impediments to progress were related to the availability and utilization of resources. For example, manpower — its development, retention, reorientation to primary health care and deployment — was an area that needed considerable attention at all levels of the health care delivery system.

Logistic support for primary health care also required much attention. The general support and supervision of primary health care programmes were seriously affected by the lack of transport and communications, especially in the case of remote facilities. Programmes were being set up to improve that aspect, and remote health centres were being linked to parent hospitals by two-way radios. Like the problem of data processing, logistic difficulties were closely linked with the process of monitoring and evaluation of primary health care.

Another area of concern was that of managerial capabilities. It had been accepted that attainment of the global goal of health for all by the year 2000 was not dependent on the activities of the health sector alone. There was a high level of commitment to the strategy in most countries, and concerted multisectoral efforts were being made towards achieving the goal. For example, the Ministry of Rural Development was cooperating with the Ministry of Health in implementing water and sanitation projects and the Ministry of Agriculture had sent nutrition extension workers to educate village populations. The coordination of all such efforts was most important. However, weak managerial capabilities continued to impede progress.

Countries had been grateful for WHO's assistance in completing the common framework and format for monitoring progress. In her country, without the help of a WHO staff member some of the questions would not have been answered satisfactorily, if at all. Her delegation felt that the questionnaire could be simplified and shortened. Since it was clear that uniformity of reporting was very difficult to achieve, it might be preferable to request only information on what had been achieved in the key elements of primary health care, in order to show the trend in the various countries.

Professor NAJERA (Spain) said that, although the item under consideration was a broad topic, he wished to highlight just four points of concern. As regards health policies and political commitment, he agreed with the Director-General that it was easier to accept the philosophy of the programme than to undertake its implementation. The right to health — or, rather, the right to the protection of health — should be included as such in countries' Constitutions and basic laws. As indicated in paragraph 1(8) of the draft resolution

1 Document WHA37/1984/REC/1, Annex 3, parts 1 and 2.
contained in resolution EB73.R6, laws and regulations should be enacted in order to facilitate the basic structural changes needed to ensure that health for all was more than just a slogan.

Progress in plans of action and health systems development had not been as great as it should have been over the past five years because of the lack of basic structural changes. Real changes in health systems required specific laws, going beyond considerations of health alone, which, if necessary, would change the course of social and economic development so that it was in consonance with the underlying philosophy of health for all. Further, the indicators used should be sufficiently sensitive to determine whether changes were actually taking place.

Because structural changes had not yet been made, community participation was as yet theoretical and passive. Participation should be spontaneous and should be a logical consequence of the proper functioning of the system and an active commitment to the philosophy and practice of the strategy.

He emphasized the special role of health sciences research, not merely medical and biological research, in the achievement of the strategy's goals. As planning had to be based on epidemiology, epidemiological research - on the health problems of the population and the effectiveness of the health services - was particularly important; it should provide the main guidelines for monitoring progress.

His country was making considerable efforts, and was overcoming many of the difficulties encountered; the recognition and analysis of such problems would bring success closer.

His delegation supported the draft resolution contained in resolution EB73.R6.

Dr BATCHVAROVA (Bulgaria) commended the Executive Board on its report. Although the results of the first evaluation of the implementation of the Global Strategy were not entirely positive, they were of great significance for Member States, since they provided a situation analysis at the national, regional and global levels. That analysis not only provided a basis for comparison in subsequent evaluations, but also indicated current shortcomings so that measures could be taken promptly to correct them at the appropriate levels. Her delegation shared the Director-General's concern at the disappointing results. At the same time, it should be remembered that a timetable had been established by the Health Assembly, and perhaps it was necessary to show more patience, allowing Member States to prepare carefully their national strategies and plans for implementation. The Director-General's comments on existing inadequacies would be of great use to Member States and provided guidance for national health administrators. The questions he had raised should be studied carefully at all levels involved in the implementation of the strategy. She also agreed with the Director-General that the specific ways in which Member States would move towards the attainment of the goal of health for all would vary, depending on the conditions prevailing in each country. On the basis of its own experience, however, the Bulgarian delegation was convinced that the elimination of social inequality in the health field would necessitate social and economic reforms. The Director-General's question as to whether countries could learn from one another raised certain questions of principle. The experience of others could, of course, be useful to avoid duplication of work - whether on a basis of bilateral cooperation, or through WHO. The importance of self-help and self-reliance could not be overemphasized. A number of countries, including Bulgaria, had considerable experience in that respect, and would be happy to cooperate with interested States in any aspect of health, including planning, management, the organization of health services, training, and health information systems.

The progress achieved in the implementation of the Global Strategy in Bulgaria had already been outlined by the head of her delegation in his address in plenary session.

Dr WARD-BREW (Ghana) said that his delegation had noted that the information provided by Member States had not been complete and that the support of the regional offices would be needed to improve health information systems where necessary.

In his own country the formerly relatively well-developed infrastructure of social services in urban areas had deteriorated in recent years, owing to the economic situation and the rapid growth of the urban population. The situation was even less satisfactory in rural areas. Only one-fifth of the country's health establishments were located outside towns, only 1 in 7 of the rural population had access to safe water, and only 1 in 50 had access to electricity supplies. The infant mortality rate was 1 in 10 births and mortality rates among children aged 1 to 4 years were high. Life expectancy at birth was 50 years for women and 47 years for men. The many reasons for the unsatisfactory health situation included social and economic problems, unhealthy life-styles, lack of health-promoting facilities such as safe water, food, housing and refuse disposal, and the poor coverage and standard of the health services. The relationship between underdevelopment, poverty and disease was too well known
to merit further discussion. Ghana had 106 hospitals, 119 health posts and 67 dressing stations, most of which were run by the Ministry of Health. Those statistics, for a West African country with a population of 13 million and two medical schools, were probably fair indicators of the status of progress in implementing strategies for health for all. The health services in Ghana were operating under great difficulties brought about by the severe shortage of personnel and financial constraints, leading in turn to lack of maintenance of equipment and a grossly inadequate supply of drugs and other essential items. By any of the known measures of health status, such as the crude death rate, infant mortality, life expectancy at birth, educational attainment, the per capita gross national product, water supply, levels of nutrition, etc. - all of which were elaborated in the 12 global indicators - Ghana was ranked among the bottom third of countries. It was now being recognized that investment in the health services could be considered as part of the investment in the country's social and economic development.

The strategy for health for all had been fashioned around concepts relating to social justice, political involvement, decentralization and intersectoral coordination. Further, the concept of community involvement was a key element of primary health care. The health system of Ghana was therefore being reorganized with decentralization of planning, implementation and evaluation of health-related activities to the district level. The present economic situation made it difficult to predict future progress toward health for all. However, with greater efforts towards making communities self-reliant in basic health care, it would be possible for the majority of his compatriots to lead socially and economically productive lives, as embodied in the objectives of health for all by the year 2000.

His delegation supported the draft resolution contained in resolution EB73.R6.

Professor BERTAN (Turkey) welcomed the Executive Board's report and the Director-General's comments on the item under consideration.

In 1979 the Turkish Government had launched a national primary health care programme to meet basic health needs and to promote relevant rural and urban health activities. National health policies were being reviewed, keeping in mind the goal of health for all. Specific targets had been set for nationwide health education to promote community participation, multisectoral collaboration, equitable distribution of health services, slowing of population growth, and reduction of infant mortality and morbidity. In the past two-and-a-half years several laws had been passed to promote primary health care at various levels. Rural health centres established in the 1960s had been revitalized and graduates of medical schools now had to serve in those centres for at least two years. Most rural health centres were adequately staffed, with at least one physician. Laws had also been passed on family planning and child nutrition: all advertisements of baby food products had been prohibited, and measures were being taken to ensure food safety; allied health personnel, such as midwives, were being trained in the use of birth control devices, and abortions under medical care had been legalized. There had been a reorganization of the Ministry of Health and Social Assistance to provide administrative integration of services within the conceptual framework of primary health care. Close and active links had been established between universities in order to mobilize adequate manpower and to strengthen multisectoral cooperation in the implementation of health strategies, with the main emphasis on primary health care. WHO's efforts to promote collaboration between the health sector and universities were to be highly commended.

The Executive Board's report indicated that only three-quarters of Member States had submitted progress reports on the implementation of national strategies. The failure to submit reports was probably not due to a lack of interest, but rather to technical problems and to shortcomings in answering the questions. Further, the answers that had been received did not necessarily give reliable information. How many countries were able to give precise values for infant mortality rates, crude birth rates, life expectancy, nutritional status etc.? The collection and analysis of health information was of course often difficult for developing countries; but such information had to be reliable in order to evaluate changes. The establishment of several well-controlled regional health centres in well-defined areas might facilitate and enhance the collection of accurate health information; such a system could be expanded nationwide as conditions allowed.

Her delegation supported the draft resolution contained in resolution EB73.R6.

Dr BJSHT (India) said that the Indian National Parliament had approved a national health policy which had clearly identified goals and targets in line with the main goal of health for all by the year 2000. The health for all strategy was an integral part of the national social and economic development plan, and India's seventh five-year development plan would be launched in 1985.
The Ministry of Health and Family Welfare had identified indicators for infrastructure, for services, for health-related aspects (such as water supply, sanitation, nutrition, the environment, and education), and for the impact of those factors. Initial work had been completed and resources were now being allocated to those areas requiring urgent attention. Rural and urban areas had been considered separately so that adjustment of allocations could be undertaken during implementation, where necessary.

India was a country with a vast population of 700 million - and a wide variation of geography and topography, ranging from deserts to the highest mountains. It was therefore extremely difficult to ensure that all the people received adequate health care coverage. However, a start had been made with the training, so far, of 300 000 workers at the primary health care level and 200 000 at the intermediate level - in itself an immense task. An experiment was being undertaken to involve medical institutions in the delivery of health services. Each institution was being made responsible for three health districts, covering a population of 100 000 to 150 000. Medical and allied health personnel from the institutions were thus being encouraged to work as a team, providing total health care.

Health services research, including field research, had been incorporated as an integral part of the health services. India had provided technical cooperation to neighbouring countries, since it possessed many teaching and training institutions for medical and allied health personnel.

His country had experienced many difficulties in its first evaluation of the implementation of the strategy for health for all. The greatest difficulty had been the human factor. It had proved difficult to involve the community and to make individuals realize that they must be responsible towards themselves, their families and the community. People involved in the delivery and management of the health services at the lower levels had been given responsibilities which were beyond their competence; at the intermediate level, in the field, they had often been more conscious of their rights than their responsibilities and had been reluctant to do what was asked of them; and at the highest level, medical and health administrators had been in need of considerable logistic support - which it was hoped could be provided under the next five-year plan. There was a need to learn to work as a team. Financial constraints would always be present, but they should not form a barrier to progress. Individual responsibility must be stressed since, in the last resort, it was the basic element which would enable the objective of health for all to be attained.

To improve progress towards achieving that goal, he suggested that support be given to the improvement of health information systems. Special sections should be established within the health services, especially in developing countries with large populations, to monitor the various indicators. Time was very short, and it would probably be necessary to speed up the development of the health services, for the quality of the information obtained depended on the standard of the services. Education of the people was needed, so that they did not confuse needs with wants, and would not clamour for high-cost but negatively cost-effective measures; in a democracy, people often demanded measures which negated planning, and succeeded in getting resources allocated to areas which did not need them.

He supported the draft resolution contained in resolution EB73.R6, while stressing that, in order to implement it, countries with vast populations and low per capita incomes would need more technical and educational support.

Dr SHERIF ABBAS (Somalia) stressed his Government's long-standing commitment to the goal of health for all by the year 2000, which aimed, in particular, at addressing long-standing injustice in the provision of health services and the socially unacceptable situation whereby a minority, but articulate, urban community accounted for a disproportionate share of health services, to the disadvantage of the nomadic, rural and urban shanty communities in the developing world. Somalia's efforts would be directed in the coming two decades to improving and extending health services for the latter communities. His country found it easy to accept the tenets of health for all since that philosophy was in line with its political and social aspirations as expressed in its Constitution.

Consequently, a national strategy had been developed in cooperation with WHO, aiming both at strengthening the existing health infrastructure and at initiating a new emphasis on primary health care. In pursuit of the latter aim, action had been taken to develop health manpower by appointing primary health care coordinators at the district, regional and central levels and providing training in managerial skills, and a referral system. In addition, efforts were being intensified to control communicable diseases, to promote maternal and child health and to improve nutritional status.

The experience of the last few years had taught his country that, although it had reason to pride itself on a certain measure of success in the implementation of primary health care, it was evident that the overall deficiency in the machinery of health management had contributed to shortcomings. Other factors, such as the resource constraints prevalent
Throughout the world, health management has been affected by the deficiencies. The most acute current problems in health management were due to lack of an essential information base. In addition, if mechanisms to attract foreign investment, both financial and technical, could be devised, further improvements might be made through international and bilateral relations.

Experience has also taught his country that high political commitment, an endeavour to ensure an equitable distribution of health resources, and the consideration of health as an integral part of development together with the coordinated efforts of the social and economic sectors, were prerequisites for successful achievement of the goal of health for all. Thus the formulation of a national health policy should be accompanied by reforms in the existing infrastructure and measures to ensure the participation of the community.

Furthermore, planning should be not only participatory but innovative, and concerned with establishing priorities and with defining what combination of resources and technologies should be incorporated at each level, starting with individuals, the family and community care and continuing with intermediate and central support and the referral level. One of the most important elements of success was the active involvement of communities in the process of development and the identification of their own needs, and the promotion of a positive attitude to one's own health. To that end, and with the aim of reaching hitherto neglected groups of the population, education of the public was essential, and a change was needed in the concept of health manpower training. Existing health workers in his country would be reoriented and re-trained and new categories of health workers provided to work with them.

In view of the enormous task involved in implementing primary health care, a satisfactory budgetary distribution was important. Cooperation was needed between developed and developing countries and between the more and less prosperous sectors within countries. In that connection, he stressed the importance of the development by WHO of the country health resource utilization reviews - a valuable tool.

A considerable change had already undoubtedly taken place in the concept of the health delivery system, but progress towards health for all could only be slow so long as "kingdoms" continued to be proclaimed in the vertical programmes of the health infrastructure. The introduction of the common framework and format for monitoring based on the 12 indicators - which his delegation believed required further simplification - should stimulate thought and action and lead to further progress.

Finally, his delegation supported the views expressed in the Executive Board's report and agreed with the Director-General's comments.

Dr REGMI (Nepal) said that Nepal had been one of the first countries to respond to the call of the goal of health for all by the year 2000, and the Government was committed to providing basic minimum health care to every sector of the population. It was endeavouring to mobilize internal resources and exploring the possibilities of receiving help and cooperation from friendly countries. In pursuit of the aim of decentralization, health committees were being established in each district. Health posts were being set up in all 75 districts of the country and basic health programmes had been started in some districts. A countrywide system of hospitals had been established. Efforts to control communicable diseases had been enhanced by the introduction of an expanded programme of immunization.

Time was short for achieving the goal of health for all by the year 2000, and new efforts were needed. The passing of resolutions and political commitment might have some effect, but the actual implementation of activities lay in the hands of administrators who had hitherto been unfamiliar with the idea of health for all. Community involvement was, of course, essential, but it was not an easy task to discover how to achieve it. All sectors should be encouraged to cooperate in pursuit of the goal.

The developed countries could help by mobilizing resources: most developing countries were particularly lacking in health service management and information systems. WHO could also help in that connection.

In conclusion, all the countries of the world should be viewed as one human body: if one part of the body was not functioning properly, it could not be considered healthy. The developed countries should help the malfunctioning parts of the world's body by providing technical assistance and, above all, finance.

He supported the draft resolution contained in resolution EB73.R6.

Dr PRIETO (Argentina) recalled that his country had a long tradition of membership of and cooperation with WHO and PAHO, but the unfortunate interruptions in its constitutional development and, in particular, the recent authoritarian regime, had led to constant changes in its health policies. Now, however, under a democratic government presided over by Dr Raúl Alfonsín, his country had returned to the World Health Assembly to reiterate its support for the goal of health for all by the year 2000 and the strategies of primary health care expressed in resolution EB73.R6, which it wholeheartedly supported.
Those comments on Argentina's recent history were made in order to facilitate understanding of the efforts now being made to reverse the effects of a disastrous economic situation which had hit hardest the most vulnerable groups of the population. In a large country with only 30 million inhabitants the task was a formidable one. Although the Government could count on the support of the legislators, health policy-makers faced many obstacles at the administrative levels, where the personnel was frequently indifferent and often opposed to change. Efforts were, however, being made to change the structures to face up to the challenge of the shift of emphasis from curing disease to fostering health.

To that end, the following policies had been adopted: priority was being accorded to primary health-care through decentralization of services and community involvement in cooperation with the social security sector; an attempt was being made to achieve a fairer distribution of national income and health services which should lead to a reduction of malnutrition and infectious and occupational diseases; a more equitable distribution of drugs, food and equipment was being ensured through appropriate legislation; and the State was assuming responsibility for hospitals, abandoning the outmoded idea of their being charitable institutions and transforming them into health centres available to all. For Argentina's new Government was convinced that a true democracy was an essential condition for the realization of the goal of health for all by the year 2000.

In conclusion, he reaffirmed his country's sympathy with all those Latin American countries which, like Argentina, were suffering the effects of the economic recession and were trying to develop despite the high social costs. With renewed courage, all were working to achieve a better life for their peoples.

Dr MANTRA (Indonesia) said that the basic concept of the strategy for health for all by the year 2000 was reflected in Indonesia's State policy and national development strategies as well as in its national health system. The latter comprised three major elements, namely, the underlying philosophy of the basic policies, the strategies for long-term development to achieve health for all by the year 2000, and the basic structure on which the various efforts in other related sectors were organized and coordinated. The long-term objectives were five: to enable the people to take responsibility for their own health and live a healthy and productive life; to promote an appropriate environment in support of the people's health; to improve nutritional status; to decrease morbidity and mortality rates; and to promote a healthy and prosperous family life through the acceptance of the small and happy family norm.

To achieve those objectives, five programmes were being carried out: strengthening of the health delivery system; development of health manpower; implementation of a national drug policy; strengthening of the nutrition and environmental health programmes; and development of health management and health legislation.

Past experience had shown that, where resources were limited, an integrated approach was essential. The health information system and the managerial capacity of middle-level and lower-level workers, especially those related to primary health care, were being strengthened, and high priority was being given to health education. Mortality rates were high in Indonesia—particularly infant mortality due to communicable and diarrhoeal diseases and malnutrition. A first priority in the fourth five-year development plan was therefore the integration of activities in maternal and child health, family planning, immunization, nutrition, and diarrhoeal diseases. Indicators were being developed, with particular emphasis on those activities, on the basis of the global indicators developed by WHO and Indonesia's policies and guidelines for the achievement of health for all. Despite the problems involved in the development of indicators, his country was convinced that monitoring and evaluation of the implementation of the strategy for health for all by the year 2000 was an essential activity.

Dr ABDULLA (United Arab Emirates) said that his country had begun efforts to implement the Strategy: that was in accordance with its Constitution, which guaranteed to all citizens the right to health care free of charge. Some problems were currently being encountered in connection with the provision of free medical care and efforts were being made to solve them and to avoid the over prescription of drugs. His Government had reported to WHO on the implementation of its national strategy in accordance with the 12 global indicators. It was necessary for all countries to work together with the Organization in order to achieve the goal and all governments should realize its importance for their respective countries and regions. Considerable progress had been made since the Declaration of Alma-Ata and he hoped that if the objective was kept constantly in mind it would be possible to provide health care for all even before the year 2000 and to ensure social and economic prosperity as well as a state of health and welfare in his country.
His Government worked in close collaboration with the Regional Office for the Eastern Mediterranean and with the Council of Arab Ministers of Health as well as with the Council of Ministers of Health of the Arab Countries of the Gulf Area, and regional problems were discussed in detail at meetings of those bodies. His Government was endeavouring to develop its health information system so that the Ministers could make use of the data collected to ensure a high level of health care throughout the Region. It also desired to collaborate with the developed countries and hoped that the latter would be in a position to provide the assistance his country needed in the field of trained health manpower and health technology.

He noted the importance of improving the standard of living of all workers and pointed out that human beings required adequate food and housing if they were to play a productive part in society.

The various ways in which the global indicators had been interpreted showed that there might be varying approaches in different parts of the world and it was for that reason that it was important for Governments to discuss a coordinated approach at the Health Assembly.

In conclusion, he expressed his approval of the reports before the Committee.

Dr BELLO (Venezuela) said that Venezuela had already achieved some of the goals proposed for the year 2000, and others would be achieved before then, but certain goals were completely out of its reach by that date for reasons of population structure. One of the goals achieved was the infant mortality rate which, for 1982, was 29.8 deaths per 1000 liveborn. He further noted that mortality for children aged 1 to 4 years was 21000 in Venezuela; that figure gave cause for concern since it was more than three times the mortality rate for children of that age in developed countries. Figures for mortality at other ages compared favourably with those of other countries. In view of the relative success achieved in Venezuela against infectious and contagious diseases in children under five years of age, the difference, in his opinion, was principally due to malnutrition even when that did not appear as the cause of death on the death certificate. Life expectancy at birth in Venezuela in 1982 was 69.18 years, and the adult literacy rate for men and women exceeded 70%.

However, despite the Government's official support for health for all by the year 2000 and its emphasis on primary health care, the truth was that in the past few decades the country had become increasingly dependent on sophisticated modern technology concentrated in the urban areas to the consequent detriment of the poorer rural areas. The challenge facing the Government was to reorient the system and transform the health infrastructure so as to achieve a better return from the amounts invested in health.

So far as global indicator 2 was concerned, although administrative and legislative mechanisms had been formed for involving people in the implementation of strategies, serious difficulties were still being encountered regarding their functioning, one being the traditional concept that everything could be left to the State. In connection with the social and economic global indicators relating to the proportion of the GNP spent on health and the use of a reasonable percentage of the national health expenditure for local health care, he was unable to give exact figures, despite the substantial sums allocated to health care in his country, because of the multiplicity of institutions and the variety of administrative systems and legal norms involved.

In conclusion, he again noted the impossibility, for demographic reasons, of achieving certain goals by the year 2000. In particular, the goal of 50% of deaths being due to circulatory diseases and 20% to tumours could not be attained in his country with its relatively young population, only 14.5% of which were over 45 years of age and 3.3% over 65. It was estimated that in the year 2000 only 17.8% of the population would be over 45 years of age and only 4.4% over 65.

Professor Renger took the Chair.

Professor JAKOVLJEVIĆ (Yugoslavia) said that he would present the views of the Ministers of Health of the non-aligned and other developing countries who had reviewed the Global Strategy at their eighth meeting, held on 9 May 1984. Expressing their approval of the report of the Executive Board and the comments by the Director-General currently before the Committee, the Ministers had decided to submit a draft resolution on technical cooperation among developing countries in support of the goal of health for all by the year 2000. The basic aim of the draft resolution, which would be sponsored by Yugoslavia and several other countries, concerned the contribution to be made by the developing countries towards the implementation of the Seventh General Programme of Work of WHO.1 The Ministers of Health of the non-aligned and other developing countries, in resolution 2 (see document

---

1 For text, see p. 86.
A37/INF.DOC./6,1 had adopted a medium-term programme for the period 1984-1989 and an initial plan of action for 1984-1985 with the aim of mobilizing all the efforts and resources of the developing countries for the implementation of the global and national strategies. The Ministers had reviewed Executive Board resolution EB73.R6 and, while endorsing the general lines of the draft resolution contained therein, proposed a number of amendments which he then read out. He would make the text available to the Secretariat for circulation in writing.2

Dr Sung Woo LEE (Republic of Korea) fully endorsed Executive Board resolution EB73.R6 and the draft resolution that it contained.

His Government had prepared a long-term prospective health plan for the year 2000 and since 1980 it had promulgated and enacted the special law on health care for rural areas which had cleared the way for the nationwide replication of the results of the community health demonstration project carried out during 1976-1980.

In addition to the existing network of health centres and subcentres, 2000 community health practitioners would be deployed throughout the country by the end of 1985. With the primary health care network, Koreans, regardless of their place of residence or socioeconomic status, would have ready access to good quality health care.

Dr SOME (Upper Volta) said that, in his view, the bad state of health of a people was to be attributed, not merely to disease, but rather to the factors of marginalization and apathy leading to general underdevelopment. Experience in Upper Volta confirmed that no unpopular regime and no economic system based on social inequality could promote a health system for all. Until the revolution of 4 August 1983, Upper Volta, although it had signed the Declaration of Alma-Ata, was carrying out a health policy for the benefit of a privileged and wealthy minority in the urban areas, which swallowed up more than 75% of the health budget. Monitoring of the health of the population had been the least concern of the authorities, which explained the current absence of usable statistics.

In spite of the substantial resources mobilized by WHO on behalf of Upper Volta, the level of health in the country was very low, but since 4 August 1983 its adherence to the strategy of primary health care had ceased to be mere lip-service for demagogic purposes and become a matter of adopting a health system in accordance with the stage of socioeconomic development of the country and a response to the need to provide essential care to the whole population mainly from the country's own resources. The primary concern was to decentralize the resources available for the benefit of the rural masses. To that end, the national health administration had been adapted to the administrative restructuring of the country into 25 provinces. A pyramidal structure had been adopted with primary health care posts at village level, 465 health and welfare centres run by nurses each serving 15,000 to 20,000 people, 50 medical centres run by doctors, 10 regional hospital centres with multidisciplinary medical teams and two national hospitals for specialist care.

The country's health policy gave priority to preventive rather than curative medicine, the latter being considered too costly, selective and limited. That approach was necessitated by the low level of development in a country in which morbidity and mortality rates were still high as a result of diseases, such as malaria, measles, diarrhoeal diseases, bronchial and pulmonary infections, meningitis, yellow fever, leprosy and schistosomiasis. His Government was convinced that the state of health of the population could only be improved by immunization, health education and other actions consciously taken by the communities themselves.

Measures taken to achieve the goal of health for all by the year 2000 took into account the vital sectors such as information, rural development - responsible for promoting self-sufficiency in food and supply of drinking-water, national education and scientific research.

No success could be achieved otherwise than through application of the principle of integrated development which, taking into account the limitations and interdependence of the different sectors, permitted national use of the resources available and was therefore paramount. In that connection, it was necessary to stress that external cooperation in health should be integrated into each country's national health plan, respecting the country's choices in matters of socioeconomic development. Otherwise it would entail only disorder and waste of resources.

Health for all by the year 2000 would not be attained without enlightened and responsible individual effort within effective community participation organized on the basis

---

1 See document WHA37/1984/REC/1, Annex 2.
2 For text, see p. 80.
of a political system devoted to the interests of the country. Without a health system organized on those lines WHO's various resolutions would remain a dead letter.

Dr TSHABALALA (Swaziland) congratulated the Executive Board on its constructive report. Her Government had developed a comprehensive national health policy which placed emphasis on the provision of primary health care to all communities and which, it was hoped, would provide guidance for both health care under government auspices and nongovernmental health care delivery systems. In addition, the Ministry of Health had drawn up an indicative health plan with specified priorities, objectives and targets, as well as providing its input to the five-year development plan.

With regard to the reorientation of the health system, her Government had already prepared guidelines on decentralization of health care, mentioning the part to be played by the task force on decentralization and the district health management teams that were starting to be formed in a few districts and included technicians from the government health care system and from non-government institutions. Furthermore, community health committees, of which the aim was to have 38 over the following five years, had been formed to help in the planning, implementation and monitoring of the communities' priority activities.

Orientation of health personnel had begun and some middle-level managers and clinic supervisors had received training in technical and management skills and a few of them in the supervision of primary health workers. Some reorientation had also been undertaken with regard to health assistants on water and sanitation projects in communities. There still remained a need for some reorientation of staff in the government and non-government health sectors. Favourable cooperation had been achieved with the non-government organizations which had formed a national body that worked closely with the Ministry of Health in the implementation and monitoring of primary health care strategies. Some discussions were still needed however.

Her country had been confronted with a number of problems due to drought and floods, and resettlement of communities had proved a slow process. But Swaziland was optimistic that the target set would be reached on time, although it was aware that, since funds had had to be diverted for rehabilitation purposes, financial problems would undoubtedly arise.

She noted the great need for Member States to give emphasis to the development of the managerial process for the implementation of the Global Strategy. It seemed to her that the importance of so doing had not as yet been generally recognized, which explained the problems encountered in planning and monitoring and intersectoral cooperation and coordination. Most countries now recognized, she assumed, that external assistance was needed for the strengthening of the process. Failing that countries would continue to have difficulty in monitoring and evaluating their health systems.

Reference had been made to policies and plans, but it did not as yet appear evident that all such plans had received full discussion within the countries themselves with those who would be called upon to implement the programmes and collect the data for the reports. There was need to look into the possibilities of team work, and the provision of adequate leadership, which was important to the timely production of monitoring and evaluation reports. Assistance in building up health information systems, as well as in the management of financial resources was also needed. She noted that very few countries had made a study of the financing of the health care system, which was why most of them did not know how much was being spent on primary health care.

Her delegation supported the draft resolution proposed by the Executive Board.

Professor SYLLA (Senegal) said that both the report of the Executive Board and the statements made in the discussion had made sufficiently evident the complexity of the task of assessing progress towards the Global Strategy of Health for All.

His delegation had noted the comments made with regard to the 12 global indicators prepared by WHO, which showed that many countries had encountered difficulties mainly in respect of indicators which were not of a specifically medical nature but related rather to social and economic factors. For instance, evaluation of the gross national product and of non-health sector resources had given rise to real difficulties where a large number of developing countries were concerned. Improved intersectoral cooperation and a better flow of information could counter such difficulties and facilitate the introduction of simplified but effective systems of monitoring and evaluation. Indeed, the previous session of the Regional Committee for Africa had strongly emphasized the desirability of a better understanding of those WHO indicators.

Accordingly, his delegation would support the draft resolution submitted by the Executive Board, and he expressed the hope that the recommendations made during the discussion in Committee A would promote greater understanding of evaluation problems in the forthcoming seminars on primary health care to be held in Africa under the auspices of WHO.
Dr SOTELO FIGUEIRDO (Peru) stated that his Government was actively and unreservedly implementing the strategies for achieving the goal of health for all by the year 2000 through primary health care and community participation. The principal features of that process had already been communicated to the Health Assembly by the Minister of Health of Peru, and he wished merely to highlight for the Committee's attention a few points that had emerged in recent months as of particular importance to the achievement of health for all in his country.

He had in mind particularly the development of human resources for primary health care based on a careful assessment of community needs and the part that those members of the community who had always participated in health work, such as volunteer health promoters and traditional birth attendants, could play in extending services.

Another matter of importance was the plan to promote health literacy, through the mass media in order to reach the whole population, with a campaign covering in a first phase the technique of oral rehydration, the benefits of vaccination under the expanded programme on immunization, and certain aspects of family planning.

The third point that he wished to single out was the application in health work of the risk approach which had begun in the field of reproductive health where the effort was concentrated on helping young women to have their pregnancies at the best age for them and better spaced, so that they would have smaller families.

The final point was the entire restructuring of the support given by the health system to the primary levels of care, particularly in administrative and financial matters.

His country commended WHO on its efforts to assess the progress being made, and he reiterated Peru's commitment to continued participation, not only nationally but also within the subregion and the hemisphere and at the global level, in its endeavours. It hoped that the external technical and financial cooperation provided for health work and applied mainly to primary health care in line with the Strategy would be used to the best effect and to that end Peru was making every possible effort for coordination of that process, which it saw as basic to ensure the most effective use of resources.

Dr FERNANDO (Sri Lanka) considered that the main emphasis of the Executive Board's report had been rightly laid on reviewing the relevance of the strategies to the goal of health for all and progress in their implementation.

Commenting on a number of points in the report, that were relevant to the position in Sri Lanka, he stated first of all, that his country was among the very few, in the words of paragraph 19, that had established a national policy and strategy review mechanism in the form of a national health development council. The comment in paragraph 24 on the lack of specific targets, a time-frame or a resource projection in national plans did not apply in the case of his country where the preparation of a prospective plan of action up to the year 2000 was under way. Paragraph 26 stated that few countries appeared to have adequate planning processes installed as an integral part of management processes and that was indeed the case in Sri Lanka. He agreed that it would be essential to give priority to such efforts. Consequently, the planning unit had been progressively strengthened over the past three years, although further strengthening was still required.

Sri Lanka had already recognized the need for reorientation of the health system (paragraphs 35 and 36). It was envisaged that the strategies adopted would be evaluated in early 1985 and presented to the national health development council. Feasibility trials would be required before new systems were implemented throughout the country.

On the question of community involvement (paragraphs 44 and 46 in particular) he explained that the community involvement had been taking place in Sri Lanka, thanks to the establishment of gramodaya mandalayas. The role of volunteer health workers called for special evaluation, both with regard to its effectiveness and to how motivation could be sustained.

With regard to the orientation and training of health workers the comprehensive approach advocated (paragraph 55) for manpower development was being developed in Sri Lanka, where a special national institute of health science was taking the proposed changes into account in its manpower development plans.

As for the mobilization of material and financial resources (paragraphs 60 and 61) Sri Lanka's expenditure on health in 1980 had amounted to only 3% of gross domestic product. The need for a review of the health budget and the allocation of resources for primary health care had been realized and, as the Minister of Health of Sri Lanka had stressed, the difficulties of moving away from the medicalization of society towards primary health care were appreciated.

Regarding coordination within the health sector and with other sectors concerned with health development (paragraphs 69 and 72), Sri Lanka would be undertaking a review of the effectiveness of the national health development network. Although a certain amount of work had been done in defining tasks of health workers, it was felt that more was required.
His Government shared the general view regarding the need for more effective cooperation with other countries (paragraph 76), considering that in manpower development, among the areas cited, that need was particularly acute. A list of requirements had been drawn up but TCDC mechanisms had not yet provided sufficient results. A recent meeting of senior officials in the South-East Asia Region should help considerably.

As regards the relevance of WHO's functions and structures in relation to implementation of the Strategy, and in particular, the measures introduced to strengthen the role of the WHO programme coordinator and representative (WPC) at country level and the participation of Member States in guiding, coordinating, monitoring and evaluating WHO activities at that level (paragraphs 103 and 107), Sri Lanka was carrying out periodic three-monthly reviews of the WHO programme in the country, and he commended the cooperation of the WHO programme coordinator in that respect.

The statement in connection with the mobilization of external resources for health—that without a serious effort at the national level in a number of directions enumerated, including consideration of alternative ways of financing the health system and strengthening health system management, it would be very difficult for countries to achieve any degree of self-reliance (paragraph 137)—prompted him to suggest that WHO should also support the bilateral efforts being made by countries towards mobilization of extra resources.

With regard to the conclusions and future outlook he agreed that health was indeed not yet receiving a high priority in the allocation of national resources (paragraph 147). That was so in Sri Lanka, but it was hoped that a better share would be set aside in 1985. The estimation of the resources currently going into the health sector was indeed far from a straightforward exercise with which most countries had difficulty (paragraph 148), including his own.

The Board had identified the strengthening of national capabilities to carry out the managerial process for health development as a suitable area for intensification of WHO technical cooperation (paragraph 149). WHO had already been undertaking that function in the South-East Asia Region and it was hoped that the effort would be intensified still further. He noted, in conclusion, that the infant mortality rate in Sri Lanka had been reduced from 38.1 to 34.4 per 1000 live births. He expressed his delegation's confidence that Sri Lanka would be able to achieve health for all by the year 2000.

Dr HASSOUN (Iraq) first of all expressed his deep regret at the recent death of Dr Braga of Brazil, whom he had considered not only as a friend but also as an outstanding personality in the Executive Board and in the Health Assembly.

Commenting the Executive Board's report, he agreed that the common framework and format had elicited a high degree of response, although not all the information submitted had proved of an adequate level. That had been the case in respect of his own Region. The reasons for that were probably not mainly the shortage of data but the type of data required. He would accordingly appeal to WHO to cooperate with developing countries facing problems in monitoring their strategies largely because of a lack of trained manpower.

He wished, in common with a number of delegates, to point out that it would be impossible to attain the goal of health for all by the year 2000 if the tragic world situation overshadowed by wars in various areas were allowed to continue. It was impossible to achieve total health without peace, and he echoed the words of the Director-General at the present session in calling for the orchestration of all voices into a harmony in pursuing the struggle for health for all.

He fully supported the draft resolution proposed by the Executive Board.

Dr QUIJANO (Mexico) presented to the Committee some of the most recent information, collected in 1981, on measures being taken in his country to implement the Global Strategy.

With reference to the indicators, he noted that the general mortality rate had decreased from 6.38 in 1978 to 5.89 per 1000 in 1981, and the infant mortality rate from 56 to 35 per 1000 live births, most of the latter mortality being due to infectious and parasitic diseases. Maternal mortality had decreased from 1.4 to 0.9 per 1000 between 1970 and 1980, and life expectancy at birth stood at 64.2 years of age. The proportion of the population with access to safe water stood at 71%. The illiteracy rate had been reduced from 22% to 13% in 1980, when children registered for primary education numbered 15 million. The number of homes available had risen by almost 3 million between 1973 and 1980, or 31%, half of the latter having adequate sanitary facilities. The trend towards urbanization was apparent from the fact that the percentage of the population living in rural areas had gone down from 43% in 1970 to 35% in 1980. The economically active population over that same period had increased from 12 to 19 million, the proportion engaged in primary sector activities remaining almost stable and the proportion engaged in the secondary and tertiary sectors showing a significant increase.
As regards population structure, the proportion in the under 15 age-group had fallen from 46% to 42% over the past ten years. During 1981-1982 over a million students were registered in higher education centres, some 90 000 of whom were intending to join the health professions, the annual output of doctors from medical schools being 13 000. Progress had been achieved in health service coverage, 43.5% of the population were receiving their care from social security institutions, while 112% increase had been achieved in the infrastructure serving the general population, in absolute terms an increase from 3479 to 7372 primary health care units. That increase had been made possible by two programmes, one a Government-financed programme catering for rural populations financed from general government funds and the other providing health coverage in urban fringe areas, run by the Secretariat for Health and Welfare. Basic services were thus provided for 16.5 million persons, not including those served by the private sector.

Mexico aimed to achieve self-sufficiency in health inputs, particular emphasis being placed on the production of biologicals and pharmaceuticals, and of medical equipment. In December 1982 the Government had promulgated a series of measures to overcome the shortage of drugs, followed in February 1984 by a Presidential Decree promoting and regulating the pharmaceutical industry. A greatly simplified list of essential drugs had been prepared, including 329 generic drugs and 484 pharmaceutical formulations, which was a useful guide to their better use.

Mr BARRIOS (Nicaragua) expressed his approval of the Board's report and the Director-General's comments for the valuable information they contained.

In Nicaragua the highest political, technical and economic priority had been given to the practical application of the right of all citizens to health and to the attainment of health for all by the year 2000. Both Government and people were making the necessary efforts to achieve those goals. However, the great inequality between the developed and the underdeveloped countries, aggravated by the economic pressures exerted by transnational corporations and international and private credit institutions, clearly reflected a political policy diametrically opposed to the goal of health for all. In the case of Nicaraguans and other friendly peoples, those pressures had gone further and involved unprovoked aggression in the economic, political and military fields, applying the law of death and destruction to everything that the people had built up with their sweat and blood.

With regard to the situation in the Americas, he wished to place on record his Government's deep concern at the political, economic and social crisis prevailing in the Region. His country's external debt situation was becoming daily more critical and the external trade deficit was increasing impressively, thus adversely affecting the importation of the inputs required for development. Attainment of the health for all goal would depend not only on the determination shown by developing countries, but also on the awareness and firm commitment of the developed countries to fulfil their historic undertakings to strive for peace, so that all could work together to attain the social goals of twentieth century man and thus make for a better world in the twenty-first century. That would be possible through the establishment of a new international economic order in which the inequalities between countries would be progressively reduced.

Mr AL-HAMER (Bahrain) said that the questions which the Committee had to consider in particular were what systematic progress had been made towards the global goal of health for all through primary health care, whether a comprehensive manpower policy had been worked out and whether sufficient attention had been paid to the important issues of health administration, health information and continuing education. In parallel it would have to assess the issue of research and its orientation towards community needs. There was general agreement, he hoped, that health was not a separate entity and could only be achieved in the context of equality, economic progress and proper living conditions. It was the function of an effective monitoring system to evaluate the progress made in the achievement of those aims. If those issues were systematically addressed the goal would be achieved by the appointed time.

Dr SYLLA (Guinea), expressing his appreciation of the realism shown by the Board, said that the striking absence of reliable information on some of the major indicators, commented upon by the Director-General, was certainly a feature of the majority of African countries, including his own. The Board's report was particularly opportune in that it brought out clearly the shortcomings of national information systems. That should incite the Organization to make greater use of all the appropriate ways and means of assisting the countries that so desired to strengthen their management capacity and promote intersectoral activities, failing which reliable information on some of the 12 global indicators would be difficult to obtain. In his opinion the multisectoral approach to health activities had to
begin at the level of the training of health and other manpower. The subject chosen for the Technical Discussions at the Thirty-seventh World Health Assembly was especially timely, since training colleges and universities had a most important part to play in implementation of the strategies for health for all. A rearrangement of health training curricula had already been undertaken in Guinea. For the past two years the three secondary health training colleges had adopted a new curriculum adapted to the primary health care profiles. A chair of public health had now been created in the Faculty of Medicine for teaching methods of epidemiological surveillance, applied nutrition and health service management. A group of 125 medical students had attended a primary health care seminar on completion of their training and were now carrying out preliminary surveys in rural areas to collect information for their doctoral theses.

Mrs BONNER (International Federation of Health Records Organizations), speaking at the invitation of the Chairman, recalled that the Director-General, in his opening address, had urged countries to use the process of evaluation as a springboard for action. During the debate, several speakers had stressed the lack of reliable information and had admitted that the collection, analysis and utilization of information needed strengthening in most countries. Very often simple, pragmatic and effective procedures and methodologies, appropriate to the economic and social conditions obtaining in each country, were all that was needed to bring about the required changes in national health systems, and to enable health services to monitor and evaluate progress and to modify indicators as required. In that connection she wished to draw attention to the existence and objectives of the organization that she represented - the International Federation of Health Records Organizations.

The Federation had been founded 30 years ago as a medical records organization. Fifteen years later, in line with modern trends in medicine, it had changed its aims and - symbolically - its name to health records. Present practice was to use the combined term medical/health records, indicating that the records were used, both for diseases, mortality and morbidity, and for health in primary health care, i.e., for both curative and preventive medicine.

A number of projects had been developed in collaboration with WHO, which was directly concerned in the improvement of health records, one of the first being a comprehensive survey of training programmes in health statistics in Member countries, mainly geared to hospital practice. Since 1978, the health for all and primary health care strategies had greatly influenced subsequent projects as could be seen from some of their titles: primary health records, reporting and using data generated from non-hospital medical/health records, training trainers of primary health workers, and ways of improving health records.

The Federation had at present a membership of only about 20 national organizations. But it believed that, with the support of WHO in channelling governments' needs and notifying specific requests, the Federation's knowledge and expertise in the collection, effective use and evaluation of health information could bring about significant progress in national health systems.

As for future projects, they would obviously depend on the knowledge available and the help needed in different parts of the world. Among the topics mentioned in the past, the following could be cited as examples: a list of education and training programmes available in Member States; a bibliography of publications in the field of medical/health records; and the organization of workshops, particularly in developing countries.

The Federation was, of course, ready to supply WHO and its Member States with whatever further information they might require and would welcome comments and suggestions so that its efforts would correspond to the needs and it could contribute effectively to the common struggle for health for all by the year 2000.

Dr KLIVAROVA (Czechoslovakia) said that she was fully aware of the difficulties involved in compiling a report on the progress made toward health for all in a single region, let alone at the global level. There were, however, a number of comments that had to be made. Some of the global indicators appeared rather too general in nature, inadequately reflecting the real conditions in the country, and the introduction of qualitative indicators by regions should be a priority task. For example, the percentage of GNP spent on health gave no idea of the amount actually spent by governments on health. On the other hand, the number of doctors and intermediate-level health workers, although a quantitative indicator, at the same time reflected the level of health care and was thus also a qualitative indicator. That applied also to the numbers of students graduating from university medical faculties and from intermediate medical schools. The number of hospital beds was also both a quantitative and qualitative indicator; it showed the population's access to hospitals and highly qualified specialist services, and not merely to primary health care. Nevertheless, it was not included in the monitoring procedure.
The question of water supply should not be confined to access to sources of supply, but should cover also the quality of those sources, both in rural and urban areas.

Another important subject was the action taken by health services to apply the results of scientific progress. In her country, for example, the immunization programme was firmly established, covering over 90% of the child population. Excellent results had been obtained in the control of diphtheria, poliomyelitis, pertussis, measles, and rubella in girls, and a programme of vaccination against mumps was now being started.

For reference purposes the Czechoslovak health service issued a yearbook on a whole range of qualitative and quantitative indicators, which was sent to the Regional Office for Europe and to WHO headquarters.

Systematic measures to provide generally available medical and health services and to create favourable living and working conditions for the population had been initiated in her country almost 40 years ago. It should never be forgotten that health care and protection were an essential criterion of a country's socioeconomic and cultural level.

One of the principal prerequisites for the achievement of health for all was world peace and the curtailment of the arms race, and she would like to see a reference to that included in the draft resolution proposed by the Board in resolution EB73.R6.

The CHAIRMAN pointed out that the discussion on the current item, was about to overlap with the Technical Discussions, which were to begin on the following day and concerned an aspect of the same subject. It was therefore desirable, in order to permit delegates who so wished to participate in both discussions, that the Committee should not proceed with its current discussion until after the end of the Technical Discussions. It would therefore take up the following item of its agenda at its next meeting.

It was so agreed. (For continuation of the above discussion, see summary record of the fifth meeting.)

The meeting rose at 12h40.
FOURTH MEETING
Saturday, 12 May 1984, at 9h15

Chairman: Dr K. AL-AJLUNI (Jordan)
Later: Mr R. EDWARDS (Canada)

INFANT AND YOUNG CHILD NUTRITION (PROGRESS AND EVALUATION REPORT; AND STATUS OF IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES): Item 20 of the Agenda (Resolution WHA33.32; Documents WHA34/1981/REC/1, Annex 3, Article 11.7 of the Code, and A37/61)

The CHAIRMAN drew the Committee's attention to the relevant documentation which included a draft resolution on the prevention and control of vitamin A deficiency and xerophthalmia, proposed by the delegations of Bahrain, Belgium, Bhutan, Democratic Yemen, Federal Republic of Germany, Jordan, Libyan Arab Jamahiriya, Malta, Mauritius, Morocco, New Zealand, Qatar, Somalia, Spain, Syrian Arab Republic, and Zaire, and invited comments on the item.

Dr FERNANDO (Sri Lanka) said that the current pattern of breast-feeding in Sri Lanka was that almost all mothers breast-fed their infants except in very exceptional circumstances. There were, however, varying patterns in the duration of breast-feeding. In general most mothers in rural areas and those in the low socioeconomic groups had a longer period of lactation than urban mothers and those in the higher socioeconomic strata. One of the factors contributing to shorten the period of lactation might be the responsibilities of employment borne by such women. The World Fertility Survey report for Sri Lanka had indicated that 96% of children were breast-fed and the mean duration of breast-feeding was 20 to 22 months. The survey carried out in 1975 had shown that 88% of children were breast-fed for up to three months, 72% up to six months, and 56% up to 12 months.

In Sri Lanka, information specially produced with the aim of promoting breast-feeding was provided to parents, the general public, policy-makers, health workers, students and others concerned with infant and young child nutrition and health through the mass media, printed literature, posters, etc. A special postage stamp on breast-feeding had been issued in 1981.

Education on appropriate young child feeding practices, pre-natal care and counselling concerning preparation for and maintenance of breast-feeding was carried out by all field health workers throughout the country. Health care practices which favourably influenced breast-feeding were promoted by all health workers in the health infrastructure of the country.

National measures designed to protect and promote breast-feeding had been included in certain routine activities of the Ministry of Health and other ministries. Thus, all female State employees were eligible for six weeks' maternity leave with pay. Estate or plantation workers were eligible for 36 days of paid maternity leave and active consideration was being given to extending the period of maternity leave for all State-sector employees to three months. After her maternity leave, the estate working mother was permitted to leave her workplace to visit the crèche at fixed intervals in order to breast-feed the baby. Each estate worker's child, between the ages of one and 10 years, was given a food supplement by the estate management of about 2 kg of wheat flour free of charge each month. Those practices were included in the estate medical requirements ordinance as part of the legal requirements. However, in the industrial and other sectors where female workers were employed there was no legal provision to enable working mothers to carry on breast-feeding once they had resumed paid employment.

With the aim of promoting and supporting appropriate and timely complementary feeding and weaning practices with the use of local food resources, the Ministry of Health promoted the use of a pre-cooked food supplement for breast-fed infants, which was centrally processed and distributed to the nutritionally vulnerable group of the population. Emphasis was laid

---

1 Document WHA37/1984/REC/1, Annex 5.
2 For text, see p. 100.
on the start of early weaning, at the fourth month, instead of the customary practice at the ninth to twelfth month. One-third of that supplementary food was made up from locally available grains and pulses and it was intended that, by 1986, the supplementary food would consist of entirely locally produced ingredients. The Government was attempting to market a new locally processed cereal-pulse food mix as a low-cost weaning food to the public at large and was also promoting home-made infant weaning foods utilizing locally available materials. One of the problems associated with the non-availability of a simple, low-cost, nutritious weaning food was the noticeable deterioration of the nutritional status of infants during the second year of life.

Efforts were being made to strengthen education, training and information on infant and young child feeding both in the basic training programmes of all health personnel and through in-service training of public health staff. Special programmes were being implemented to educate community workers from other sectors on infant and young child nutrition through voluntary agencies, while information on infant and young child nutrition was also included in the primary school curriculum. The implementation of the primary health care programme already initiated provided training and education in infant and young child nutrition and feeding to all instructors and supervisors of the field health personnel and to all health staff in the regions.

Turning to the subject of the marketing and distribution of breast-milk substitutes, he informed the Committee that the State had formulated a code for the marketing of breast-milk substitutes and infant foods for Sri Lanka based on the International Code. National legislation was being prepared to give emphasis to the code. While campaigning to promote breast-feeding of infants, the Government had, in April 1981, removed all existing subsidies on imported milk food preparations. Implementation of the code was being monitored under the consumer protection act which covered all manufacturers and traders in infant milk foods. The code had been published in the local languages and circulated amongst policy-makers and professionals working in both the health and other child activity fields.

Dr VIOLAKI-PARASKEVA (World Federation of United Nations Associations (WFUNA)), speaking at the invitation of the Chairman, outlined the objectives of WFUNA which had been established in 1946 and whose basic aims was "to be a peoples' movement for the United Nations". On every possible occasion WFUNA publicized the achievements of projects undertaken by the United Nations and the specialized agencies. The Twenty-ninth Plenary Assembly of WFUNA had adopted unanimously a resolution supporting and calling for the implementation of the International Code of Marketing of Breast-milk Substitutes as a contribution towards achieving the goal of health for all by the year 2000.

Her personal experience was that among nongovernmental organizations there was a lack of awareness of the United Nations Development Programme and the results it had achieved. There was also insufficient awareness of the work of the specialized agencies and, in particular, of the implications of the Strategy for Health for All by the Year 2000. WFUNA had therefore noted with satisfaction the information contained in paragraph 209 of the Director-General's report that in November 1982 an informal gathering had been organized at the Regional Office for Europe at which, inter alia, the role of nongovernmental organizations in implementing the International Code had been discussed. The report issued at the end of that meeting under the title "Strategies for the legal implementation of the International Code of Marketing of Breast-milk Substitutes" should be useful and she hoped it would have a wide distribution among nongovernmental organizations.

It was, moreover, encouraging that the Technical Discussions for the Thirty-eighth World Health Assembly were to be on the subject of collaboration with nongovernmental organizations in implementing the Global Strategy for Health for All by the Year 2000.

Dr QUAMINA (Trinidad and Tobago) expressed her approval of the Director-General's comprehensive report, the precise and orderly arrangement of which was much to be commended. Her delegation particularly welcomed the importance attached in the report to low birth weight. For some time that particular indicator had assumed additional importance as improved medical technology, rather than health care, had reduced maternal mortality and the stillbirth rate. The quality of life of the newborn infant and its future development should now be the subject of scrutiny.

The global statistics had been presented as averages, as a reasonable means of comparative examination. However, it must be remembered that averages often concealed the range of values, a matter which was particularly pertinent with regard to the statistics given in the Director-General's report, for the estimated number of births of all live infants and of low-birth-weight infants, 1982, and estimated proportion of low-birth-weight infants, 1979 and 1982 (Table 1). Her Government had recently received the results of an investigation in Trinidad and Tobago which showed a low-birth-weight percentage of only 5%.
The survey results, based on hospital deliveries - and about 80% of births in Trinidad and Tobago took place in hospitals - would be closely analysed to identify high-risk groups, so that further remedial action could be taken. The vulnerability of the teen-age mother had already been highlighted.

Her delegation noted with appreciation the tremendous number of activities being geared to promote breast-feeding, with particular reference to the production of teaching materials. In Trinidad and Tobago, despite sustained educational programmes by the Ministry of Health and Environment and by nongovernmental organizations, including participation in several international educational programmes, there had not been the degree of response which might have been wished. Many mothers still unnecessarily supplemented breast milk. Her delegation was therefore of the view that health workers, and particularly general medical practitioners, required further education regarding lactation and the factors affecting breast-feeding. Hospital staff in her country had already been included in such educational programmes and each hospital had designated a senior doctor to act as a focal point for monitoring hospital practices.

The Ministry of Health and Environment was continuing to monitor the nutritional state of the pre-school child with particular regard to the introduction of an appropriate weaning food, but was encountering problems in getting that food produced on an industrial scale. The Government had also ordered the preparation of legislation to control day nurseries and child minding. Legislation concerned with occupational health and safety was also proposed and would contain a provision for the Minister to make regulations requiring employers to provide crèches where large numbers of women were employed. The new Mount Hope Medical Complex would have a crèche for the use of employees.

The School Nutrition Company, a government-owned enterprise, was continuing to supply midday meals to a large number of children. Those schools not able to supply a full meal were providing a fortified milk drink. Moreover, the School Nutrition Company had joined the Ministry of Health and Environment in promoting education on the feeding of the school and pre-school child through meetings with parent-teachers' associations and parents.

Her delegation had noted with appreciation the large number of activities devoted to monitoring the International Code in many countries. It appeared that considerable pressure was still being placed on mothers to supplement breast milk by the use of general milk products rather than designated formulas. That was an area to which attention must be directed in the future.

Furthermore, the whole problem of child nutrition in the second year of life was one to which the Director-General should give further attention. She hoped that there would be further meetings on that subject.

Professor SAGHER (Libyan Arab Jamahiriya) said that despite the scientific and technological progress which had been made in public health and medicine, many developing countries still suffered from problems due to malnutrition and avitaminosis, which could be dealt with. More than 10 million children throughout the world suffered from vitamin deficiencies, which caused xerophthalmia and, ultimately, blindness; in Asia more than a million children lost their sight every year. In certain African countries, as well as in Latin America, the Middle East and the Far East, children died from avoidable causes. The lives of those children could be saved because it was no longer difficult to treat deficiency diseases and methods of dealing with avitaminosis were well known.

It was essential that efforts should be made to provide the appropriate treatment. Member countries and international organizations should unite to produce a study showing the importance of vitamin A and should devise a 10-year programme for the application of a sound strategy, as well as a detailed plan to determine and treat the causes of avitaminosis and thus overcome the problem.

His delegation had taken the initiative in proposing that humanitarian project which he hoped would receive the support of all, but he pointed out that support for the draft resolution before the Committee would be meaningless unless adequate funds were forthcoming from Member countries. In conclusion, he expressed the hope that Member countries would cooperate not only in that project but also in other humanitarian projects.

Dr ACOSTA (Philippines) said that his Government had established a national committee on breast-feeding under the auspices of the Ministry of Health. Working with governmental and nongovernmental national agencies, the committee had looked into the factors affecting infant and young child feeding and, over the past three years, had implemented a series of training and educational activities, directed to all categories of health workers as well as to the public. The medical curriculum was being evaluated with respect to the content of infant and young child feeding and new modules were being developed to meet the special needs of the country.
In collaboration with WHO and UNICEF, promotional programmes had been conducted throughout 1983, which had been highly successful in alerting policy-makers, health workers and the public to the nutritional needs of young children. A survey of knowledge, attitudes and practices on breast-feeding among health personnel in the Philippines had just been completed and that information would be incorporated in the planning of training projects for health workers during 1984-1985.

The national committee on breast-feeding, working with the Ministry of Health and other ministries, had been instrumental in preparing a national code of marketing of breast-milk substitutes which was currently being reviewed by the Government.

Professor HAMZA (Tunisia) said that the nutritional state of the infant and young child could not be divorced from the nutritional state of the mother during pregnancy. From studies carried out in Tunisia, the birth-weight of infants had been found to be very similar to that of infants in industrialized countries, i.e. about 3.3 kg. The rate of low birth weight, namely under 2.5 kg, had been found to be between 7% and 8.32%. That suggested that in general the diet of pregnant women was satisfactory at least in urban and periurban areas.

Adequate nutrition of infants and children was encouraged in various ways. Since 1980, a national committee had been studying nutrition problems and promoting breast-feeding. In 1983, the National Institute of Child Health had organized three seminars on rehydration and on breast-feeding as a means of preventing diarrhoea. A film on breast-feeding, prepared by the Ministry of Public Health and the Ministry of Information, had been shown on television and publicity material was distributed to all regions for the training of health personnel. In 1984, the National Union of Tunisian Women had organized a seminar on breast-feeding and in April of that year the National Institute of Child Health and the Office of Family Planning had held a seminar on natural methods of family planning and the influence of breast-feeding on fertility.

In 1983, studies had been carried out on the role of breast-feeding in preventing acute respiratory diseases and those studies would be continued in collaboration with WHO within the programme for the prevention of those diseases.

Recent changes in legislation included the extension of maternity leave in the civil service to 8 weeks, with the possibility, on request, of an additional 16 weeks on half salary. Those provisions would tend to prolong breast-feeding by at least 6 months.

In all the studies made in Tunisia, the weight increases in infants up to the age of 5 months was identical to that of European or American infants, but the most critical phase for the health of the child occurred at that age and it had been decided to recommend diversification of feeding, by introduction of the current weaning foods or use of recommended recipes, and extension of breast-feeding for as long as possible. In a recent study dealing with the years 1982-1983 in a poor suburb of Tunis it had been found that only 0.7% of children were suffering from third-degree protein-energy malnutrition according to the Gomez classification.

So far as specific nutritional deficiencies were concerned, vitamin A deficiency, as indicated by eye symptoms, was no longer a health problem in Tunisia and vitamin D deficiency, because of prophylactic treatment carried out at the same time as vaccination, had considerably diminished. Iron deficiency among pregnant and nursing mothers and children was still frequent, and it had been estimated that 30% to 60% of pregnant women and 23% of children under the age of 5 suffered from it. A survey and preventive programme would be begun shortly with the help of the International Development Research Centre of Canada.

It was essential to incorporate nutrition in primary health care and growth monitoring as part of primary health care would also make it possible to identify the population at risk. The national survey on child morbidity and mortality currently being carried out in collaboration with WHO and UNICEF, the results of which would be available in 1986, would also make it possible to improve action for mother and child health.

Marketing and distribution of breast-milk substitutes in Tunisia were governed by the provisions of Act No. 83-24 of 3 March 1983, applicable as from 4 March 1984, which also regulated the quality control of such substitutes and related products and information on them. The Act prohibited the distribution of specimens, advertising for breast-milk substitutes, and gifts and sales at reduced prices except to children's institutions. Even before the coming-into-force of that Act its effects had been beneficial as a result of the vigilance of the Government and the cooperation of professional groups and breast-milk manufacturers.

He believed that his Government's policy on nutrition, which had been implemented for more than 10 years, its campaign against diarrhoeal diseases begun in 1980, sanitation measures, the increased availability of safe drinking-water, the expanded programme of immunization, and the forthcoming campaign against acute respiratory infections, would make it possible to ensure better child growth. Surveys currently being carried out on child
morbidly and mortality and on nutritional knowledge and practice would make it possible to
direct action towards the groups most at risk.

Mr VAN DEN DOOL (Netherlands) said that the information in Part I of the
Director-General’s report remained very disturbing. The figures on the incidence of low
birth weight by region showed that the populous countries of Middle South Asia remained among
the most affected. With the exception of Northern America and Europe, the prevalence of
protein-energy malnutrition among children under five was practically a worldwide problem,
while nutritional anaemia among women in developing countries, affecting as many as 30% of
pregnant women in the Americas, and 63% in Africa, reflected the unsatisfactory nutritional
status of millions of pregnant women. Iodine deficiency diseases and xerophthalmia remained
damaging in many areas. Badly needed improvements were hampered by many socioeconomic and
sociocultural barriers; it was clear that agricultural development, in close association
with sanitation and the promotion of primary health care, was a basic key factor, together
with vigorously pursued family planning programmes. Although bilateral assistance and the
participation of international organizations were of great importance, it was the primary
responsibility of national governments to take steps to improve the situation. It was
encouraging to note that specific measures such as those mentioned in paragraph 39 (iron
fortification of food) and paragraph 47 (vitamin A distribution programmes) could be
effective. To the extent that resources permitted, his Government would continue its support
in that area.

Part II of the report gave an impressive overview of national and international efforts
to implement infant and young child feeding policies based upon the philosophies developed
within WHO and, in particular, on the International Code. In the Netherlands, the promotion
of breast-feeding was being actively pursued on the initiative of various private
organizations and groups. Promotional material had been developed and distributed among
expectant mothers and a film was being produced for use in the training of nurses. The
National Institute of Health and Environmental Protection was investigating the presence of
polychlorinated biphenyls (PCB) in breast milk, following studies elsewhere in Europe and the
United States. Advisory practices concerning complementary feeding were under review, and
the findings would be used to develop guidelines for complementary feeding for use by medical
practitioners. A multidisciplinary study group had been set up to develop guidelines for
feeding healthy and full-term infants up to the age of one year; the project would be
completed in 1985.

The Netherlands was still in the process of developing national legislation, based on
the International Code, concerning the labelling and composition of infant foods destined for
export. Within the framework of the European Economic Community, where a Directive on infant
foods was also being developed, the Netherlands delegation was actively advocating conformity
of the Directive with the WHO Code. It must, however, be added, that his Government was not
in a position to withdraw its reservations with regard to Article 9.2 of the Code, although
it would continue to support the further development of national and international programmes
in that field.

Mr SONG Lianzhong (China) commented on the work in the field of infant and child
nutrition that was being carried on in China, pointing out that newspapers, broadcasting,
television and manuals were all used to publicize the advantages of breast-feeding.

Nutritional and hygiene standards for infant and child food had been formulated by the
Ministry of Public Health in collaboration with the Department responsible for the production
of breast-milk substitutes, and had been implemented since 1 January 1984. It must, however,
be admitted that surveys and research concerning breast-feeding had, on the whole, given poor
results; for the healthy growth of the new generation of the population it was necessary to
implement the proposals put forward at a national workshop on breast-feeding held in 1982 in
Shanghai and place renewed emphasis on the social and domestic significance of breast-feeding.

In rural areas there was a tradition of breast-feeding and the rate was comparatively
high (about 70%), but in urban areas, because of lack of facilities for working mothers, the
rate was only some 30%. Widespread publicity was therefore necessary to make people
understand that breast-feeding was economic, safe, convenient and conducive to the child’s
mental and physical development. Various sectors of society, such as women’s federations and
youth leagues, would be mobilized to promote the development of breast-feeding. Steps would
also be taken to improve conditions during pregnancy and lactation by according maternity
leave of absence from the place of work. The role of doctors and scientific research workers
in promoting work on infant and child nutrition was obviously of great importance.

His delegation endorsed the contents of the Director-General’s report.

Dr HEDAYETULLAH (Bangladesh) pointed out that mothers and children accounted for more
than 50% of the world population and constituted a vulnerable group, especially in the
developing world, where they were the victims of numerous handicaps, such as low birth weight, protein-energy malnutrition, nutritional anaemias, endemic goitre and vitamin A deficiency, their situation being made even more critical by the incidence of diarrhoeal diseases and infection. Unless it was possible to ensure positive health for mothers, infants, and young children of the underserved populations, the achievement of health for all by the year 2000 would remain a mere hypothesis.

In Bangladesh, some 30% of infants were born underweight due to the poor nutritional status of mothers, and the Government had embarked on an extensive mother and infant nutrition programme, supported by WHO, UNICEF and aid agencies, aimed at improving that state of affairs. Two thousand out of a planned total of 6000 health/family welfare centres had already been established, covering 20,000 persons per centre. Cases of protein-energy malnutrition among infants and young children, especially in larger families, were also quite common in his country, as were cases of nutritional anaemia and acute vitamin A deficiency, especially in the villages, where 90% of the population resided. The high potency vitamin A distribution programme in Bangladesh had yielded very good results in reducing the incidence of xerophthalmia and blindness among young children. In the northern part of the country, a programme for the administration of iodine in injectable form would shortly be launched with the aim of preventing disability as a result of endemic goitre due to iodine deficiency.

The measures described in Part II of the Director-General's report would have a direct impact on the realization of the Global Strategy for Health for All by the Year 2000, and the issues raised deserved serious attention on the part of the Health Assembly. Commenting on the five-theme framework outlined in paragraph 50, he said that, as a highly populous country where mothers and children comprised more than 60% of the population, Bangladesh attached high priority to improving the health and happiness of that target population. Recently, a health services infrastructure at the grass-roots level had been set up to provide total coverage for maternal and child health feeding programmes and primary health care to the underserved and unserved people.

As regards the discouragement of the advertising of breast-milk substitutes, his Government had taken the bold step of introducing sanctions, involving imprisonment of up to two years and/or a fine, against the promotion of breast-milk substitutes and the marketing of substitutes in conditions which did not provide for hermetically closed containers bearing a readily understandable message in the local language, printed on a conspicuous part of the packaging, to the effect that no substitute could be equivalent or superior to breast milk; instructions for preparing the reconstituted milk also had to be provided.

In conclusion, he said that his Government fully endorsed the report of the Director-General.

Professor MAMMERI (Algeria) recalled that his delegation had for a number of years taken an active interest in the matters covered by the Director-General's report, and praised the document before the Committee.

In Algeria, infant and young child nutrition was considered to be of vital importance, and had accordingly been taken fully into account in a wide-ranging action programme for the protection and promotion of family health which formed an integral element of primary health care. Since 1974, the Ministry of Public Health had been endeavouring, on the basis of research undertaken during the previous decade, to put into practice a coherent food and nutrition policy, complemented by a policy for the standardization of milk and milk-powders used in infant and young child feeding; measures had been introduced to regulate the production, marketing and distribution of breast-milk substitutes and weaning foods.

Stress was laid on the encouragement of breast-feeding and appropriate weaning practices. Although breast-feeding was widely practised as a matter of tradition and custom, changes in modern living, which had had a considerable impact on social and individual behaviour, together with the growing number of women working outside the home, had given rise to a need for health education and information for the female population, as well as for the training of health personnel to work in family protection services. It was vital to encourage breast-feeding among the younger generation of mothers, and to explain appropriate practices for weaning following the fifth month of life. Consequently, technical instructions, drawn up by the nutrition services, were available to personnel working in the field of family protection, and a module of nutrition and food hygiene, together with a module of maternal and child protection, were included in the training programme for all medical and paramedical students.

As far as the standardization of breast-milk substitutes was concerned, national standards governed such matters as chemical formulas and microbiological quality, packaging, and labelling, which must be in the local language whatever the origin of the product and include a notice setting out the advantages and superiority of breast-feeding. Algeria produced a high-protein complementary (weaning) food; quality control tests were carried out...
daily by the factory concerned; marketing was subject to a permit from the Ministry of Public Health. Normal-protein milk powder, produced in accordance with national standards, was imported under national supervision, subject to the provision of a guarantee of conformity by the producer. Inspection was ensured by a laboratory of international standing, and a permit from the Ministry of Public Health following laboratory tests was also required before it could be marketed. Manufactured milks, which were also imported, were only recommended in cases where breast-feeding was not possible.

The Algerian health authorities believed that their nutrition strategy in respect of infants and young children was in keeping with the principles laid down by WHO and by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding in 1979, as well as with the International Code of Marketing of Breast-milk Substitutes.

Professor SZCZERBAN (Poland) said that considerable efforts had been made during recent years to reorientate the pattern of infant and young child feeding in his country.

A low incidence of breast-feeding, particularly in the urban areas, remained a problem, although there was recent evidence to show that the undesirable trend was being reversed. The recommendations contained in the International Code of Marketing of Breast-milk Substitutes were an important source of help in that connection. In recognition of the importance of social conditions and the health of the mother where breast-feeding was concerned, appropriate steps had been taken to grant mothers 24 months of paid leave from work following delivery in addition to normal maternity leave. High-protein products were provided during the lactation period, and mothers were also entitled to special privileges enabling them to feed their infants during working hours. Long-term information programmes had been undertaken by the mass media to publicize the superiority and advantages of breast-feeding, and scientific and medical societies and institutions had been encouraged to perform research in that field. Education and industrial organizations as well as medical bodies had become involved in the campaign to promote breast-feeding. Poland now manufactured 4 types of breast milk substitutes and 3 types of complementary foods, all in accordance with the requirements of the International Code of Marketing of Breast-milk Substitutes.

The action programme he had described was planned as a long-term undertaking by health services and other appropriate cooperating sectors, and the contents of the important report submitted to the Committee by the Director-General would be a source of encouragement in that connection.

Mr Edwards took the Chair.

Professor LUNENFELD (Israel) said that his delegation was distressed and concerned that there had been no significant change in the number of malnourished children in the world. In the name of more than 145 million undernourished children, he urged the Committee to make a serious attempt at a global solution of the problem through the institution of concentrated control programmes, which would involve the monitoring of trends of feeding practices (including the promotion of breast-feeding); the introduction of standard, family-based records using simplified indicators (with minimal reference values for those indicators at a global level and optimal reference values specifically adapted to regions and countries); the encouragement of community-based day care centres (as an extension or outreach of maternal and child health centres) to monitor the proper feeding of children and the early detection of health and development problems; and the initiation of emergency regional programmes for the early identification and prevention of nutritional and vitamin deficiencies, such programmes being endowed with the necessary resources and tools to deal with the problem effectively.

Lactational anovulation associated with amenorrhoea due to exclusive breast-feeding constituted an important child-spacing mechanism, which could be turned to good account in national policies and guidelines. The latter should cover the promotion of breast-feeding, the handling of local problems involved in breast-feeding and weaning and the continuation of breast-feeding after the introduction of supplementary foods. In his country, for example, the iron-enriched baby cereal officially recommended by the Ministry of Health had been actively promoted by maternal and child health centres and was being more and more widely used.

In conclusion, he endorsed the contents of the Director-General's report, and urged rapid follow-up action.

Dr TSHABALALA (Swaziland) said that the report before the Committee listed a number of successes, such as the close cooperation between WHO and UNICEF, DANIDA and other organizations, the development of methodologies for the determination of infant and young child feeding patterns, the publication of useful guidelines for the management of
breast-feeding and the provision of teaching and learning materials. She was also pleased to note the striking response from Member States in all regions to the International Code of Marketing of Breast-milk Substitutes. Growing national and international awareness and the increasing efforts made in that field were a vital element in primary health care.

During the past year, the Swazi Government together with nongovernmental organizations had undertaken a number of important activities, such as the organization of a nationwide nutritional survey, to be published shortly, on the under-five age group covering the period from December 1983 to January 1984; the aim was to determine the social and economic factors affecting infant and young child feeding and to provide sufficient information to formulate a national nutrition policy and strengthen and expand the nutrition surveillance system. The Government had also convened an international conference at Mbabane from 1 to 5 May 1984 for the discussion of measures to promote breast-feeding and appropriate weaning practices, which had been sponsored by the International Baby Food Action Network (IBFAN), UNICEF, the Norwegian Agency for International Development (NORAD), and the Interchurch Coordination Committee for Development Projects. Delegates from Botswana, Ethiopia, Kenya, Malawi, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe, as well as Swaziland, had submitted for examination more than 100 examples of violations of the International Code relating to labelling and the information given on infant formulas, full cream milk and cereals, some of the cereals being advertised for use from as early as the second day of life. Serious violations had been reported in regard to feeding bottles, including the use of different colours of plastic bottles, some of which were in the shape of animals and difficult to clean. Some weaning foods were found to have been prepared in bottles designed to take the meat of a feeding bottle. The conference had stimulated greater awareness in political circles, among the public and among the shop-owners concerned. A nine point statement - the Mbabane Memorandum - had been issued at the end of the conference, urging: effective legislation on the promulgation and enforcement of the International Code; the provision of maternity leave and other benefits, enabling women in employment to breast-feed successfully; the issue by ministries of health of up-to-date information on the management of lactation in the interests of the promotion of sound health practices and community education; priority action to improve the health and nutritional status of pregnant and lactating mothers; the provision of counselling by health workers on breast-feeding; and consistent monitoring by governments and nongovernmental bodies of the compliance or noncompliance of companies with the International Code.

Her delegation firmly believed that the monitoring of compliance by food industries should be continued by governments, and further stimulated by the establishment in all countries of action groups with strong support from organizations such as WHO, UNICEF, etc. The International Code of Marketing of Breast-milk Substitutes should, moreover, be widely circulated to all strategic primary health care centres. In addition, she earnestly requested support in the form of expertise and funds for the development of a suitable locally-produced weaning food.

She hoped that a draft resolution would be tabled requesting the Director-General to convene a technical meeting to examine whether the scope of the Code was adequate. Her delegation would support such a draft resolution.

Dr Nakamura (Japan) recalled that the aim of the International Code was to contribute to the provision of safe and adequate nutrition of infants and children by the protection and promotion of breast-feeding and by ensuring the correct use of breast-milk substitutes. Research was at present being carried out in Japan on the influence of breast-feeding in infant nutrition, on the nutritional elements of breast milk and on the psychological aspects of the mother-infant relationship. At the same time, information on infant and child health, including the encouragement of breast-feeding, had been widely publicized by the mass media in conjunction with the World Health Day slogan "Children's health - tomorrow's wealth".

Dr Bramer (German Democratic Republic) emphasized that the recommendations of the International Code had been implemented and were strictly complied with in his country. The production of breast-milk substitutes and of food for young children was governed by the guidelines in the Recommended International Code of Hygienic Practice for Food for Infants and Children, which were stringently enforced by the health authorities. His delegation believed that allowance should be made for specific physiological peculiarities in the production of food for infants, especially during the first few months of life, an aspect which was not covered in the existing FAO/WHO recommended international standards for infant and children's foods. In his country, the development, production and distribution of all kinds of infant foods was carried out under the supervision of the Ministry of Health in cooperation with the competent scientific institutions. There was no doubt that breast milk provided the best nourishment for infants and his delegation strongly supported WHO's firm stand in favour of breast-feeding. He also endorsed the recommendation in the
Dr WALSH (Ireland), outlining the position of his Government in regard to the implementation of the International Code of Marketing of Breast-milk Substitutes, said that a national code of practice for the marketing of infant formulas was currently being implemented in Ireland and a special committee had been set up to monitor the code. That committee had originally consisted of health professionals, officials of the Department of Health and the Health Education Bureau, and representatives of the manufacturers and distributors of infant formulas in Ireland, but it had recently been decided to include a trade union representative because of the need for non-technical representation. Both the Minister for Health and the food industry considered that the trade unions, as one of the social partners together with government and industry and representing a broad spectrum of consumer and social opinion, were a suitable body to provide such representation. The code monitoring committee had met on a number of occasions and reviewed the operation of the code, but no complaints had yet been received of any breaches of it.

The Health Education Bureau was continuing to implement infant feeding education programmes aimed at providing both health professionals and the public with relevant information, as part of its public education programmes on life-styles. Liaison with voluntary organizations was being continued and the Bureau would be sponsoring a seminar on breast-feeding organized by the La Leche League International in June 1984. An education programme on maternal nutrition was currently being planned and a recent report by the National Food Advisory Committee on the nutritional preparation for pregnancy would be used in that programme. The National Survey of Infant Feeding Practices was one important element in the monitoring of the effectiveness of the above measures by the Department of Health and had revealed a gradual but significant increase in the breast-feeding rate between 1981 and 1983.

The quality of infant formulas on sale in Ireland was monitored on a routine basis for compliance with the sale of food and drugs acts and regulations on hygiene, additives and contaminants. It had been found that the products on sale were nutritious and wholesome and complied with the provisions of the Irish Code of Marketing and the relevant legislation on composition and labelling.

His Government fully supported the aims of WHO in the area of infant feeding.

Dr BELLO (Venezuela) commended the Director-General's report which gave a praiseworthy summary of the situation. He noted that, at the Thirty-sixth World Health Assembly, held in May 1983, the delegate of Venezuela had informed Committee B that a resolution based on the International Code of Marketing of Breast-milk Substitutes had been promulgated by the Ministry of Health and Social Welfare, and that a code of ethics on the use of breast-milk substitutes in the first six months of life had been adopted by the Venezuelan society of puericulture and paediatrics in 1980. In July 1982, the Ministry had specified the requirements to be met by infant formulas, one of which was the inclusion of a statement on labels, packaging and advertising that breast milk was superior and that such formulas should be used as replacements for breast milk only under medical supervision. All advertising had to be reviewed in advance by the Food Hygiene Division of the Ministry. Furthermore, the wording used on packages and in publicity and labelling should not promote the use of infant formulas to the detriment of breast-feeding, and promotional activities such as the offering of free gifts were prohibited. Provision was also made for penalties to be imposed on those contravening the regulations. Most of the companies concerned had complied with the requirements of the Ministry's resolution. A group which had not done so had been warned and punished. The maternal and child health authorities had recently met the manufacturers and distributors of baby and infant foods, who had promised to do their utmost to satisfy the legal requirements. He would submit copies of the relevant documents to the Secretariat.

The promotion of breast-feeding was being undertaken by both public and private organizations, including the Venezuelan society of puericulture and paediatrics. The Health Education Department of the Ministry of Health and Social Welfare had prepared promotional material for distribution by the relevant services. UNICEF had provided financial support for the promotion of breast-feeding by means of a publicity campaign which had yielded positive results. Venezuela's major paediatric institution, the Children's Hospital (Santa María de los Ríos) in Caracas, was the headquarters of a recently created association for breast-feeding, which would be an important factor in promoting breast-feeding in the country. Although proper feeding in the first six months of life was of fundamental importance, proper feeding in the first year was equally important. Table 2 of the Director-General's report showed that, except in one region - the one including Democratic Yemen, India, Islamic
Republic of Iran, Philippines and Yemen - the highest levels of malnutrition occurred in children aged one year. A workshop on that topic had been organized in Venezuela in September 1983 by the Ministry of Health and Social Welfare in association with other organizations, including six Venezuelan universities, the Venezuelan society of puericulture and paediatrics, the national institute for nutrition, the national institute for social security and the Venezuelan nutritional society. That workshop had recommended breast-feeding alone during the first six months of life. A group of experts from many disciplines had been set up to prepare a pamphlet giving guidelines to mothers in the poorer areas on the preparation of home-made foods for the first year of life. The pamphlet contained illustrations together with a simple text, and had been widely distributed.

Recent observations had shown improvements in nutritional status in Venezuela, especially in relation to body measurements, anaemia, low birth weight, xerophthalmia, and goitre in young children, and in maternal nutrition. Those observations, together with the results of a recent national nutrition survey, would be communicated to the Director-General.

Dr WESTERHOLM (Sweden) noted that "Children's health - tomorrow's wealth" had been the theme for World Health Day in 1984. The Director-General's excellent report contained many examples of the steps that might be taken to deal with factors responsible for malnutrition and gave hope for an improvement in children's health.

The influence of smoking during pregnancy should not be forgotten in considering low birth weight. The adverse effects of smoking were increased in women suffering from malnutrition. Furthermore, studies had shown an increase in perinatal mortality and morbidity among the children of women who smoked.

She agreed that the adoption of a primary health care strategy was the key to success in improving the health and nutritional status of women, infants and young children. Primary health care could, for example, provide health education on the hazards of smoking and alcohol abuse during pregnancy and breast-feeding.

Breast-feeding had nutritional, immunological and psychological benefits. It also influenced child spacing. It was gratifying to note, therefore, that so many Member States had taken steps to comply with WHO's International Code of Marketing of Breast-milk Substitutes. In addition to the information given in the Director-General's report concerning the implementation of the Code in Sweden, she reported that an agreement had been reached, in November 1983, between the National Board for Consumer Policies and the relevant commercial companies, whereby the latter would abide by the recommendations of the Swedish authorities and by the WHO Code in their activities both in Sweden and abroad.

The Swedish adaptation of the Code was particularly concerned with nutritional products for children up to the age of six months. Several other countries had also reported marketing regulations for infant formulas. Although this was to be welcomed, the importance of timely weaning products should not be overlooked. The proper use of weaning food and marketing and weaning practices should be given special attention in the continuing evaluation of the implementation of the Code.

Dr BEHAR (Guatemala) felt that it was appropriate to present a follow-up of the programme on the feeding of infants and young children in the context of world nutrition. He appreciated the efforts that had been made to evaluate nutritional trends in the regions. While recognizing that the information available was not as reliable or accurate as was desirable, it was nevertheless useful to analyse such data, while at the same time taking steps to improve them. He therefore congratulated the Director-General on the report.

He was concerned that, in the introduction to the report, malnutrition was defined as a medical and biological problem, without proper regard for the social aspects in both its epidemiology and its repercussions. He had already expressed his appreciation of the analysis of trends, and was glad to see that significant progress had been achieved in the control of malnutrition in a few countries; in many others, however, the situation had remained at an unsatisfactory level or was deteriorating. That was not clear from the report, and complacency was surely dangerous in the face of a problem of such magnitude.

He wished to clarify the statement made in paragraph 48 of the report that sugar fortified with vitamin A was being distributed through the maternal and child health services of the primary health care system in Central America. The fortification of sugar had been adopted in Guatemala and other Central American countries because vitamin A deficiency was a major cause of blindness in children. All the sugar consumed by the population at large was fortified in that way but was supplied through the normal commercial channels and there was no special means of distribution.1 The measure had been inspired by the success in the

---

1 In the light of this clarification the statement in question was deleted from the report as reproduced in document WHA37/1984/REC/1, Annex 5.
control of goitre, achieved by the compulsory iodization of salt, and was based on the need to reach large sectors of the population that were not otherwise easily accessible; in addition, consumption of the fortified sugar was not harmful to those who had no deficiency, and the measure was relatively inexpensive.

He noted with satisfaction the balance that had been achieved among the different components of the infant and young child nutrition programme; while the promotion of breast-feeding and the marketing of breast-milk substitutes had not been ignored, efforts had also been made to improve weaning practices, the education of health staff, and the social conditions of women - all matters of great importance in child malnutrition where greater efforts were still needed. He welcomed the proposal that special attention should be paid to vitamin A deficiency, although experience had shown that there were few circumstances in which such problems could be tackled in isolation. For effective action, as suggested by the delegate of Trinidad and Tobago, problems of nutrition in the second year of life should be seen in conjunction with those of the breast-feeding period, continuing and extending the efforts made during that period. In countries such as Guatemala, problems of malnutrition frequently arose because complementary foods were given too early or too late and were unsatisfactory. Measures for the control of the marketing of breast-milk substitutes and the promotion of breast-feeding should not be isolated from those for the control of complementary foods, which were also often marketed in inappropriate ways, as had been emphasized by the delegates of Swaziland and Sweden, whose initiative he strongly supported.

Dr WARD-BREU (Ghana) commended the summary presented in the report, noted the critical situation in Africa, and welcomed the retention of the five-theme framework used in previous reports.

As mentioned in the report, while there was a need to protect and maintain breast-feeding, the main priority in African countries was that of the weaning diet and how to make the best use of local, low-cost and highly nutritious foods. He was therefore pleased to note that WHO had helped several African countries, including Ghana, to develop guidelines on infant feeding. In Ghana, the guidelines finalized by the national nutrition committee had been translated into eight different national languages. UNICEF was printing 10 000 copies of the initial English text. Earlier 2000 copies of similar guidelines for field personnel had been produced and distributed by the secretariat of the FAO/WHO/OAU Regional Food and Nutrition Commission for Africa, in Accra, and the Nutrition Division of the Ministry of Health.

Paragraph 88 of the report drew attention to the nutritional surveys being undertaken in Ghana. Apart from some small surveys on breast-feeding, more complete ones, including surveys in infant feeding practices, individual dietary intakes and the nutritional status of vulnerable groups, had been undertaken six months earlier by the Ministry, with the help of UNICEF, in four villages in the Eastern Region and four in Brong-Ahafo; there appeared to be severe problems in the former but not in the latter. Currently, follow-up surveys were being done in the same villages and steps were being taken to organize ongoing surveillance and remedial measures, such as local production of weaning foods. In another village in the Central Region, surveys of dietary practices, nutritional status and agricultural practices had been undertaken in 1983. A similar survey was to be carried out in a village in the Volta Region in 1984, with the collaboration of the secretariat of the joint Commission. In both villages, the main focus was on women's groups, which had established a community farm producing legumes with a view to making weaning foods (cereal/legume mixtures) in the local corn mills, as recommended by the joint Commission. The first batch had already been made in the Central Region and production in the Volta Region was to be started in June 1984. The projects, which were fostered by the Community Development Department of the Ministry of Rural Development, were characterized by keen community participation.

The WHO budget provided funds for the nutrition programme in 1984-1985. In Ghana, it was hoped to provide equipment for a national nutritional surveillance programme and a minicomputer for processing survey data. The Nutrition Division, with the help of UNICEF, was going to establish a rapid-survey team in each region of the country. Such teams would permit the rapid identification of problem areas and the initiation of ongoing community-based surveillance, nutrition education and the local production of weaning foods. The projects in the Northern Region, which were also mentioned in paragraph 88, had not yet been started owing to a lack of response from the expected donor. Efforts were being made to find a donor but, in the meantime, the project would start, with UNICEF support, with rapid surveys, nutritional surveillance and local production of weaning foods.

His delegation wished to be included in the list of co-sponsors of the proposed draft resolution on prevention and control of vitamin A deficiency and xerophthalmia.

Dr SADRIZADEH (Islamic Republic of Iran) said that the main problem of the developing world appeared to be hunger due merely to poverty; there were 750 million people living in
the poorest countries of the Third World with a per capita income of less than US$ 75 per year. According to UNICEF, 25% of children in the developing countries were suffering from invisible malnutrition, which meant that they were more likely to contract diarrhoeal and respiratory infections; the probability of their dying during the first year of life was three times greater than that of children who had been properly fed. Malnutrition impeded the physical and mental growth of the child, making learning more difficult in childhood and adequate productivity almost impossible in adult life, with the result that poverty was intensified. Urgent action had to be taken by affluent countries and by international organizations to interrupt the vicious cycle of malnutrition, low energy, low productivity, and finally more severe malnutrition, otherwise the goal of health for all by the year 2000 would never be achieved.

His Government considered the nutrition of pregnant women, lactating mothers and children under two years of age to be one of its main health priorities. Food supplements were being provided to 30% of the nation's children attending maternal and child health clinics. Because of war and budgetary constraints, only a small proportion of pregnant women had been covered by nutrition support programmes. A campaign had been launched to encourage mothers to use local foods. Breast-feeding up to the second year of life was highly recommended by Islam, and most Iranian mothers breast-fed their children. The Government had assumed monopoly rights with regard to the importation and distribution of breast-milk substitutes and was endeavouring to reduce the number of brands available locally.

Breast-feeding was also being encouraged by religious leaders and through the publication of pamphlets and the broadcasting of educational programmes on national radio and television.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that without satisfactory and adequate infant and young child feeding, especially in the developing countries, the successful implementation of a number of WHO programmes and the achievement of the goal of health for all by the year 2000 would not be possible. In his country, work to promote breast-feeding had been initiated long before the adoption of the International Code of Marketing of Breast-milk Substitutes and was closely associated with the creation of appropriate conditions for pregnant women and lactating mothers. All breast-milk substitutes were subject to careful quality, microbiological and health controls, although much still remained to be done. In cooperation with WHO, scientific research was being carried out on the social and biological aspects of breast-feeding. Unless mothers themselves were adequately and appropriately fed, breast-feeding could hardly be completely satisfactory, and unless the International Code of Marketing of Breast-milk Substitutes was strictly complied with, the same would be true of breast-milk substitutes; in either case the normal development of the child would be impeded. The work done by WHO, by other organizations and by Member States to implement the Code and to promote breast-feeding and decrease the use of breast-milk substitutes and the related advertising was therefore both important and timely.

Dr PRIETO (Argentina) said that the unfortunate circumstances through which his country had lived from 1976 to 1983 had produced a serious food shortage among large sectors of the population, with a considerable increase in child malnutrition. The new Government was tackling the problem from a number of different angles. The Ministry of Health and Social Affairs had launched a campaign to promote breast-feeding up to at least four months of age among all social classes, thereby reversing a trend towards greater use of breast-milk substitutes. Parliament was currently considering a bill which would facilitate breast-feeding up to at least six months of age.

It had also been found necessary to protect mothers and other persons at risk against the danger of malnutrition, special attention being given to proteins and essential vitamins. The Ministry of Health and Social affairs had prepared a bill establishing a national food programme, which had just been unanimously approved by Parliament and was beginning to be implemented throughout the country. Hunger and malnutrition in Argentina were not due to any real shortage of food, which abounded in the country, but to the lack of means with which to pay for it. Solutions at the economic and social levels were therefore needed. The Government had taken emergency action to bring relief quickly to the hungry, especially children and pregnant women. Under the national food programme packages containing 14 kg of non-perishable supplementary foods that varied according to regional feeding habits were delivered twice a month through a special distribution network to a place as near as possible to the recipient's home, thus promoting the habit of eating at home with the family rather than in a collective dining room. The programme was also linked to other health activities, such as health education, hygiene, correct cooking and eating habits, monitoring the height and weight of children under six years of age, and prenatal examinations of pregnant women. Advice was also given on general health problems.

Although precise figures regarding the number of persons living below the poverty line were not available, it was estimated that the programme would initially cover 500 000
families, or almost 9% of the total population. The population was widely scattered and the physical geography of the country varied considerably, making it extremely difficult to achieve total coverage of the population at risk; it was hoped that 25% would be covered by the end of the first year and at least 50% by the end of the second year. The first groups to be covered by the programme would be the industrial populations of the large cities. A campaign had also been launched to promote food production on family and community plots and farms and at schools, with a view to making large sectors of the population self-sufficient.

His Government would greatly appreciate the assistance and technical cooperation of all countries and international organizations, particularly WHO and UNICEF, at such a critical juncture.

Dr MANTRA (Indonesia) said that malnutrition was a major problem in his country, especially among children under five years of age. A lack of breast-milk was considered to be one of the underlying causes, particularly in the case of the children of working mothers in urban areas. In rural areas the problem was not so great because most rural mothers breast-fed their children, but it had been difficult to determine what kind of supplementary food should be given and when it should be given. In some rural areas supplementary food was already being provided during the first week of life in the form of mashed rice or bananas. Mothers normally fed their babies only from the left breast, with the result that the babies did not receive enough milk.

In urban areas attractive ways of marketing breast-milk substitutes had persuaded mothers to feed them to their babies. Various campaigns to promote breast-feeding had been undertaken under the auspices of a national coordinating forum. The new regulations for the marketing of breast-milk substitutes were due to enter into force in 1984. In addition to the Ministry of Health, the Ministry for Women's Affairs had an important programme to promote breast-feeding.

Professor SENIAULT (France), after noting the serious problem of malnutrition in many parts of the world, said that, in order to encourage breast-feeding, his Government and other institutions had long been engaged in public information and education campaigns aimed especially at girls and young women, health workers, and, in particular, midwives, whose attitude could be very influential at the time when the mother— to-be entered the maternity hospital; that was specially important in France, where most births took place in such hospitals. Particular attention was being paid to the effects which heavy smoking during pregnancy could have on birth weight. Pertinent legislation had been enacted and regulatory provision had been made for the necessary social support measures, including measures to ensure that working mothers were provided with special rooms at their workplaces where they could breast-feed their babies during the first few months of life.

His Government attached great importance to the question of the appropriate marketing and distribution of breast-milk substitutes. Manufacturers had been officially reminded of the regulations prohibiting the distribution of free samples of such products in maternity hospitals and their sale in such hospitals at other than normal commercial prices. A study of a representative sample of public and private maternity hospitals carried out in 1982 had shown that the practice of offering free samples had decreased but had not disappeared, and the Government was therefore watching the situation carefully. Breast-milk banks were also being developed for the benefit of certain categories of infants. Preparations were being made to convene an interministerial meeting at which officials and manufacturers would consider the drafting of a code of advertising.

Miss BELMONT (United States of America) commended the Director-General on his comprehensive report. Her delegation appreciated the need for more reliable data, but nevertheless found the information given on trends and the current status of infant and child nutrition of great value. Her delegation was also pleased to see improvements, however slight, in the various indicators of nutritional status. Further improvements were obviously required in almost all the regions to enhance the nutritional status of infants and young children, especially to reduce the proportion of low-birth-weight infants and the prevalence of protein-energy malnutrition, nutritional anaemia and vitamin A deficiency. The United States Government was committed to a policy of promoting and encouraging sound infant nutrition practices, including the promotion of breast-feeding. Prenatal programmes had been designed to identify high-risk pregnant women in order to minimize the possibility of low-birth-weight infants. Programmes in supplementary feeding for nursing mothers, postnatal leave from work, and education had been designed to promote breast-feeding and appropriate postnatal care. A woman, infant and child feeding programme provided basic foods for lower income groups to ensure an adequate level of nutrition for mothers and children. Those services, combined with the normal maternal and child health services, provided a solid base
for infant and young child nutrition. It was worthy of note that United States data continued to show an increase in the percentage of women breast-feeding their children after discharge from hospital.

The United States delegation urged the Director-General to continue to utilize his resources to the greatest extent possible in technical cooperation activities designed to reduce nutritional deficiency diseases. Through its Agency for International Development (USAID), the United States was actively involved in programmes designed to improve the nutritional status of mothers and children, in cooperation with United Nations agencies. In 150 cooperative primary health care projects in 50 countries, USAID's maternal and child health programmes were a major focus, with emphasis on oral rehydration therapy, immunization, promotion of breast-feeding and of weaning practices using local foods. In addition, USAID was assisting more than 70 countries with family planning programmes with emphasis on birth spacing, and with programmes for the provision of basic foods through supplementary feeding projects for undernourished children and mothers.

In the area of food production, USAID was assisting some 50 countries with agricultural programmes, including support for agricultural research institutes in Asia, Latin America, Africa and the Middle East. Support was also being provided for nutrition and health services research to reduce diarrhoeal diseases which interfered with the child's ability to absorb nutrients, and for the provision of basic food supplies to many parts of the world, especially countries suffering from drought or climatic disasters. Much still needed to be done to improve infant and child nutrition, but it was to be hoped that programmes such as those described would help alleviate the incidence of nutritional deficiencies referred to in the Director-General's report. WHO was in the meantime to be congratulated for its leadership and technical accomplishments in that field.

Dr KEAN (Australia) commended the Director-General on his excellent progress report. An additional activity being undertaken in Australia had not been covered in Part II of that report. A working party of the National Health and Medical Research Council had been set up to develop guidelines for the implementation by the health sector of the International Code of Marketing of Breast-milk Substitutes. During the past year its terms of reference had been expanded to include the development of national guidelines in five general areas of concern: education of the public, prenatal care, hospital practices, post-hospital or discharge practices, and special education programmes for health professionals. The working party consisted of maternal and child health specialists representing the state, federal and territory health authorities and representatives of the Australian colleges of paediatricians, obstetricians and gynaecologists, the aim being to establish national guidelines in those areas in terms of practice and for possible future legislation at federal or state levels.

Professor HAVLOVIC (Austria) said that the Austrian Foodstuffs Act provided the legal basis for practical measures concerning infant and young child feeding in accordance with the International Code. The Federal Ministry of Health and Environmental Protection had endeavoured to achieve a voluntary agreement with the infant food industry on commercial advertising, marketing and distribution of breast-milk substitutes, and particularly product samples. The discussions had been attended by representatives of the relevant government institutions, the infant food industry and nongovernmental organizations (for example, the Austrian Society of Paediatrics and the consumers' organization). Furthermore, a special information and promotion programme had been prepared by the Federal Ministry to back up education and information with regard to infant and young child feeding and to encourage breast-feeding; it included the publication of an information booklet for mothers distributed through hospitals, maternity consultation centres, gynaecologists and paediatricians. Another information booklet for physicians, midwives and other health personnel dealt with organizational aspects in the same field. In 1983 a public health research grant had been awarded for a survey on the status of infant and young child feeding which was also expected to reveal the effectiveness of the latest recommendations on the subject by the Austrian Society of Paediatrics. A further public health research grant for a survey on the encouragement of breast-feeding in health institutions was to be awarded in the near future.

The combined effect of all those measures and activities had been to increase the awareness of the Austrian population in matters of infant and young child nutrition and stimulate the interest of the health institutions and infant food industry in improving the present situation in accordance with the International Code and resolution WHA33.32.

Dr Sung Woo LEE (Republic of Korea) said that, as far as the promotion of breast-feeding in his country was concerned, activities in the government sector included information and
education through the distribution to health care institutions of posters bearing appropriate slogans, and maximum utilization of the media to emphasize the value of breast milk and give advice on the management of breast-feeding, weaning and weaning foods. In addition, breast-feeding was included in the training curricula for health personnel and members of women's groups. Guidelines on breast-feeding had been issued to health care institutions, covering rooming-in procedures for mothers and infants in maternity wards, the establishment and operation of maternal and child health consultation services and the prohibition in health care institutions of sales promotion activities for infant formulas. Guidelines had also been issued to manufacturers on the marketing of breast-milk substitutes, which included self-regulatory restrictions on the advertising of breast-milk substitutes and the compulsory inclusion of a statement on product labels indicating the superiority of breast milk.

In the private sector, training programmes on breast-feeding had been established by health-related associations such as the Korean Hospital Association, Korean Medical Association, and Korean Nursing Association. Those programmes were being carried out by the Korean Citizens Alliance for Consumer Protection, a nongovernmental organization affiliated to the International Organization of Consumers Unions. Among its objectives were the promotion of public awareness of the importance of breast-feeding, the development of materials for the information and education of the general public, and of manuals for training breast-feeding promoters and conducting training courses for promoters from all the relevant sectors. In the field of research, studies on nutrition with special emphasis on breast-feeding and supplementary foods were being carried out by the Korean Institute for Population and Health.

Regarding future activities, the Government had formulated a plan which included the amendment and revision of existing laws (for example, upgrading standards for the quality control of baby foods), support for the development of materials and channels for effective information and education and promotion of locally available weaning diets, reinforcement of the promotion of breast-feeding in close cooperation with maternal and child health programmes, the provision of paid maternity leave, paid breast-feeding breaks, and inducement to provide crèches for working mothers. In the private sector, future activities included the encouragement of all health workers to promote breast-feeding practice, and support for the activities of women's and other groups for the promotion of breast-feeding.

Finally, he expressed thanks to the Regional Office for the Western Pacific for help in formulating programmes, particularly a one-year education and information programme to encourage breast-feeding which was now under way.

Dr HYZLER (United Kingdom of Great Britain and Northern Ireland) expressed his delegation's appreciation of the highly informative and interesting report of the Director-General. It shared the concern expressed by previous speakers about the present state of infant malnutrition in many parts of the world, but the many and varied initiatives being taken at national level and by WHO and other international health agencies to promote and support breast-feeding were encouraging. A great deal more was still required, but the trends were in the right direction.

The United Kingdom Government had for many years been committed to a policy of support and encouragement for the promotion of breast-feeding and good infant feeding practices. Various reports issued over the past 10 years had recommended that professional staff should encourage mothers to breast-feed and ensure that parents received adequate advice to enable them to make informed choices. Health authorities had been encouraged to provide the resources and facilities necessary for the promotion of breast-feeding, including the provision of education in schools, ante-natal clinics, maternity units and at family level. Special attention had also been given to the particular needs of ethnic groups. A survey commissioned by the Government in 1982 had indicated that the initiation and maintenance of breast-feeding had increased significantly since 1975.

As indicated in the report, the United Kingdom had taken positive action to implement the aims and principles of the International Code and the provisions of the Code had been used as a basis for a code of practice for the marketing of infant formulas. Special baby foods required prior approval by the Ministry of Agriculture, Fisheries and Food and the Department of Health and Social Security before they could be placed on the market. The code of practice had been produced by the United Kingdom Food Manufacturers Federation in consultation with the Department of Health and Social Security and Ministry of Agriculture, Fisheries and Food, and circulated to all health authorities in the United Kingdom with a request that action should be taken in certain specific fields directly concerning the work of health care professionals in order to implement fully the International Code. In addition, a monitoring committee, consisting of members nominated by the Government from among health care professionals, consumer interest groups and members of the Food Manufacturers Federation, was being established to monitor compliance with the Food Manufacturers Federation Code, and would start work later in the year.
The United Kingdom Government continued to support the activities being undertaken by WHO in the field of infant and young child nutrition and in the wider programme of family health promotion.

Dr NDLOVU (Zimbabwe) said that a widely distributed booklet on breast-feeding had been enthusiastically received in her country. Its major focus had been on the many dangers associated with bottle-feeding and the superiority of breast-feeding. In 1982, following the publication and distribution of the International Code, her country had felt the urgent need to have its own code on breast-milk substitutes. It had accepted that legislation was essential for the implementation of such a code if the exploitative machinations of manufacturers of breast-milk substitutes were to be reduced to a minimum; an intersectoral committee had therefore been set up, including high-level representatives of such sectors as education, community development and women's affairs, local government, labour and social services, legal and parliamentary affairs, commerce and industries, municipal services and nongovernmental organizations. In addition to preparing a national code the committee had drawn up a strategy to ensure that consistent information on infant and young child feeding was disseminated to all sectors of the community and that teachers and community workers were provided with appropriate health-promotive information to enable them to complement the activities of health workers. The committee had prepared a document which was undergoing legal drafting prior to being submitted to the Cabinet. It had laid down directives relating to advertising, distribution of samples and bulk marketing of breast-milk substitutes, which had been approved by the Minister of Health and distributed to health institutions and to manufacturers of breast-milk substitutes. As a measure to strengthen mother and child health services the activities of traditional birth attendants were being coordinated and supported by the Ministry of Health and other relevant government departments; that was particularly important in Zimbabwe since the activities of traditional birth attendants continued well beyond the delivery stage into early childhood. Another major area where the committee had been active was that of maternity leave. Since national independence, unpaid maternity leave of 90 days for all civil servants had become a right, the employee's job or promotion opportunities were no longer jeopardized as had previously been the case, because maternity leave had come to be considered as essential to enable the family to adapt and prepare for the new baby and its care within the home. Another related issue under study was provision for time off during working hours for breast-feeding mothers upon their return to work. Health education, including information on breast-feeding, weaning foods and nutrition in general, was being made available to those involved in national literacy campaigns, under the auspices of the Ministry of Community Development and Women's Affairs. Breast-feeding and the nutrition of young children continued to occupy a very important place in the national primary health care strategy, and the community was becoming increasingly aware of the strong social, economic, physical, psychological and cultural advantages of breast-feeding.

Dr RWASINE (Rwanda) said that the field of application of the International Code should extend to all products having the effect of discouraging breast-feeding. There were situations where provision of food aid created a false impression among local populations, who came to believe that local products were inferior and that only imported products could offset malnutrition. Whenever aid was discontinued, in some instances very abruptly, the population became further alarmed and more dependent on it. Breast-milk substitutes, for example, were often distributed as food aid at maternal and child health centres, so that many mothers came to believe that their own milk was inadequate and that bottle-feeding was essential. In applying the International Code at the national level the country's actual situation must be borne in mind, and it should be recognized that many products were being misused as breast-milk substitutes. The Code should therefore apply to all commonly used products, even when they were not sold expressly as breast-milk substitutes. Traditional diet had been distorted by the temporary and haphazard introduction of foods the nutritional value of which was in many cases inferior to that of local foods.

Dr AL-JABER (Qatar) said that it was distressing to observe the extensive continued use of breast-milk substitutes, indicating that mothers doubted that their milk was best for their babies. The implications of the marketing of breast-milk substitutes must be most carefully examined, and a high standard of supervision of the nutritional content of substitutes ensured. His delegation presented the following draft resolution:

The Thirty-seventh World Health Assembly,
Recalling resolutions WHA27.23, WHA32.47, WHA33.32, WHA34.22, WHA35.26, which dealt with infant and young child feeding;
Recognizing that the implementation of the International Code of Marketing of Breast-milk Substitutes is one of the important actions required in order to protect healthy infant and young child feeding;
Recalling the discussion on infant and young child feeding at the Thirty-sixth World Health Assembly, which concluded that it was premature to revise the International Code at that time;

Having considered the Director-General's report\(^1\) and noting with interest its contents;

Aware that many products unsuitable for infant feeding are none the less promoted for this purpose in all parts of the world, and that some of these products may not be considered to be covered by the International Code;

1. ENDORSES the Director-General's report;

2. URGES continued action by Member States, WHO and nongovernmental organizations to put into effect measures to improve infant and young child feeding;

3. REQUESTS the Director-General to continue to support Member States in their efforts for monitoring the implementation of the International Code as a minimum measure at national level and to report to the Thirty-ninth World Health Assembly on any measures needed to further enhance the effective implementation of the Code in its entirety.

The CHAIRMAN requested the delegate of Qatar to communicate the text of the draft resolution in writing to the Secretariat.

Dr CABRAL (Mozambique) said that child nutrition continued to be a subject of great concern in his country. Efforts were being continued to ensure that children formed a priority group in terms of health, growth and development, but they had been hampered by the enormous natural and manmade problems besetting the country, including the effects of drought and subsequent flooding in the central and southern provinces, and acts of aggression by armed bandits. As a result, in the areas affected, there were alarming degrees of undernutrition, mortality and morbidity. Children were an important target group for nutrition rehabilitation programmes being undertaken in those areas with the technical and material support of the international community. Collaboration continued with the food industry in feasibility studies, acceptance trials and efforts to produce weaning foods locally to replace those currently being imported. The National Food and Water Hygiene Laboratory of the Ministry of Health was continuing to control the quality of infant feeding products proposed for import. It had also been involved in ensuring that the standards of the Codex Alimentarius were maintained for products currently being imported. In accordance with resolutions WHA33.32 and WHA34.23, his Government had offered to the Regional Office for Africa the services of the National Food and Water Hygiene Laboratory, and hoped that a regional network for hygiene safety control would soon become operational.

Considerable progress had been made in the implementation of the International Code in Mozambique; a campaign to promote breast-feeding had included the preparation of posters and a film on the topic to be shown throughout the country and was supported by the national press and the Government. In the second part of 1983 a system had been introduced in Maputo for controlled distribution of breast-milk substitutes and other infant foods for babies who could not be breast-fed, for such reasons as illness or death of their mothers, and children of women workers obliged to leave their babies at home from two months of age onwards because of lack of facilities in their places of work. Breast-milk substitutes were given only to babies up to the age of six months and only on prescription from the health centres, to which all newborn babies had to be brought as part of the maternal and child health programme. Although controlled distribution had not yet been extended to other urban centres, many provinces had started to control the use of artificial milk products and breast-feeding was being promoted as widely as possible. Efforts were being made through the establishment of day-care centres to guarantee to an increasing number of working mothers adequate conditions at their places of work to enable them to continue breast-feeding. It was hoped by such activities to maintain the use of breast-milk substitutes at as low a level as possible. Specific projects were to begin very shortly in at least one area of the country with the aim of making optimum use of the benefits of increased agricultural production in order to improve child health and nutrition. The International Code was an integral part of the course on infant feeding followed by all categories of health personnel during their professional training.

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

The meeting rose at 13h00.

---

\(^1\) Document WHA37/1984/REC/1, Annex 5.
GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000: REPORT ON MONITORING OF PROGRESS IN IMPLEMENTING STRATEGIES FOR HEALTH FOR ALL: Item 19 of the Agenda (Resolutions WHA34.36, WHA35.23, WHA36.34, EB73.R3 and EB73.R6; Documents EB73/1984/REC/1, Annex 1, A37/4, A37/5 and A37/INF.DOC./6) (continued from the third meeting)

Dr MATTHEIS (Federal Republic of Germany) said that all speakers had unanimously supported the goal of health for all by the year 2000 and the importance of monitoring as an instrument for reaching that goal. She fully agreed with the delegate of the United Republic of Tanzania that the data collected should be standardized and adjusted to suit the situation in the specific region or country. She also agreed with the statement made on behalf of the Nordic countries; average data might conceal the range of variation existing even within one country and was not therefore an adequate foundation for decision-making and effective action. Hence it was essential in future to improve the technique of data collection and analysis, and her Government wished to cooperate with other countries, both developed and developing, in that regard.

Her Government also hoped for more intensive collaboration with the developing countries in setting up and carrying out programmes for primary health care, on the understanding that priorities for technical cooperation in the field of health were established within those countries.

Although, despite the efforts made, shortcomings in monitoring had been found and slower progress had been made than was hoped for, all should, nevertheless, pursue the primary health care concept until the common goal was reached. In that spirit, her delegation supported the draft resolution proposed by the Executive Board in resolution EB73.R6.

Dr JADAMBA (Mongolia), after congratulating the Executive Board on its excellent report (document A37/4), said that his Government attached the highest priority to providing comprehensive medical care to the entire population of the country and had taken a number of steps to ensure the most efficient utilization of the existing health infrastructure.

National health strategies had been developed with clearly defined objectives, in which public health care was interpreted as a properly coordinated comprehensive medical and social service ensuring the constitutional right of the people to enjoy a state of health that would permit them to lead socially and economically meaningful lives.

The people's health had been made the concern of all governmental, nongovernmental and voluntary organizations, as well as of each individual in the country. However, it was still necessary to take steps to mobilize active participation by the community in formulating and implementing health plans. His delegation believed that the Board's report would be useful as a basis for the future assessment of health-for-all strategies at the global level; that WHO initiative should receive every possible support from Member States.

He noted that not all countries had been in a position to provide the data required and suggested that the Organization should look into the situation carefully to find out the reasons for that situation. It should also see whether the information provided was correct and reliable with a view to helping countries to develop proper information systems, which could be used as a springboard for action.

It was discouraging to note that, although countries had been invited in 1979 to formulate national health policies and strategies and plans of action for attaining the goal of health for all by the year 2000, only 87 out of 129 developing countries had so far developed their strategies. It was high time to expedite that process, in view of the urgent need for such strategies to determine the internal and external resources required for achievement of the goal and for establishing the necessary health priorities and restructuring the health infrastructure.

In his country there were no political, social or economic factors causing any group of the population to be underserved in terms of health facilities but, because of the vast territory to be covered and inadequate transport and communication facilities, there were difficulties in providing medical and health care to the rural population. With a view to improving the situation, his delegation fully supported all WHO efforts to monitor progress in implementing strategies for health for all and he supported the Executive Board's draft resolution.

Dr GURMUKH SINGH (Malaysia) said that it was encouraging that the two concise but comprehensive reports (documents A37/4 and A37/51) before the Committee provided such a clear picture of the global health situation barely three years after the adoption of the Global Strategy. It was now necessary to identify the reasons for the difficulties faced by some countries in responding to the call for information. In view of the high rate of non-response from the more developed Regions, he inquired whether many countries in those Regions felt that some of the existing indicators were of little relevance in monitoring their progress. If that was so, it might be necessary to seek alternative solutions in order to get a more favourable rate of response.

So far as the developing countries were concerned, he noted that their basic health information systems urgently needed upgrading and believed that the Health Assembly needed to pay serious attention to that weakness.

He was not convinced that the returns submitted by many developing countries regarding the percentage of their GNP spent on health gave a true picture. He thought that in many cases they indicated only the percentage spent by the government health sector and hence the data collected did not allow meaningful comparisons to be made. Although many useful documents on the subject had been prepared by WHO, adaptation still posed practical problems and he doubted whether the situation could be changed unless further guidance was made available. In many developing countries good-quality health care was provided by traditional health workers and their contributions were not easily costed.

He further asked what use was to be made of the information in the two reports before the Committee. The essential feature of any monitoring system was that it should lead to positive action, and the Organization must not make the mistake of concentrating only on improving the monitoring system itself to the detriment of future action.

He appreciated the Director-General's comments on the need to strengthen the managerial capabilities within national health systems which, he was convinced, would be a major determinant of the success or failure of their efforts.

The reply to the Director-General's question as to why the documents prepared by the Managerial Process for National Health Development unit were not more extensively used might merely be non-awareness of their existence or non-availability. The question should be looked into.

He was pleased to note the statement in paragraph 18 of the Board's report that "a high level of political sensitization to the goal of health for all has taken place", but the report did not state what effect that sensitization had had in bringing about significant changes in health policies resulting in: (a) developing action plans aimed at social equity; (b) giving priority to less advantaged groups; and (c) placing emphasis on the key elements of primary health care.

The process of political sensitization must be seen as a multi-stage one, of which the first stage had been successfully achieved by securing the agreement of the political leadership to the concept of health for all by the year 2000. It was necessary, as the next stage, to identify more specifically the further steps that needed to be taken to convert political acceptance into political action, and that might be one of the major areas to be stressed in the coming years. The monitoring system would then be seen in its proper perspective as the tool whereby the critical areas where efforts were needed at national level and the supportive role of WHO in relation to those efforts could be identified.

In conclusion, he supported the Executive Board's draft resolution proposed in resolution EB73.R6.

Dr SOFO (Niger) welcomed the report of the Executive Board, which was a valuable working tool, and the comments on it by the Director-General.

In Niger, health programmes had for long been drawn up at the central level but, since 1975, with the introduction of new development structures, the people themselves had been more closely associated with decision-making at all levels in matters of health care. Health structures, like administrative structures, had been decentralized. Each of the seven départements had a hospital, which was concerned chiefly with curative medicine, and a

---

1 Document WHA37/1984/REC/1, Annex 3, parts 1 and 2.
departmental directorate, which organized primary health care through medical centres, medical posts, rural dispensaries and village health teams. Niger currently possessed 249 health centres and a training programme for primary health care workers was in operation.

In order to work effectively towards the achievement of health for all by the year 2000, it had been necessary to reorientate medical and paramedical personnel away from the old approach to health by providing information, increasing awareness and continuous training through seminars and re-training courses. In that process, his country had received international assistance, for which it was grateful. A nurse had to become at the same time a manager, an educator, a provider of care, and a permanent watcher over local health activities, working in close cooperation with illiterate voluntary village health workers whose training had not been carried out in the national language. In spite of the international aid received, the reorientation had not been an easy task because of the drought and the world economic recession. Numerous difficulties were encountered in the field, arising out of logistic problems and certain aspects of health education: how could people be taught correct nutrition in an area devastated by drought? Nevertheless, training of health personnel had been possible, thanks to a proper distribution of resources, 85% being set aside for rural areas as opposed to 15% for urban areas.

That had made it possible to achieve the active participation of the community in responsibility for its own health. Apart from respiratory disorders, which accounted for 14% of cases of disease, village health workers had participated in the control of malaria, accounting for 20% of cases, diarrhoeal diseases, accounting for 10%, wounds, accounting for 9%, and conjunctivitis and trachoma, accounting for 7%. Out of a total of 9000 villages in Niger, 4000 were served by 12 000 health workers, made up of illiterate voluntary midwives and first-aid workers. In 1983, the latter accounted for 43% of health training activities, and the former for 51% of deliveries throughout the country. The path followed had been a difficult but an effective one, and at present, although difficulties of all types had arisen, total coverage had been achieved. While Niger counted on international cooperation, it also recognized that the main effort had to be based on the complete and active awareness of the populations in the rural areas.

Dr KOINANGE (Kenya) recalled that his country had not only endorsed the concept of primary health care in 1978 but, in 1979, had initiated a rationalization of national health strategy by means of a document prepared by the Ministry of Health, which had subsequently become the basis of Kenya's development plan. Health services had been considerably influenced by advances in development made in other sectors, particularly with regard to education and communications. Furthermore, activities to promote development of water resources had had beneficial effects on health, although they were difficult to quantify.

The number of static rural health facilities had doubled over the past decade, and there were now 1204 such facilities, 30% of which were managed by nongovernmental organizations. With the exception of some districts with extreme environmental conditions, the great majority of the population had access to a health facility within 20 km of their homes, all such out-patient services being free. Since 1982, all rural health facilities were staffed by at least one qualified Kenyan, in most cases a nurse, and all government hospitals had at least one Kenyan doctor.

Despite that relative success in improving access to health facilities, it was fully realized that equitable distribution of health care had not yet been achieved, although the accessibility achieved would provide a basis upon which to build up other components of primary health care. Mobilization of local resources, which constituted the focus of the next four-year development plan, would afford a favourable opportunity for monitoring the progress of the national health strategy.

It was not his intention to provide statistics on the health situation in Kenya, but he wished to make particular mention of the infant mortality rate, which had been found to bear a direct relationship to the level of education of women, since the rate fell in districts where higher education was more widespread. That factor was also apparent with regard to the prevalence of malaria, a conclusion that was in no way surprising, since interaction in health development was to be expected. Consequently, government investment in education as well as in health was gratifying.

While the Kenyan health authorities were keeping a close watch on health indicators, it was most encouraging that there had been an improvement in the developed countries in respect of the infant mortality rate, as well as in some of the diseases currently facing developing countries, long before the discovery of the various vaccines, drugs and sophisticated equipment currently available, since it could be deduced that overall development constituted an essential ingredient in improving health status.

As part of its assessment of the necessary health reorganization in relation to primary health care, Kenya had requested WHO to make available a consultant to assist in a review of
The Ministry of Health and Social Affairs was training a group of individuals, called basic health agents, to cover each of the villages, which themselves selected those agents. They received appropriate basic training in primary health care, in accordance with the main causes of mortality in the area. Training was also provided to midwives in both delivery and infant care. The plan was directed by a coordinator at the national level, and was supported by other doctors and nurses responsible for ensuring coordination and supervision at regional and sectoral levels. Training courses were also taking place with the aim of solving the problem of supervision of the basic health agents. Those agents were generally required to educate the village population in such matters as handling food and water, sewage disposal, etc., to administer preventive drugs, to treat some symptoms and to refer cases to hospitals where necessary. Their activities also covered midwifery and infant care. During the first six months, drugs and materials were paid for by the Government, after which time the village was responsible, by means of contributions which made it possible for drugs to be purchased at a nominal price. Basic health agents received no payment from the State, and continued to carry out their normal agricultural or other work. However, in many villages, other members of the community devoted some of their time to working on the agents' land or gave them some agricultural produce in appreciation of services rendered. That was evidence of the favourable reception that the plan had received. The number of basic health agents had risen from 149 to 366 over the past three years, during which time the population covered had increased from 28,000 to 44,700.

Much still remained to be done in Guinea-Bissau before the goal of health for all by the year 2000 was achieved. The obstacles to the achievement of that aim were fully realized, and Guinea-Bissau counted on the support it would receive to that end from WHO, friendly countries and nongovernmental organizations. He supported the draft resolution proposed by the Executive Board.

Dr. FANNENBORG (Netherlands) stated that his delegation had been impressed by the contributions to the debate, and more particularly by the candid nature of the reporting on the progress made towards the goal of health for all by the year 2000 in the various countries. It had accordingly become apparent how important it was for WHO to take more specific account of the structural and other serious problems facing many countries, which might even take precedence over the priorities embodied in the Global Strategy. Certain national and international problems were of a nature and magnitude which demanded that health action be taken only in a strongly intersectoral framework if true progress were to be made.

Commenting on a few aspects of the progress being made in the Netherlands towards the objective of health for all, he said that the monitoring of progress of national strategies to that end was experiencing all the difficulties that any new evaluation system generally encountered in its infancy. The Netherlands believed that monitoring progress was an essential part of the entire exercise of priorities, and that, without such a monitoring and evaluation system, approaches under the Global Strategy might well fade into oblivion. The report on monitoring progress was welcomed by his Government as a positive stimulus in the long road ahead in the field of structural health policy analysis in terms of strategies and targets for health for all by the year 2000.

The reorientation of the Netherlands health system was at present in one of its more active phases, although affected by the current economic stringency. The new Health Services Act and Health Care Financing Act were being harmonized with a view to merging planning and budgeting into one logical process. Primary health care had officially been given priority over hospital facilities but, in a complex and highly diversified country like the Netherlands, it should be realized that such reorientation was bound to take several years.
With regard to long-term plans, his Government had initiated the formulation of a "Health 2000 report", which provided an outline of strategic priorities up to the year 2000 and beyond, and presented a number of alternative scenarios, all specifically reflecting the corresponding strategies and targets, such as, for example, life-styles. Another development influenced by such strategies was the shift away from health care planning towards explicit health planning with an intersectoral approach, emphasizing the relationship between health and sectors such as housing, unemployment, social services, work ethics, economic development, etc. That approach was in principle based on an intersectoral health risk factor analysis of a single coherent national health system.

Important international conferences on health systems development had, however, stressed the difficulty of the concept of such a coherent system if it were to be fully in line with all the priorities and targets laid down under the Global Strategy. In terms of systems dynamics, some of them, such as, for example, the progress made in achieving social equity and in decentralization, might in time even be contradictory. The forthcoming WHO European conference on planning and management for health, to be held in The Hague in August of the current year, might well be instrumental in clarifying a number of those difficulties.

His country belonged to the group of countries where concern about the constant rise in health expenditure currently took precedence over almost all other priorities, and a direct drive was being mounted to mobilize resources only to the extent that they could be utilized effectively and have a real impact on the improvement of the health of individuals. A system of cost-effectiveness and efficiency was also being introduced in the Netherlands; that system was still in its early stages and its introduction would be a difficult task. Monitoring of progress in that field would, however, be increasingly necessary in order to arrive at a realistic evaluation of what constituted adequate mobilization of material and financial resources in the health field.

Coordination with environmental hygiene enjoyed traditional prominence in the Netherlands. Monitoring and reporting in that connection generally operated at a much higher level than the progress monitoring it was possible to report with regard to the health field. In policy terms, environmental hygiene had, in the past, been given priority over the health objectives under the Global Strategy for Health for All by the Year 2000 in more than one way, and had become an objective in itself.

Much of the Global Strategy and the monitoring, indicators and eventual targets appeared to be somewhat static in character. In keeping with the statement made to the plenary session by the Netherlands delegation, he therefore stressed the desirability of incorporating more dynamic elements into the Global Strategy and its monitoring. Since the problems of the year 2000 would to some extent be entirely different from those of the present day, there was a need to anticipate such changes and to adapt the strategies accordingly. Initiatives, such as the proposed European Health Futures Group in the Netherlands could provide a dynamic input.

In the light of the Technical Discussions that had just been held, he announced the intention of his delegation, together with a number of others, to submit in due course a draft resolution on the role of universities in the strategies for health for all.1

Mr WILLETT (Australia) pointed out that, after reaching a consensus on the objective of health for all by the year 2000 - the easiest part of their task - national health administrations, in cooperation with WHO as the coordinating body, were faced with the establishment of management reporting or information systems which would provide the framework for achieving the goal.

The Organization had made a first attempt to gather data from all Members with the aim of determining the point that each had reached. The outcome of the questionnaire on health indicators had been that a significant number of countries had not reported at all, others had found that they could only report partially and others, including Australia, had experienced difficulties in completing the questionnaire. For those administrators who had adopted or tried to adopt a management by objectives or similar management system, it would come as no surprise that at the end of the first cycle the outcome was far from perfect. However, deficient though the result was, it was an improvement on what had preceded it, namely, no information at all.

Some would argue that the cost of establishing information systems outweighed the advantages. He, however, would suggest that the cost of not having a proper and disciplined management framework was likely to be greater and that the inevitable outcome would be that the established goals and priorities would simply not be achieved. Inevitably, there would be difficulties in developing the management information system due to climatic, economic, cultural and social differences between Member States, which meant that common denominators would be elusive. That did not mean, however, that the task was impossible.

1 For text, see p. 135.
He suggested that, in the first place, the Health Assembly should confirm that WHO itself should devote greater efforts to the management information reporting task and that the Secretariat, through the regional offices, should be used in the first place. The whole subject deserved a higher priority: dealing with it solely by correspondence was not adequate, and the regional offices should hold meetings and discussions with each country on the framework of the report. That would ensure that respondents understood the framework within which they had to report; it would also identify what other indicators might be available, as well as those areas for which information was not available, and would provide a basis for suggestions as to how deficiencies in the framework might be remedied.

The Australian Minister for Health, at the plenary session, had referred to recent changes in the health care arrangements in Australia designed to provide better information bases for health services planning; they would be developed in such a way as to accord with the health indicators required for international assessment and comparison. His Government would welcome discussions with the WHO Regional Office for the Western Pacific to help shape the information bases and to provide practical advice on the relevance and practicability of the health indicators already established. If such discussions were held with other administrations, then the stage would be set for progress in that area. Until that process was undertaken and repeated on a cyclical basis, the quality and relevance of reporting from Member States would remain static and unsatisfactory.

At the outset of the debate, the delegate of the United Kingdom had referred to the need for review and adjustment of the common framework and format, particularly in the light of the fact that the European Region had one of the lowest reporting rates. Other delegations had also referred to that need and his own delegation stressed that it was the area which should be the real focus of the debate. Without a proper and adequate reporting basis within national organizations and through them to WHO headquarters, the call for health for all by the year 2000 would lack the disciplined approach necessary to achieve the goal.

His delegation supported the draft resolution recommended by the Executive Board.

Dr AL-AWADI (Kuwait) said that the comments by the Director-General and the draft resolution submitted by the Executive Board had reaffirmed the importance of sustaining action in pursuit of the goal of health for all by the year 2000 and of continued evaluation of progress. Many countries, both developed and developing had, however, encountered obstacles and problems even in filling in the WHO common framework and format, and the mere review of the strategy had made many of them aware of the shortcomings in their own health services.

The first step towards the implementation of the goal, namely, to find a common framework and format for reporting, had been taken. He agreed with the previous speaker that there were difficulties in understanding the current framework and format and in formulating the ideas required and hoped that by the following year countries would have improved their reporting systems.

So far, efforts to achieve the goal of health for all had been directed mainly at seeking to increase the awareness of health workers and governments of the importance of that goal; it must not be forgotten, however, that, after successfully convincing governments and health authorities and after training health workers and distributing them appropriately, the next step, namely to translate the strategy into action and to introduce the concept underlying it into the daily life of individuals, would be the most difficult.

The basis of the achievement of health for all, which all sought to attain, was participation by every member of society in that great human endeavour. Without such participation, Member States might find that they had simply been talking to themselves or to the empty desert. The most important next step, therefore, was to seek to introduce the concept of health care into the values and concepts of society, starting with primary schools and continuing through religious or other education. Governments must be careful not to contradict themselves or to establish goals that were in conflict with the expectations of individuals; the goals must be in harmony with the values held by individual members of society, otherwise all efforts would fail. Thus, it was not sufficient to provide medical aid, or to teach a mother how to take care of her children or to encourage her to breast-feed them. Health care must not merely be a routine, but should go beyond the simple activities of everyday life.

At the previous Health Assembly he had himself urged participants not to forget the spiritual dimension in any health concept. That phraseology had given rise to some misunderstandings. Some had thought that it referred to religious or atheistic teaching, but that had not been his intention. As the Director-General had rightly understood, what was meant was the spirit of endeavour which should be transmitted to every individual. He therefore wished to reaffirm his belief in the need to strengthen human values which were consonant with health. The Alma-Ata Declaration had been based on the principle that every individual should have the possibility of enjoying a prosperous and healthy life and it was
because of the principles underlying that Declaration that, at the previous Health Assembly, he had stressed the spiritual dimension of the goal of health for all. He hoped to be able to introduce the draft resolution proposed by his own and several other delegations on that subject. If health for all was not based on such a dimension, he felt that it would be reduced to empty words.

Professor LAFONTAINE (representative of the Executive Board) said that the discussions on the report on monitoring progress in implementing strategies for health for all reflected the widespread interest of all countries in that subject which had led them to undertake a process of self-examination which, even if still only tentative, showed a high degree of political awareness and the will to reach the goal. He was convinced that special attention should be paid to increasing the awareness of existing health personnel and to training the health workers of the future. Universities certainly had an important part to play in that connection, but every individual needed to be aware that he or she had an active role to play in that field, and efforts to that end should start in primary school.

In particular, not enough attention had been paid to a group midway between children and adults namely adolescents, not only in the context of the health for all strategy, but in general. Adolescents were especially conscious of certain problems and could be favourably influenced in that respect.

The discussions might have been more effective if they had focused on the various issues in turn, such as the interpretation of indicators, data collection, analysis and assessment, the integration of strategies in primary health care with other health problems, the identification of obstacles and the choice of means of overcoming them, the availability of resources, and increasing the awareness of both health workers and the general public.

Much had been said about the heterogeneous nature of the documents submitted to regional committees, but the preparation of progress reports based on a common framework and format should enable every country to lay the foundations of the future, both for itself and for other countries. He had the impression that groups of States faced similar problems and he suggested that they should be put in touch with one another so that they could pool their efforts.

Another important aspect of the problem was to find ways and means of integrating health strategies with social and industrial development strategies, while economic policies, if they were to be of any value, needed to be backed up by effective action to prevent any possible direct or indirect adverse effects on the health of individuals and on the environment.

In the so-called developed countries, in particular, traditional "classical" systems of health care existed, and account had to be taken of the habits of health workers, if systems based on primary health care were to be successful and the necessary changes made at the political, administrative and individual levels.

Health was a state of complete physical, mental and social wellbeing and not merely the absence of disease. By itself, strategy could not adequately deal with physical and mental illness; it could be fully successful only under conditions of peace and social and spiritual harmony. He was convinced that Member States, the Secretariat and the Executive Board could together achieve their common goal.

Dr HAMON (Assistant Director-General) said that, as many speakers had pointed out, the fact that most Member States had prepared progress reports on the implementation of the strategies of health for all and had submitted them to their regional committees was a positive element, but most speakers had stressed the difficulties encountered in the preparation of national progress reports and the heterogeneous nature of the documents submitted to regional committees. Recommendations had been made to improve that process so that the evaluation of national, regional and global strategies, which was the next phase, could be carried out more easily and efficiently.

There was no doubt that uniformity of presentation of national progress reports - and later of evaluation reports - as well as the basing of the reports on a common core of basic data, would enable Member States, both collectively and individually, to carefully follow up the progress made in the implementation of the Global Strategy in both political and health terms. That in turn would enable the national authorities concerned to evaluate global, regional and subregional developments.

Such an approach was obviously essential for the periodical adjustment of strategies, especially with regard to action plans. It would also greatly help to identify the opportunities for technical cooperation between countries and to determine priorities by international bodies, regional institutions and national technical cooperation agencies.

1 For text, see p. 82.
However, the use of a common framework and the presentation of a common core of basic data would never eliminate a certain heterogeneity stemming from shortcomings in primary sources of information, the subjective nature of some of the areas concerned, and differences in the significance of the same numerical value within different socioeconomic contexts.

National strategy monitoring reports, and in the near future national reports on the evaluation of the effectiveness of the strategies, were essentially national working documents designed to improve the national analyses of the health situation, the operation of the national health care system and the necessary adjustment of the national strategy, action plans and activities in the field of health.

Monitoring and evaluation of the strategy was not only the responsibility of the health sector but should also be a matter of concern to all sectors and to the highest political and administrative authorities, so that the health sector would receive the priority and attention that it merited.

It was not an easy task to achieve intersectoral coordination and the need to increase awareness in other sectors had been recognized. That task should obviously start at the national level. At international level, the need to continue the dialogue with the United Nations agencies concerned in order to achieve the goal of health for all by the year 2000 had been perceived and WHO would intensify its efforts to that end.

The quality and relevance of national reports would depend above all on the way in which they were prepared and used. Far better than flawless reports prepared by competent technicians for the sole purpose of transmittal to the regional committees would be the less than perfect reports based on thorough nationwide discussions of the issues by both the general public and the responsible government departments. Such reports would have a far greater and more lasting impact on health policy. If it were accepted that the process served national ends, most of the problems raised during the current discussions could be solved at national level.

Undoubtedly it was desirable for the reports to deal with all the indicators, but it must be admitted that, in the less developed countries, in-depth studies based only on a few global indicators, such as infant mortality, vaccination coverage and nutritional status, by district and province, were surely preferable to superficial reports which attempted to present all the indicators recommended, only giving their average national values.

For more developed countries, the indicators recommended retained their value provided that they were used at the level of the appropriate administrative unit and of distinct socioeconomic groups.

Long- and medium-term health objectives could be validly expressed in quantitative terms in most cases only at national level. In the case of large countries, those quantitative goals should even often be defined for smaller geographical (e.g., provinces) or socioeconomic units (e.g., rural populations, immigrant workers).

Many difficulties seemed to have been encountered in quantifying certain of the health indicators, so that health planning, where it existed, was often based on inadequate availability of essential information, and that was the cause of the many difficulties encountered in quantifying health indicators. Even greater difficulties were encountered in attempts to quantify health-related social and economic indicators.

Several delegations had referred to the difficulties of using the common framework and format and in preparing satisfactory monitoring progress reports. It should be stressed that the common framework and format was just a recommended tool to facilitate the national monitoring of the strategy. That tool should be used in a flexible manner.

What was most important was the process for monitoring and evaluating national strategies. Emphasis should be placed on the analysis and interpretation of data and the identification of progress or lack of progress as well as the identification of major constraints encountered in the implementation of strategies, in order to find solutions to those problems.

The Secretariat was aware of the fact that the improved common framework and format recommended for the forthcoming evaluation of the strategies still did not live up to the expectations of many countries and would make still greater efforts in the preparation of the next cycle of national monitoring reports scheduled to take place in 1987-1988.

The great majority of Member States had taken up the challenge that they themselves had formulated by collectively approving the Global Strategy, the essential indicators and the plan of action, and the Secretariat would stand by them in doing so.

Dr ASWALL (Director, Programme Management, Regional Office for Europe), replying to comments by the delegate of Malaysia and others on the lower response rate from the developed countries as compared with developing ones, said that in 1982 when the Regional Committee had discussed the monitoring process which countries would carry out, a subcommittee had examined the implications for the European Region. The majority of the members of that subcommittee had thought that, while the monitoring as such was very relevant, some of the indicators were
not particularly challenging for the more developed countries, and that in fact for several of the indicators many European countries had already reached levels advocated on a global scale.

The strategy of health for all was based on three levels: global, regional and national. When the countries of the European Region came to draw up the regional strategy for Europe in 1980, they had adopted a strategy somewhat different from that of the other regions, i.e., one that looked at problems from the viewpoint of the most developed countries. As a result, a regional strategy had been adopted that had three major thrusts: life-styles and health, environmental problems and the health care system itself. The Regional Committee had also decided to establish concrete targets for the European Region: that work had been going on for the past two years, and had involved many expert groups. A first draft had been discussed by the Regional Committee in 1983 and had subsequently been sent out to all Member States for detailed written consultation. It had been examined by the European regional Advisory Committee for Medical Research, and a second draft had been presented in April 1984 to the Regional Health Development Advisory Council, which had given it broad support. It was therefore very likely that, at its meeting in September 1984, the Regional Committee would adopt quite a number of specific regional targets covering all major areas of the regional strategy. A set of indicators had been developed covering each of those targets. Thus, as the European countries went into the evaluation process the following year, they would, in addition to the global indicators, also have reports on specific regional ones. He was sure that that development would lead to greater interest in European countries in monitoring and evaluating health-for-all strategies and a higher response rate than had been the case for the 1982-1983 monitoring. In reply to questions from the United Kingdom delegate on what the Regional Office could do to help in that process, he said that the Regional Office for Europe, in fact, would organize a special seminar for all the countries of the Region during the Regional Committee, where the common framework and format for health-for-all strategy evaluation and related problems would be considered.

The CHAIRMAN invited the Committee's attention to the amendments to the draft resolution recommended in resolution EB73.R6, which had been proposed jointly by a number of delegations, and which read as follows:

1. In the third preambular paragraph, in the second line, after the word "development", insert the words "based on the principles of the New International Economic Order", the paragraph to read:

   Noting that the attainment of the goal of health for all by the year 2000 is intimately related to socioeconomic development based on the principles of the New International Economic Order, and commitment to and the preservation of world peace;

2. After the third preambular paragraph, add two new paragraphs, to read:

   Recognizing the determination of all countries to contribute fully to achieving the goal of health for all through reinforcement of individual and collective self-reliance, of which technical cooperation among developing countries is an essential element;

   Awe that cooperation among all countries and support by developed countries and international organizations can significantly contribute to a more rational use of available resources;

3. After paragraph 4(2), insert a new subparagraph (3) to read:

   (3) to call upon the developed countries to provide urgent and appropriate technical and economic support to developing countries on a bilateral basis or through WHO, other United Nations agencies and international organizations;

   former subparagraphs (3) and (4) being re-numbered accordingly.

4. In former paragraph 4(4) in the third line, after the words "competence to", delete the words "support countries" and insert "provide countries with technical and financial support", the subparagraph to read:

   (4) to further strengthen collaboration within the United Nations system and with other intergovernmental, nongovernmental and voluntary organizations in their respective fields of competence to provide countries with technical and financial support for the attainment of the goal of health for all.
Dr EL BERMAWY (Egypt) recalled his suggestions at the Committee's second meeting as to the need to find measuring tools for monitoring progress by means of global indicators 4, 5 and 7; he had mentioned rates of coverage and effectiveness of immunization, local expenditure on health care, safe water supply and sanitation. The target of 100% coverage might be unattainable by many countries, and frustration might even inhibit their efforts. For that reason he had suggested adding to operative paragraph 4 of the draft resolution contained in resolution E/E.73.R.6 a request to the Director-General to quantify global indicators 4, 5 and 7, and therefore proposed that a new subparagraph (4) be inserted in that paragraph to read "to take steps to review the global indicators and to further develop practical tools of measurement for these indicators to help Member States in their monitoring of progress towards the targets of the Strategy". The present subparagraph (4) would then become subparagraph (5).

Miss BELMONT (United States of America) drew attention to the first proposed amendment, which called for the insertion of the words "based on the principles of the New International Economic Order" after the word "development" in the third preambular paragraph of the draft resolution recommended in resolution E/E.73.R.6. Her delegation believed that socioeconomic development could, and indeed had, occurred without implementation of the New International Economic Order. She thought that many countries, both developed and developing, were finding that the principles of the so-called New International Economic Order were not a panacea for all societies. Her delegation believed that the amendment was a little too broad: it should either be deleted and the original text preserved or the word "is" in the amended paragraph should be changed to "can be". She preferred to retain the original text. With regard to the last amendment, which called for providing countries with technical and financial support, she had no objection in principle, but assumed that the amendment did not have financial implications and would include appropriate programming of existing resources for the generation of new voluntarily contributed funds.

Dr SAVEL'EV (Union of Soviet Socialist Republics) supported the proposal made by the United States delegate since the first draft amendment reduced the scope of the idea originally contained in the third preambular paragraph. While recognizing the importance of the New International Economic Order, he nevertheless thought that a reference to it should not be included in that paragraph and suggested instead that the sponsors of the draft amendments insert the words "based on the principles of the New International Economic Order" after the word "countries" in the second of the proposed additional preambular paragraphs.

Dr KLIVAROVA (Czechoslovakia) supported Dr Savel'ev's proposal.

Miss ILIC (Yugoslavia) asked for consultations to be held before a vote was taken.

The CHAIRMAN agreed with the suggestion and proposed that the delegates of Yugoslavia and of the United States of America, as well as any others interested, might consult together in order to submit an amended text at the next meeting.

It was so agreed.

The meeting rose at 10h55.
SIXTH MEETING
Monday, 14 May 1984, at 14h30

Chairman: Dr K. AL-AJLOUNI (Jordan)

1. GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000: REPORT ON MONITORING OF PROGRESS IN IMPLEMENTING STRATEGIES FOR HEALTH FOR ALL: Item 19 of the Agenda (Resolutions WHA34.36, WHA35.23, WHA36.34, EB73.R3 and EB73.R6; Documents EB73/1984/REC/1, Annex 1, A37/4, A37/5 and A37/INF.DOC./6) (continued)

Monitoring progress in implementing strategies for health for all by the year 2000

The CHAIRMAN said that during the discussion at the previous meeting on the draft resolution proposed by the Executive Board in its resolution EB73.R6 there had been some confusion in regard to the amendments proposed. A number of interested delegations had in the meantime met as an informal working group and reached agreement on certain proposed amendments. The text would be circulated, and the draft resolution would be considered at a later stage (see page 87).

Dr RAY (Secretary) read out the amendment submitted by the Egyptian delegation, consisting of a new subparagraph for insertion in paragraph 4, worded as follows: "to take steps to review the global indicators and to further develop practical tools for the measurement of these indicators to help Member States in their monitoring of progress towards the targets of the Strategy".

The spiritual dimension in the Global Strategy for Health for All by the Year 2000

Dr AL-AWADI (Kuwait) introduced the following draft resolution on behalf of the delegations of Bahrain, Iraq, Kuwait, Oman, and the United Arab Emirates:

The Thirty-seventh World Health Assembly
Having considered the Director-General’s report on the spiritual dimension in the Global Strategy for Health for All by the Year 20001 and the recommendation of the Executive Board thereon contained in resolution EB73.R3;

Understanding the spiritual dimension to imply a phenomenon that is not material in nature but belongs to the realm of ideas, beliefs, values and ethics that have arisen in the minds and conscience of human beings, particularly ennobling ideas;

1. THANKS the Director-General for his report and the Executive Board for its recommendation;
2. CONCURS with the reflections contained in the report;
3. NOTES that ennobling ideas have given rise to health ideals which have led to a practical strategy for health for all that aims at attaining a goal that has both a material and non-material component;
4. RECOGNIZES that if the material component of the strategy can be provided to people, the non-material or spiritual one is something that has to arise within people and communities in keeping with their social and cultural patterns;
5. CONSIDERS that the realization of the health ideals that form the moral basis of the goal of health for all by the year 2000 will itself contribute to people's feelings of wellbeing;

1 Document EB73/1984/REC/1, Annex 1.
6. RECOGNIZES that the spiritual dimension plays a great role in motivating people's achievement in all aspects of life;

7. AFFIRMS that ennobling ideas have not only stimulated worldwide action for health but have also given to health, as defined in WHO's Constitution, an added spiritual dimension;

8. INVITES Member States to consider including in their strategies for health for all a spiritual dimension as defined in this resolution in accordance with their social and cultural patterns;

9. REQUESTS the Director-General to study further the role of the spiritual dimension in promoting the attainment of the goal of health for all by the year 2000.

Dr AL-AWADI (Kuwait) recalled that, after some discussion at the Thirty-sixth World Health Assembly, the subject had been referred to the Executive Board and the Director-General had prepared a report (document EB73/1984/REC/1, Annex 1). Some delegations appeared to believe that the term spiritual dimension referred to the theological aspect, but the matter had been fully and clearly explained by the Director-General. Societies could only conduct their affairs properly in accordance with their traditional values, customs and beliefs. The spiritual dimension was what distinguished the actions of man from the instinctive reactions of animals. What was required was that every individual should not only be able to identify that dimension, but should also believe in it, so that the health-for-all strategy became an integral part of the daily life of every family, at work and at play, at home and in the street.

Every goal contained a material and a non-material element and the latter could only be achieved by a fully oriented effort of faith against the background of a society's traditional values. The draft resolution reaffirmed the ideas set out in the Director-General's report, enumerating clearly all the separate elements which went to make up the spiritual dimension, reminiscent of the definition of health in the Constitution of the World Health Organization. The heart of the resolution was contained in paragraph 8 which invited Member States to include a spiritual dimension in their health-for-all strategies so as to prevent any contradiction between social values and the principles of health care. He urged all delegations to support the draft resolution, in particular the developing countries since they were the ones who still possessed a great store of non-material values which should not be wasted or dissipated.

Dr SAVEL'EV (Union of Soviet Socialist Republics) said that the Thirty-sixth World Health Assembly, after considering the question of the spiritual dimension, had referred the subject to the Executive Board. The Board at its twenty-third session, had given careful consideration to the report prepared by the Director-General, and had adopted resolution EB73.R3, recommending that the present Health Assembly note the Board's conclusions. While agreeing that moral, ethical and social aspects and cultural traditions were very relevant to the implementation of the Global Strategy, he could not accept the concept of the spiritual dimension as outlined, for the reasons which he had explained in detail at the Thirty-sixth World Health Assembly. Since the Executive Board had already completed consideration of the matter, the Health Assembly could scarcely ask the Director-General to undertake a further study. He suggested that delegates might consider adopting only the first preambular paragraph and paragraph 1 of the draft resolution.

Dr BISHT (India) said that the idea of adding a further dimension to the definition of health had first been mooted at the Executive Board in 1978, since it was felt that the physical, mental and social dimensions were insufficient alone. He had pointed out at that time that, although a pack of wolves could be physically strong, mentally alert and socially well-knit, they still lacked something, and that lack distinguished them from human beings. A concept of health had to transcend mere animal health, and he had suggested that the difference could be defined by postulating a factor X which was an essential element in the health of the individual, the community and the State, and perhaps in the health of mankind as a whole.

At the request of the South-East Asia regional Advisory Committee for Medical Research, his Government had prepared a background document on the subject, and one conclusion had been the continuing need for research into the spiritual dimension. Not to be satisfied with the existing state of affairs provided the necessary stimulus to develop a society in which all individuals had the opportunity to enjoy what was commonly known as the quality of life. At the same time, as Socrates had said, the first step toward knowledge was to know that one knew nothing. It might be that we knew nothing of the spiritual dimension, but it could not
be said that the spiritual dimension did not exist, and it was a worthy aim to seek to find it. The key to health in all communities and throughout the world might well be the addition of the factor X - better expressed, perhaps, as "heart for all", defining the heart not in the anatomical but in the literary sense, as the centre of being.

Dr IVANOV (Bulgaria) said that the question of the spiritual dimension in the Global Strategy had been discussed at the Thirty-sixth World Health Assembly and, in consequence of the decision then taken, again at the seventy-third session of the Executive Board. His delegation fully endorsed the decision taken by the Executive Board on that question and therefore supported the amendment proposed by the delegate of the Union of Soviet Socialist Republics.

Dr KLIVAROVÁ (Czechoslovakia) said that her delegation, which had participated in the discussions on the spiritual dimension at the Thirty-sixth World Health Assembly supported the views expressed in the Director-General's report and the recommendation of the Executive Board. The question had already been adequately covered and there was therefore no need for the Director-General or the Secretariat to consider the matter any further; thus, at all events, paragraph 9 of the draft resolution should be deleted.

Professor SZCZERBAN (Poland) agreed with the previous speaker that paragraph 9 should be deleted. In view of the consideration that the matter had already received and of the recommendation of the Executive Board, no further study was required.

Dr AL-AWADI (Kuwait) feared that delegates might not have made a sufficiently careful study of the Executive Board's deliberations at its seventy-third session, or of the Director-General's report, and he quoted the conclusion from that report (paragraph 16). The Director-General's views had been endorsed by the Executive Board.

There was possibly some misunderstanding of the term "spiritual dimension". It was important to distinguish the spiritual dimension from the religious dimension. As the delegate of India had said, whatever one's ideology the spiritual dimension affected every human being as an integral part of his or her entire life. It was the only dimension that distinguished man from animals. The spiritual dimension should be safeguarded if values were to be preserved and health for all was to be attained. The draft resolution under consideration was in accord with the Director-General's conclusions and he urged delegates to give it their full support. Most countries recognized the value of the spiritual dimension. In his opinion, however, the question had not yet been properly studied and there was still confusion with the religious dimension, which was in fact a component of the spiritual dimension. The Director-General should be requested, therefore, to help Member States to incorporate the spiritual dimension in their strategies for health for all.

Dr LARIVIERE (Canada) commended the previous speaker on the way in which he had conveyed the message of the Director-General's report. His delegation supported many of the ideas incorporated in the draft resolution. WHO was moving towards the inclusion of the spiritual dimension in considerations of health. The delegate of India had indicated that the concept was not new to WHO; indeed it was not limited to WHO. The agenda of the recent meeting of UNICEF Executive Board had included an item on the psychosocial aspects of child development. Psychosocial considerations presupposed that human beings were spiritual and loving creatures. The spiritual dimension was an intrinsic part of the word "care" for health care workers and health care services. However, the spiritual dimension in the Global Strategy should not become a new research programme for WHO; rather, it should be a concept that would be borne in mind in developing and implementing health programmes.

The proposal of the delegate of the Soviet Union to delete all but the first preambular paragraph and paragraph 1 of the draft resolution was rejected by 19 votes to 10, with 60 abstentions.

The proposal of the delegate of Czechoslovakia to delete operative paragraph 9 of the draft resolution was approved by 28 votes to 19, with 31 abstentions.

The draft resolution, as thus amended, was approved by 55 votes to none, with 31 abstentions.1

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.13.
Basic plan on priority health needs of Central America and Panama

Dr GARCÍA GARCÍA (Panama) introduced the following draft resolution, on behalf of the delegations of Antigua and Barbuda, Argentina, Bahamas, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Spain, Trinidad and Tobago, Uruguay, and Venezuela:

The Thirty-seventh World Health Assembly,

Informed of the initiative taken by the Governments of the countries of Central America and Panama, embodied in the "basic plan on priority health needs" in that subregion, which they have drawn up in concert and are collectively committed to executing;

Considering the special significance of this initiative for social development, for the solution of health problems, and as a link to promote understanding, solidarity and peace among the peoples of Central America and Panama at a particularly difficult juncture in their history;

Noting that this initiative is in keeping with the principles of solidarity and cooperation that guide WHO's activities aimed at the attainment of the goal of health for all;

1. CONGRATULATES the governments of the countries of Central America and Panama on this initiative;

2. EXPRESSES its full support for the initiative and the measures for implementing it properly;

3. INVITES Member States to support the initiative effectively and to the fullest extent possible;

4. RECOMMENDS that the Director-General take appropriate action and seek all possible means of supporting the implementation of activities aimed at ensuring the success of the initiative; and

5. REQUESTS the Director-General to submit a report on the matter to the Thirty-ninth World Health Assembly.

He recalled that at the fifth plenary meeting the Minister of Health of Panama had informed the Health Assembly that the countries of the Central American Isthmus hoped to achieve peace through a plan for health as a source of and bridge to peace; it was hoped that implementation of the plan would enhance the efforts of the Contadora Group to secure the wellbeing of the people of the region. He expressed the hope that all delegations would vote in favour of the draft resolution.

Dr LARIVIÈRE (Canada) and Miss BELMONT (United States of America) said that their delegations wished to co-sponsor the draft resolution.

Dr TJON JAW CHONG (Suriname) said that his delegation fully supported the draft resolution.

The draft resolution was approved.¹

Implementing the Strategy for Health for All

The CHAIRMAN invited the Committee to consider the following draft resolution, submitted by the delegations of Afghanistan, Democratic People's Republic of Korea, India, Mozambique, and Yugoslavia:

The Thirty-seventh World Health Assembly,
Noting with satisfaction the decisions taken by a group of Member States - the non-aligned and other developing countries - concerning the implementation of the Strategy for Health for All by the Year 2000;²

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.14.
² Document WHA37/1984/REC/1, Annex 2.
Recognizing the importance of the decisions adopted by the non-aligned and other developing countries in their resolutions on:

(i) implementation of the Strategy for Health for All by the Year 2000;
(ii) technical cooperation among developing countries to attain the goal of health for all by the year 2000;

1. CONGRATULATES the non-aligned and other developing countries on their continuing political commitment and vigorous efforts to attain the goal of health for all;

2. REQUESTS the Director-General to continue to mobilize support for these and other Member countries for the implementation of their strategies for achieving health for all, and for technical cooperation among them and to report periodically to the Health Assembly on the progress achieved.

The draft resolution was approved.

Technical cooperation among developing countries in support of the goal of health for all

Miss ILIC (Yugoslavia) introduced the following draft resolution, on behalf of the delegations of Afghanistan, Algeria, Angola, Argentina, Bangladesh, Cape Verde, China, Cuba, Cyprus, Democratic People's Republic of Korea, Egypt, Guyana, India, Indonesia, Jordan, Libyan Arab Jamahiriya, Malta, Mozambique, Pakistan, Sao Tome and Principe, Sri Lanka, Suriname, Thailand, Tunisia, United Republic of Tanzania, Yugoslavia, and Zambia:

The Thirty-seventh World Health Assembly,
Reaffirming that technical cooperation among developing countries (TCDC) constitutes an important vehicle for health development and for the implementation of national health strategies;
Bearing in mind the resolutions of the United Nations General Assembly encouraging technical cooperation among developing countries, and its endorsement of the Declaration and the Plan of Action of the United Nations Conference on Technical Cooperation among Developing Countries, held in Buenos Aires in 1978;
Recalling resolution WHA30.43 which called on all countries to collaborate in the achievement of the goal of health for all by the year 2000, and resolution WHA32.30 endorsing the Declaration of the International Conference on Primary Health Care;
Taking into account resolution WHA31.41, calling for the strengthening of technical cooperation among developing countries and active collaboration between WHO and the developing countries in the promotion of such cooperation;
Taking note of resolution WHA35.24 congratulating the non-aligned and other developing countries on their expression of political commitment to the goal of health for all;
Noting with satisfaction the adoption by the ministers of health of non-aligned and other developing countries of a medium-term programme on TCDC for health for all (1984–1989) and an initial plan of action on TCDC for health for all (1984–1985), as a contribution by developing countries towards the implementation of the Seventh General Programme of Work;

1. WELCOMES the launching by non-aligned and other developing countries of the medium-term programme (1984–1989), together with the initial plan of action (1984–1985), being convinced that these initiatives will contribute to reinforcing the implementation of national health strategies;

2. CALLS UPON all Member States to give every possible support to this programme and plan of action and to any other relevant programmes and activities based on TCDC, and to make optimal use of WHO resources, particularly at the country level, for carrying out TCDC activities;

3. ESPECIALLY CALLS UPON the developed countries to provide the developing countries, particularly the least developed among them, with technical cooperation and financial resources through bilateral and multilateral channels, including WHO, to assist in carrying out these programmes;

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.15.
4. EMPHASIZES in this connection the importance of reinforcing multilateral institutionalized cooperation within the framework of priorities fixed by the developing countries and including cooperation among these countries;

5. REQUESTS the Director-General to support these programmes, drawing upon the technical and financial means at his disposal, and to mobilize technical and financial support for the medium-term programme, the initial plan of action and other TCDC programmes and activities, by strengthening collaboration with other components of the United Nations system and with other international organizations.

The sponsors wished to make a technical correction to the end of the third preambular paragraph, which should read: "the Alma-Ata Declaration of the WHO/UNICEF International Conference on Primary Health Care". The sponsors were unaware of any objections to the text, and hoped that it would be approved without a vote.

Dr OLIVER (United Kingdom of Great Britain and Northern Ireland) said that operative paragraph 3 as drafted gave the impression that the developed countries were not yet helping the developing countries. He proposed that the words "continue to" be inserted between the words "to" and "provide".

His delegation did not understand the meaning of the words "multilateral institutionalized cooperation" in operative paragraph 4.

Miss ILIC (Yugoslavia) said that the sponsors could accept the amendment to operative paragraph 3 proposed by the delegate of the United Kingdom.

"Multilateral institutionalized cooperation" meant cooperation through established channels such as WHO and other organizations of the United Nations system.

The draft resolution, as amended, was approved.1

Monitoring progress in implementing strategies for health for all by the year 2000 (resumed)

The CHAIRMAN drew the Committee's attention to the text of the draft resolution incorporating the amendments proposed at previous meetings, reading as follows:

The Thirty-seventh World Health Assembly,
Reaffirming resolutions WHA30.43, WHA34.36 and WHA35.23 concerning the policy, strategy and plan of action for attaining the goal of health for all by the year 2000; Recalling resolution WHA33.17 concerning the concentration of the Organization's activities on support for the attainment of this goal; Noting that the attainment of the goal of health for all by the year 2000 is intimately related to socioeconomic development and commitment to and the preservation of world peace; Recognizing the determination of all countries to contribute fully to achieving the goal of health for all through reinforcement of individual and collective self-reliance, of which technical cooperation among developing countries is an essential element; Aware that cooperation among all countries and support by developed countries and international organizations, based on the principles of a new international economic order, can significantly contribute to a more rational use of available resources; Recognizing that monitoring and evaluation are fundamental elements of the managerial process required for the implementation of the strategies, and that the commitment and courage of Member States and a spirit of mutual trust among them are essential for the effective implementation of the Strategy for Health for All; Mindful that only three-quarters of the Member States submitted progress reports in due time on the implementation of their national strategies; Noting the progress made thus far in the implementation of the Strategy, but also being aware of the magnitude of the overall task and the relatively short period left to achieve the collectively agreed goal of health for all by the year 2000;

1. URGES Member States:
   (1) to accelerate the reorientation and the modifications of health systems towards primary health care, further strengthen the managerial capacity of their health system, including the generation, analysis and utilization of the

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.16.
information needed, and emphasize continuing education of health personnel to support their health management process;
(2) to accord the highest priority to and assume full responsibility for the continuing monitoring and evaluation of their strategies, individually as part of their managerial process for national health development, and collectively in a spirit of mutual trust in order to identify jointly factors which contribute to or impede the implementation of the Strategy;
(3) to further refine and update as necessary their national strategies and plans of action for health for all, with clearly defined objectives and targets and appropriate allocation of resources, and apply corrective measures required for accelerating the pace of implementation of their national strategies;
(4) to promote the importance of multisectoral approaches and their linkages to achieve health for all;
(5) to pay attention to the planning and evaluation of health manpower development programmes consonant with the needs of their health systems;
(6) to accelerate efforts to mobilize national and external resources in support of activities that are essential to the implementation of the strategies, ensuring that these resources are adequately directed towards underserved and socially and geographically disadvantaged groups;
(7) to use WHO's resources optimally, directing them to the mainstream of activities required to implement, monitor and evaluate the national strategy;
(8) to consider the desirability of enacting health legislation incorporating the basic principles of health for all;

2. URGES the regional committees:
(1) to give increased attention to the review and analysis of the findings of the monitoring and evaluation of national strategies by Member States in the region;
(2) to identify factors and issues facilitating or impeding the implementation of national strategies in the region and promote the required action to foster positive factors and to resolve impeding issues;
(3) to stress the importance of mutual cooperation among Member States in this process;
(4) to carry out a first evaluation of the regional strategy in 1985 in keeping with the plan of action for implementing the Global Strategy for Health for All;

3. REQUESTS the Executive Board:
(1) to continue to monitor actively the progress in implementing the Global Strategy, identifying issues and areas requiring action by Member States individually and collectively;
(2) to participate actively in the Organization's efforts to support the Member States in the implementation of national strategies as well as the monitoring and evaluation activities;
(3) to carry out a first formal evaluation of the Global Strategy and submit its report thereon to the Thirty-ninth World Health Assembly in 1986, in keeping with the plan of action;

4. REQUESTS the Director-General:
(1) to focus further the resources of the Organization on the acceleration and improvement of the implementation of the Strategy for Health for All;
(2) to ensure the provision of intensive, appropriate and targeted support to Member States for the implementation, monitoring and evaluation of the Strategy, especially in countries where the needs are greatest and which are ready for it;
(3) to call upon the developed countries to provide urgent and appropriate technical and economic support to developing countries on a bilateral basis or through WHO, other United Nations agencies and international organizations;
(4) to intensify technical cooperation with Member States in order to strengthen their managerial capacities, including monitoring and evaluation and the related generation, analysis and use of supporting information;
(5) to take steps to review the global indicators and to further develop practical tools for the measurement of these indicators to help Member States in their monitoring of progress towards the targets of the Strategy;
(6) to further strengthen collaboration within the United Nations system and with other intergovernmental, nongovernmental and voluntary organizations in their
respective fields of competence to provide countries with technical and financial support for the attainment of the goal of the health for all.

The draft resolution, as amended, was approved.¹

(For consideration of a further draft resolution, see summary record of the tenth meeting, section 3.)

2. INFANT AND YOUNG CHILD NUTRITION (PROGRESS AND EVALUATION REPORT; AND STATUS OF IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES): Item 20 of the Agenda (Resolution WHA33.32; Documents WHA34/1981/REC/1, Annex 3, Article 11.7 of the Code, and A37/6)² (continued from the fourth meeting)

Dr. ÉLIAŚ (Hungary) said that the importance of adequate nutrition for infants and young children in the struggle for health for all could not be overemphasized. Although starvation and famine were virtually unknown in Hungary, malnutrition was a major public health problem. Growth deficiencies attributable to various causes also posed an increasing number of problems.

Since deficiency anaemias occurred in infants and young children, pregnant women were screened thoroughly, as were the infants and young children themselves. When required, changes in diet were introduced and pharmaceutical preparations were administered under medical supervision.

His Government had been combating iodine deficiency for decades, with a measure of success. Schoolchildren were regularly checked for goitre and the results obtained were used to identify areas where iodized salt should be more extensively used. In 1983 a programme had been introduced for screening infants and young children for congenital thyroid deficiency.

Several national institutes had set up teams to work in the field of early detection and treatment of diseases and growth deficiencies caused by malabsorption. Special foodstuffs and financial assistance were made available to affected families.

Vitamin A deficiency was uncommon in Hungary and, when it did occur, it was usually attributable to disease rather than malnutrition.

There was a large-scale programme aimed at integrating children with systemic diseases into normal child communities and thus enabling them to live like healthy children. Group activities and holidays were organized for them and where possible they attended normal schools. In that way, such children were helped to overcome their social handicap.

Breast-feeding was encouraged by the appropriate professional and non-professional organizations and community groups. The results were not spectacular; the proportion of infants over four months old fed on maternal milk had increased from 31% in 1977 to 39% in 1983. No effort was spared in school education to make the importance of breast-feeding understood at an early age. Materials emphasizing the significance of breast-feeding, and describing the methods of promoting it had increasingly been included in professional and medical training. The provisions of resolutions WHA33.32 and WHA34.22 on the marketing of breast-milk substitutes were implemented in his country. Maternal milk substitute preparations, including those made in Hungary, were available on medical prescription and were obtainable free of charge. In the case of products for older infants, the label had to show that the product was no substitute for maternal milk. The quality of the maternal milk substitutes made in Hungary was up to international standards advocated by WHO.

Hungary fully supported the efforts of WHO to improve infant and child feeding and his Government gave all possible assistance to countries requesting it.

Dr. NJIE (Gambia) said that breast-feeding was still practised almost universally in the Gambia. That, however, was not a cause for complacency; for an undesirable trend away from it had been observed among working mothers in urban areas.

The promotion of breast-feeding was desirable but should be conducted carefully in order to avoid misleading mothers. There was scientific evidence to show that breast-feeding alone was not adequate for child growth after the third or fourth month, as most mothers in his country were well aware. The problem lay not in the introduction of weaning foods but in their quality and type. Experience in the Gambia showed that the weaning foods used left

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.17.
² Document WHA37/1984/REC/1, Annex 5.
been endemic, accompanied introduction unpaid maternity.  Fields, information, breast-feeding, countries with decrease from on the strategies, and developing countries. Between health programmes, between programmes particularly bringing development would continue vitality. They were overworked malnutrition bound Kingdom cooperation children. There was been low-food, it self-reliance, were suffered most field. For Where nutritional deficiencies were concerned, the report of the leitmotiv of the discussions so far. That cooperation was no less important in the field of child nutrition. For instance, the continuing desertification of the Sahel was bringing famine and starvation to areas where they were previously unknown and those who suffered most were, as always, the children and their mothers. Supplementary feeding programmes particularly when, as was often the case, they took no account of national self-reliance, were no substitute for sustained intersectoral cooperation. The fields he had mentioned were just a few of those that illustrated the multifaceted nature of the problem. Progress towards a solution called for cooperation and coordination between health programmes, between the health and other sectors and between developed and developing countries. Indeed he was not far from thinking that, since proper child growth and development could be achieved only through that kind of full deployment of the strategies, it could serve as a measure of their effectiveness, presupposing as it did progress with the other indicators. It was indeed the focus of the challenge since it was crucial to the attainment of health for all by the year 2000.

Dr EL BERMANY (Egypt) said that his delegation wished to co-sponsor the draft resolution on the prevention and control of vitamin A deficiency and xerophthalmia. He expressed his satisfaction with the Director-General's report. It indicated a global decrease from 17% to 16% in the estimated proportion of low-birth-weight infants; however, it should not be overlooked that the absolute numbers had remained nearly the same and exceeded 20 million. Moreover, that global figure should not hide the fact that in certain countries with a total combined population of about 1000 million, the proportion of low-birth-weight infants remained unchanged and was very high, ranging between 30% and 50% of live births. The report also provided an overall view of activities and measures taken to encourage breast-feeding, to improve weaning practices, to strengthen nutrition education and information, and to develop support for the improved health and status of women. In those fields, Egypt's civil service regulations provided for fully-paid maternity leave for three months after delivery; a nursing mother was allowed one hour per day of working time for breast-feeding throughout one year; and, on request, mothers were granted two years unpaid maternity leave for breast-feeding and child care.

Where nutritional deficiencies were concerned, the iodization of salt and the introduction of canned sea-fish into the diet of the people in the few areas where goitre had been endemic, accompanied by an intensive nutrition education programme, had sufficed to eliminate the problem.

For text, see p. 100.
He fully agreed with the report's conclusion but would like to add to the interacting factors, enumerated in paragraph 222, that were important to nutritional status of children, family size, family income, parents' education, food distribution within the family, and local food traditions and eating habits. With regard to paragraph 226, he wished to emphasize that national strategies should combine the efforts of both governmental and nongovernmental sectors. The governmental sphere should include the various sectors of health, agriculture, education, the food industry and food importation, while community participation should be through voluntary associations, women's organizations and consumer groups. Both should have the support of strong intersectoral collaboration.

He recalled that in the Introduction to the Proposed programme budget for 1984-1985 it was made clear that social needs should dictate priorities. Everyone agreed that malnutrition was, and would remain, an important factor contributing to high infant and child mortality; those who survived suffered from stunted growth, lowered resistance to infections, and environmental hazards. The Director-General's report indicated that nutritional anaemia affected two-thirds of pregnant women and half the non-pregnant women in developing countries; if so, about 290 million women were suffering from nutritional anaemia in those countries, the population of which was steadily increasing and, with it, the numbers in the vulnerable groups. Yet the total provision for nutrition programmes was 6.5% less in 1984-1985 than in the previous biennium, and 37% less for the Eastern Mediterranean Region. If allowance were made for continuing inflation at the rate of 17.4%, the real decrease in total budget would reach about 24%. His delegation raised that issue so that it would be taken into account in the preparation of the proposed budget for 1986-1987.

Professor ORDÓÑEZ CANCELLER (Cuba) said that for the past 25 years his Government had implemented national programmes which included improvement of maternal and child nutrition through the promotion of breast-feeding, the supervision of adequate weaning procedures, and the development of health education with special reference to the status of women and rational and appropriate marketing of breast-milk substitutes. Those programmes had been closely integrated with primary health care which, in Cuba, was available to the entire population.

In the second half of the preceding decade, Cuba had instituted a national nutritional surveillance programme for infants and young children. In 1972, a national study on growth and development had been carried out, using a random sample of more than 50,000 children from birth up to 20 years of age, which included the recording of 15 anthropometric measurements, sexual development and bone maturation. As a result, national growth and development standards had been adopted for application countrywide. The study had been repeated in 1982 and the data were now being processed and analysed. The study, together with perinatal research follow-up to the age of seven years, and a more recent study of risk factors during gestation, together with the nutritional surveillance programme and the continuing statistics of the national health system, enabled the Cuban Government to analyse the nutritional status of the country in depth.

The national study on growth and development had shown that during the first six years of life the weight-for-height standards in Cuba were in line with the most recent figures of the National Center for Health Statistics of the United States, which had been taken as reference standards by WHO. Infant mortality in Cuba for 1983 was 16.8 per 1000 live births and the corresponding rate for 1 to 4 year-old children was 0.8 per 1000 population. The results of the national surveillance programme had demonstrated that in the past two years the proportion of children under one year suffering from undernutrition was 4%, using the Harvard standard. Although malnutrition among children due to physical defects was a thing of the past, malnutrition from overfeeding and obesity affected 9.8% in the same age-group nationwide and was increasing with its repercussions on health in the short- and long-term.

With regard to the improvement of the status and health of women, the protection of pregnant women at work was guaranteed by law in Cuba, an important provision since 38.9% of the active labour force consisted of women, who also constituted 53% of the working population with technical qualifications. In addition to the special diet which pregnant women were allowed, evaluations made by international organizations indicated that there was a daily average per capita calorie intake of 2855 calories, with a daily consumption of almost 80 g of protein.

With regard to the marketing and distribution of breast-milk substitutes were concerned, their production in Cuba was in the hands of a non-profit-making State enterprise that came under the Ministry of Food. Consequently, there was no direct advertising to doctors or any members of the health team, nor any advertising in the mass media; no free samples were distributed to mothers in order to promote sales. In short, there was no problem in Cuba, regarding the implementation of the International Code adopted by WHO because the system worked against any attempt to profit at the expense of the health of the people.

In conclusion, he referred to future projects in Cuba. The system of nutritional surveillance would be structurally improved. The changing socioeconomic situation required a
constant search for indicators that would better reflect the problems inherent in each phase of development. Consideration was being given to the inclusion of new indicators such as the weight and height of schoolchildren at seven and 12 years of age, as well as of adults attending the primary health centres. Special attention would be given to the problems of obesity and the need for more specific measurement of body fat bearing in mind the need for indicators to be simple and usable.

Another very important problem was to adapt the results of national growth and development study for use as reference standards for anthropometric purposes, improving the primary data through training and supervision of personnel and accelerating data analysis by computerization in order to speed up the consolidation of the information and feedback to local units. It was planned to develop the surveillance system, at present limited to the health sector, through an integrated approach to include indicators of the level of health, and concerning the production, processing and distribution of foods. The prerequisites for those developments already existed since the national nutrition programme was based, at the municipal, provincial and national levels, on the existing structures of the people's government at those levels; and it coordinated and advised all the sectors participating in the food-nutrition chain, influencing State and community decisions from supply to consumption.

Dr WILLIAMS (Nigeria) commended the Director-General on his comprehensive report. The data provided on the incidence of low birth weight in the developing countries gave great cause for concern. In Nigeria low fetal weight and low birth weight were still major causes of stillbirths and infant deaths in the first month of life. Many of the developing countries did not possess the skilled manpower or the facilities to provide the necessary care for low-birth-weight children. The provision of proper prenatal care and supervision, still regrettably lacking for most mothers in Third World countries, would significantly reduce the incidence of low birth weight and maternal morbidity and mortality and increase the chances of infant survival. It should be focused on low-income and socially disadvantaged women, and should be well organized and readily available.

He welcomed the prominence given in the report to the connection between closely-spaced pregnancies and low birth weight, and stressed the importance of family planning in that respect, while conceding that family planning, often equated with population control, was a highly delicate issue in many African countries. He believed that it should be promoted more forcefully by the Organization as a means of improving maternal and child health and fostering infant and child survival.

The Organization's leadership role with regard to infant and young child nutrition was widely recognized. His Government had placed the import of breast-milk substitutes under special licence, thereby reducing the quantities imported and placing the limited quantities available on the domestic market beyond the economic reach of the average consumer. The proportion of breast-feeding mothers appeared to be rising again. He felt sure that encouragement of breast-feeding, coupled with the programme of the International Drinking Water Supply and Sanitation Decade would result in a significant reduction of diarrhoeal diseases, still the main cause of child mortality and morbidity in his country.

In connection with the introduction of protein-rich weaning food, his country's institute of industrial research had developed an excellent product but was having difficulty in finding industrial sponsors to produce and market it commercially.

A programme was shortly to be launched in Nigeria to control vitamin A deficiency in response to reports of its high incidence among children in the northern part of the country.

The Nigerian Government, aware of the prevalence of malnutrition, aggravated by drought, was placing renewed emphasis on investment in agriculture to ensure food self-sufficiency and the availability of food at affordable prices. Short-term deficiencies in food production were being met by imports, while active steps were being taken to ensure that the food was being channelled to those most in need, through improved distribution and storage.

Dr KAKITAHI (Uganda) said that nutritional deficiencies were still a major cause of child morbidity and mortality in his country, especially in the under-five age-group. Malnourished mothers often gave birth to underweight babies whose normal growth and development were further hindered when they grew up in underprivileged areas. The chances of adequate infant and young children nutrition would therefore be enhanced if concurrent measures were taken to improve both maternal nutrition and infant and young child feeding.

Breast-feeding was a matter of course in Uganda, and the small quantities of imported breast-milk substitutes did not reach the rural areas. That trend would be maintained by ensuring a responsible attitude towards the use of substitutes if it proved necessary.

Through the primary health care network, more emphasis had been placed on health education to encourage mothers and the community as a whole to use locally available weaning foods and to encourage good and timely weaning practices. He appealed for more support from
the Organization and other United Nations agencies, such as FAO and UNICEF, to help developing countries to produce weaning foods from local resources.

His Government had been represented at the conference, held in Swaziland, to which the delegate of Swaziland had referred, and his delegation conveyed to the Committee its approval of ideas expressed on that occasion, including the Mbabane Declaration. He endorsed the comments he had made in that connection.

His delegation wished to co-sponsor the draft resolution on infant and young child nutrition proposed by the delegations of Bahrain, Egypt, Kuwait, Qatar and the United Arab Emirates but wished to suggest a few amendments. In the first preambular paragraph, the symbols WHA27.23 and WHA32.47 should be amended to WHA27.43 and WHA31.47 respectively. The phrase "with particular emphasis on the use of foods of local origin" should be added at the end of operative paragraph 2, and operative paragraph 3 should be reworded to read:

REQUESTS the Director-General:

(1) to continue and intensify collaboration with Member States in their efforts to implement and monitor the International Code of Marketing of Breast-milk Substitutes as a minimum measure at the national level;

(2) to take steps to monitor the inappropriate promotion and use of foods unsuitable for infant and young child feeding;

(3) to report to the Thirty-ninth World Health Assembly on progress in implementing this resolution together with recommendations for any other measures needed to further improve sound infant and young child feeding practices.

Dr SHERIF ABBAS (Somalia), expressing his appreciation of the Director-General's report, pointed out that poverty was one of the main determining factors in malnutrition, and consequently that a study of the incidence and causes of poverty was of great importance when planning measures to improve health and nutrition.

Massive rural-urban migration, with its attendant ills, was a grave problem in Somalia, as in most developing countries. His Government had given it serious consideration when drawing up the current five-year development plan, a guiding principle of which was to improve the quality of life in rural areas, where the proportion of households living below the poverty line was estimated at 76%, as against 49% among nomads and 42% in urban areas. Malnutrition and undernutrition were the direct result of a number of interrelated factors associated with poverty. Among the most deprived sectors of the population the inability to obtain the bare minimum of even staple foods was accompanied by illiteracy, unsatisfactory environmental conditions, and natural and man-made disasters such as drought and war - all of which aggravated the situation.

Several important studies and surveys had been carried out in his country, confirming that protein-energy malnutrition was a major problem among infant and pre-school children in Somalia. The decline in growth after the age of eight months was attributed to the combined effect of inadequate supplementary feeding and repeated infections. It had been found that a high percentage of children received no food other than milk until their second year of life. The problem of low birth weight was exacerbated by the fact that many women deliberately lowered their food intake during the final three months of pregnancy in order to give birth to a smaller baby and have an easier delivery. The national health plan (1980-1985) estimated that 26% of children below five years of age could be classified as suffering from grade II and grade III malnutrition, according to the Gomez scale. The 7% incidence of grade III malnutrition reported in the national health plan was a matter of grave concern when seen against the 2 to 3% incidence reported in WHO's analysis of 101 surveys in 59 countries.

Health service reports indicated a high prevalence of anaemia in his country, with an incidence of 50% among pregnant women and women of child-bearing age.

A national conference on food and nutrition organized by his Government in collaboration with WHO and UNICEF had proposed a series of recommendations designed to improve the critical nutrition situation in his country. It was now hoped that the assistance to be provided by the Joint WHO/UNICEF Nutrition Support Programme would reinforce the Government's resources and efforts to develop the technical and managerial capacity to plan and implement a comprehensive set of measures to improve the health and nutritional situation of mothers and children.

While Somalia had subscribed to the International Code of Marketing of Breast-milk Substitutes, the influx of refugees, currently numbering over half a million, posed a serious threat to its effective implementation because large quantities of breast-milk substitutes were entering the country. Such generous and well-meaning donations were indeed appreciated and were often the sole means of ensuring the survival of the communities concerned despite all the risks involved. His delegation would welcome any suggestions as to possible ways of dealing with that critical problem.

The meeting rose at 17h30.
SEVENTH MEETING

Tuesday, 15 May 1984, at 9h00

Chairman: Dr K. AL-AJLOUNI (Jordan)

1. FIRST REPORT OF COMMITTEE A (Document A37/33)

Mrs MAKHWAD (Botswana), Rapporteur, read out the draft first report of the Committee.

The report was adopted (see document WHA37/1984/REC/2).

2. INFANT AND YOUNG CHILD NUTRITION (PROGRESS AND EVALUATION REPORT; AND STATUS OF IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES): Item 20 of the Agenda (Resolution WHA33.32; Documents WHA34/1981/REC/1, Annex 3, Article 11.7 of the Code, and A37/6) (continued)

The CHAIRMAN, inviting the Committee to proceed with the general discussion of the item, stated that the draft resolution on prevention and control of vitamin A deficiency and xerophthalmia would be considered at the conclusion of the debate,1 and that a further draft resolution on infant and young child nutrition, sponsored by the delegations of Bahrain, Egypt, Kuwait, Qatar and United Arab Emirates, would be considered in due course.2

Mrs MATI (Kenya) noted that activities in Kenya in respect of the extremely important subject of infant and young child nutrition were summarized in paragraph 134 of the Director-General's report (document A37/6).3 Furthermore, a joint study on the subject had been carried out by WHO and the Kenyan Ministry of Health.

She emphasized the fact that it was now prohibited in Kenya for any posters to appear advertising breast-milk substitutes in any health unit. Moreover, no health worker was allowed to give any substitutes except when there was a specific instruction to that effect from a competent health supervisor. Kenya already had a national code in operation, drafted by the Ministry of Health in conjunction with the Kenya Bureau of Standards.

Her delegation refuted the inference made earlier in the debate concerning Kenya in connection with xerophthalmia, and would, if necessary, be willing to prove its inaccuracy.

Dr MAFIAMBA (Cameroon) said that the Director-General's current report was of the same high standard as the excellent document on the subject prepared the previous year. However, in view of the difficulties of assembling up-to-date worldwide data of that type, a number of errors had inevitably slipped in. For instance, his own country was shown, in Fig. 1 - Prevalence of infants with low birth weight, by country, 1982, as among those with low birth weight in the range 10 to 19.9%. While it was true that no comprehensive nationwide birth-weight studies had been undertaken, information presented at a meeting held in Yaoundé in January 1983, based on data collected by various workers, showed the average birth weight in Cameroon to be about 3.2 kg and the current low birth-weight rate as about 8.5%. Unpublished studies in five ecological zones in the country showed protein-energy malnutrition as critical in the age-groups 7-9 and 15-17 months of age.

The difficulties of obtaining reliable data on specific nutritional deficiencies was even greater. In his own country, for instance, there were pockets of endemic goitre in certain geographical areas, but it was not possible to define its true extent and gravity since available studies were out of date. Efforts had been made to combat that public health problem by means of intramuscular injections of iodinated oil, but obstacles had been encountered in obtaining supplies even though the necessary funds were available.

---

1 See p. 100.
2 See p. 117.
3 Document WHA37/1984/REC/1, Annex 5.
His delegation suggested that it would be desirable for the Secretariat, having made the necessary corrections, to combine elements of the Director-General's reports on the subject over the past two years, namely, documents A36/7 and A37/6, and seek to ensure the widest possible distribution of the resulting document, since the data were difficult to obtain outside national frontiers.

With regard to Part II of the report under consideration, his country, following a national nutrition seminar held in May 1983 with the assistance of FAO and a visit by a WHO consultant from the Regional Office for Africa later that year, had finalized its draft legislation on the marketing of breast-milk substitutes. Certain changes had been proposed following an interministerial meeting towards the end of the year, but work on the text had unfortunately been suspended temporarily due to the constitutional changes which had taken place early in the current year. However, a new post of Vice-Minister of Public Health, with special responsibility for maternal and child health, had been created, and infant nutrition would receive special attention within the framework of the rejuvenated maternal and child health activities soon to be initiated. Among the indirect ways of encouraging breast-feeding, he pointed out that labour legislation in Cameroon gave working mothers one hour in the morning and half an hour in the afternoon to breast-feed their children at home. Moreover, the steep increase in the price of breast-milk substitutes might prove a deterrent to their sales. The proposed legislation now under study would strengthen the measures for the strict control of sales, storage and advertising of breast-milk substitutes.

He supported the draft resolution on infant and young child nutrition submitted at the previous meeting, as amended by the delegation of Uganda.

Dr QUIJANO (Mexico) believed that the Director-General's report fully performed its function of providing objective and reliable data on the problem throughout the world, particularly with regard to the poorer areas.

In his own country, coordination had already been achieved over the past two years between the three official bodies responsible for the provision of health services, namely, the Secretariat for Health and Welfare, the Social Security System and the National System for Social Assistance and Integrated Family Development. Standards had been laid down for the minimum technical requirements which were to be met over a relatively short period of time and were aimed at a wide range of practical solutions, covering epidemiological surveillance of various indicators not only of nutritional status of lactating women and young children but also of that of pregnant women.

As mentioned in paragraph 71 of the report, a wide-ranging survey had been undertaken in his country in order to investigate the causes of the decline in breast-feeding. That survey was based on a group of 14,000 mothers, with a view to obtaining quantitative and qualitative data aimed at conferring maximum effectiveness on the standards he had previously mentioned. Another epidemiological research activity in broad sectors of the population related to child growth and development, for the purpose of evaluating indicators and obtaining up-to-date information on the scope of the problem and on any regional and cultural factors which could easily be dealt with.

In addition, a programme for training orientation in the field of nutrition had been undertaken in selected places, including the deprived areas of large cities as well as others in rural areas, which were particularly vulnerable in view of their extreme poverty and arid terrain.

Furthermore, an intersectoral commission on food supplies had been set up by presidential decree, with the participation of both the Secretariat for Health and Welfare and the Ministry of Agriculture; it was hoped that that would enable important practical steps forward to be taken in making the best use of food-producing areas, which would in turn be reflected in improved nutrition for the sectors of the population most likely to suffer from deficiencies.

Mr AL-NAMER (Bahrain) expressed support for the Director-General's report and for the draft resolution on the prevention and control of vitamin A deficiency and xerophthalmia. One of the problems which had emerged was the sharply rising demand for breast-milk substitutes due to the countless numbers of breast-milk substitutes available. His Government had adopted a comprehensive approach to the issue, one of the first steps it had taken having been to prohibit advertising of such products. In particular, special emphasis had been placed on ensuring that any form of commercial promotional activity relating to breast-milk substitutes would not be allowed in any health facility.

He had been particularly interested in the reference in the report to the draft model scheme to evaluate infant food marketing strategies, prepared by the Regional Office for Europe. That was precisely the type of monitoring plan which, as his delegation had suggested at the previous Health Assembly, could be useful to Member States, and it would be helpful for copies of that model scheme to be distributed so that countries could adapt it to their own situations. That would assist them in making objective evaluations with regard to
the progress being achieved in the implementation of, and compliance with, the International Code.

In addition to restrictions on the marketing of breast-milk substitutes, Bahrain had felt that national action was also called for in respect of the promotion of, and education in, breast-feeding during the pre- and immediate postnatal period in hospitals, and a series of films and educational material had been produced for use in group sessions for mothers in maternity wards. Those films not only showed how and when to supplement breast-feeding but also how to prevent and treat diarrhoeal diseases and when to bring the infant for immunization. Thus, social workers could reinforce action regarding immunization with monitoring of infant feeding and promotion of breast-feeding, and vice versa. Maternity leave was being extended and the need for sound maternal nutrition, both during and after pregnancy, was being stressed. In that context, national research was being promoted into foods which could be locally produced and prepared in the home, so as to arrive at the most cost-effective and health-efficient ways of producing and promoting such foods for use with infants. Moreover, in the light of recent scientific information on the interaction between certain pharmaceutical products and lactation, information guides were being developed for the use of mothers, giving the indications and contraindications for certain drugs during lactation.

Although much remained to be done, his Government felt that regular monitoring of infant and young child feeding practices and the factors influencing them should be carried out as widely as possible, since it served as a central tool in the planning and evaluation of maternal and child health activities.

He noted that Bahrain, as one of the Arab countries of the Gulf Area, had agreed to uniform draft legislation for the implementation of the International Code of Marketing of Breast-Milk Substitutes.

Extremely important contributions were being made by some nongovernmental organizations in helping to raise awareness in connection with infant and young child feeding. One such group, for example, had compiled an excellent report on the current situation with regard to infant feeding in the Middle East and, on the basis of those findings, was now working closely with Member States to design a programme to improve the situation. Initiatives of that type deserved support.

Dr RADILOVIĆ (Yugoslavia) emphasized the importance of widespread malnutrition, particularly in respect of mothers and infants and young children; it was a matter of crucial importance to the entire world community. Although the Director-General's report indicated some improvement, it was still the case that that problem remained one of the most fundamental public health problems in the world, not only in itself but also as a factor in the economic and social situation. The impact of economic development on malnutrition was obvious, and the greatest problems in regard to malnutrition existed in the least developed countries and were caused by the current world economic situation.

Yugoslavia, as a developing country, accorded the highest priority to the improvement and protection of the health status of children, young people and women, and, by means of various economic and social measures, was raising the status of women in order also to influence the health of infants. It had become evident that the adoption of a primary health care approach to the problems of infant and young child nutrition constituted one of the key methods for resolving those problems. It was also essential to continue and intensify action in respect of the implementation of the International Code of Marketing of Breast-milk Substitutes in all Member States as part of the efforts to improve the health and solve the nutritional problems of infants and children.

Dr IVANOV (Bulgaria) said that the problem of infant and child nutrition was an essential part of maternal and child health in the context of primary health care services, and a priority in the strategy for health for all. Inadequate nutrition was the result of many factors the elimination of which required close national and international cooperation.

With regard to the nutritional deficiencies mentioned in the document, iron-deficiency anaemia was still a problem in Bulgaria, as was iodine deficiency in certain areas. Screening for haemoglobin was therefore being carried out in certain age-groups for purposes of early detection and, in children in whom a low level was found, further tests were made to determine the causes so that appropriate treatment could be given. The prophylaxis of iron-deficiency anaemia in infants was started before birth by detecting and treating anaemia in pregnant women. Children who were unable to receive breast-milk were given adapted milk containing iron and, at an appropriate time, purées of meat and vegetables. The prophylaxis of iodine deficiency was effected by means of iodized salt and, in regions where goitre was endemic, iodine-containing preparations were given free to the population and to children in kindergartens and schools.
With regard to the influence of the method of feeding on infant mortality and morbidity, he wondered whether the studies carried out in some industrialized countries and which had indicated that there was no clear difference in the incidence of morbidity as between children fed naturally or artificially (paragraph 67 of the Director-General's report) had been carried out under normal conditions or in an epidemiological investigation. It was only logical that, where the level of hygiene was high, the morbidity of both groups would be practically the same, but that when there were epidemics there would be marked differences. The Bulgarian Institute of Paediatrics had carried out studies during epidemics of influenza and other viral diseases which had shown a lower morbidity in children who were breast-fed.

Efforts were being made in Bulgaria to increase the immunological properties of breast milk. If mothers were exposed to ultraviolet light during the lactation period it was found that their milk contained a higher level of interferon. That method, which was inexpensive and easy to apply, was being used in practice. Some families were being given portable quartz lamps to use at home and ultraviolet radiation could also be provided to groups of mothers at health centres; that did not require highly trained staff.

To bring the information in the report up to date, he informed the Committee that the National Institute of Health Education had published a new brochure, aimed at a wide public, on the advantages of breast-feeding. There were also television programmes on the subject and courses on infant and child nutrition in medical schools stressed its value.

The packages of modified milk satisfied the requirements of the International Code of Marketing of Breast-milk Substitutes and both the accompanying text and the formulation had been corrected. With regard to complementary feeding, Bulgaria had commenced large-scale production of children's foods based on milk, fruit, meat and vegetables, using raw materials available in the country and taking national food habits into account. The State subsidized the production of infant foods, so that they were sold at prices which all could afford.

Mass distribution of those products enabled all children to be weaned at any time of the year in any region of the country and to receive complementary feeding at the proper time.

Professor MATEJICEK (Czechoslovakia) said that in Czechoslovakia particular attention was paid to infant and young child nutrition. Even just after the end of the Second World War, under conditions of high infant morbidity and scarcity of foodstuffs, a uniform system had been established for infant and young child nutrition. A large variety of milk products had been offered and a programme to supply breast-feeding mothers and children with vitamins A and D free of charge had been initiated. State enterprises had produced various types of dried milks for dietetic purposes under strict quality and safety controls. Sick children had received, and continued to receive, dietetic milk preparations free of charge.

Considerable attention was paid to maternal nutrition, as a factor of major importance in child health and development. In the health education given to pregnant women, emphasis was placed on the fact that breast-feeding was a natural biological need of both children and mothers and that breast milk was not only a food but also a source of protection for the child. The political and state agencies had created all the necessary conditions for that purpose; both mothers and children received considerable material and financial support. Programmes were currently in operation to promote and improve breast-feeding and to ensure proper nutrition. The Ministry of Health, on the basis of the latest findings and results in food science, regularly issued standards of recommended quantities of nutrients, minerals and vitamins for various age-groups by sex and occupation.

A programme had been worked out to develop the appropriate technology for the manufacture of food products for infants and young children and to ensure their correct use. By means of legislative and social measures, the workload of pregnant women had been reduced and facilities provided for the feeding of young children. A wide, easily accessible network of clinics had been established where preventive health measures, including health education and the checking of the physical and mental development of infants and young children, could be undertaken, and mothers instructed in correct feeding practices.

Particular attention was paid to children in kindergartens, where the food was prepared by qualified workers and checked by a paediatrician and the agencies of the hygiene service to determine its biological value. The level of awareness of health factors among mothers and the questions of infant and young child nutrition and breast-feeding were being studied by the country's scientific institutes and the results of their research were applied in practice. All those measures were reflected in the constant improvement in the physical and mental health of children in Czechoslovakia.

Professor NAJERA (Spain), stressing the importance of the item under consideration, said that it was not appropriate to conclude, as stated in the Director-General's report, that there had been a reduction in low birth-weight rates, since that conclusion was based on highly approximate data and, in any case, the reduction was very small — about 1%. The data provided might, in fact, point in the opposite direction. The only conclusion that could be drawn was that the data did not indicate any important change either way.
The same comments applied to other problems analysed in the report, and especially to the evaluation of protein-energy malnutrition. As pointed out, it was very difficult to evaluate its extent during, and the changes in its prevalence between the periods 1963-1973 and 1973-1983, but the report optimistically stated that it had not become worse. At the most, the data indicated that no significant change had taken place.

Although the data were not very reliable, they could, nevertheless, have been better evaluated. If they had been grouped according to the type of health system of the area or country, the sociopolitical or economic system, or economic factors such as per capita income, the relative value of the data and of the variations observed would have been more easily perceived. The grouping chosen, by geographical regions, rendered them devoid of all interest because they could not then indicate any correlation which was not already obvious for the subregions concerned.

In that connection, he considered that the system of grouping data by regions, which was frequently used in WHO documentation, was a mistake and should be replaced, or at least complemented, by a system based on socioeconomic parameters or on the organization and type of health services; that would shed more light on the effectiveness of the actions taken.

Finally, he expressed doubts about the advisability of using sugar as a vehicle for vitamin A. It was totally inappropriate that sugar should be distributed by the paediatric services of the primary health care system, as happened in the Central American programme referred to in paragraph 48 of the report.1

Dr MATTHIEIS (Federal Republic of Germany) said that a few years previously she had informed Committee A about the increase in breast-feeding in her country, a trend which was still persisting. Its opinion leaders were, and continued to be, well-educated young mothers who wished to bring pregnancy, childbirth and infant feeding "back to nature" as far as possible. In the same groups of young women, however, an opposite trend had recently appeared, caused by the fear of transmitting harmful chemicals found in the environment through breast milk. The health authorities had investigated the matter and had had difficulty in reassuring mothers about the advantages of breast-feeding.

Her delegation had wished to share that experience with members of the Committee in order to remind everyone that trends might change quickly and that it was necessary to watch closely ideas prevalent in the community so as to prevent undesirable developments.

Dr MARKIDES (Cyprus) said that his Government intended to undertake research into the problem of the abnormally high number of premature births occurring in Cyprus, which might be due to the working conditions of young mothers, their smoking habits, their age or bad nutritional habits, or to some other cause which must be detected.

Breast-feeding was now gaining ground in his country, as a result of a campaign started a few years previously with the assistance of health workers. A further increase in the number of mothers breast-feeding their children would depend on social changes and measures to support women in their role as mothers. His Government was currently studying a report on that subject prepared by a national committee for the rights of women which had been established in connection with International Women's Year.

As paragraph 186 of the report indicated, his Government had taken steps to implement the International Code of Marketing of Breast-milk Substitutes. Paediatricians, gynaecologists and all health workers were enthusiastically taking part in the campaign to encourage breast-feeding and to stress its value.

In conclusion, he suggested that, in view of the vital importance of infant and child nutrition, the Director-General should introduce the same monitoring process for evaluating progress in that field and implementation of the International Code, as he had done for the Global Strategy for Health for All by the Year 2000. The coming generation would be grateful for that emphasis.

Mr VAIDYANATHAN (India) recalled that his country had already formulated and adopted a national health policy that recognized the need to provide health for all. That policy had the support of political will at the highest level. It recognized that investment in health was investment in human resource development; it indicated an integrated approach to all-round development in various social sectors, such as hygiene, sanitation, water supply and nutrition, as well as preventive, promotive and rehabilitative health care. Maternal and child health was an integral part of India's national health programme; the national health policy had established certain indicators for the attainment of health for all by the year 2000, e.g., reducing maternal mortality to less than two per thousand births, reducing the infant mortality rate and bringing down the proportion of babies born with a birth weight of 2500 g or less to under 10% of the total number of births.

1 See footnote on p. 64.
Diarrhoea, respiratory diseases and neonatal tetanus were perhaps the factors that accounted for a high rate of child mortality; in certain parts of India iron deficiency accounted for a large proportion of infant and child morbidity. Nutrition was therefore an essential part of the maternal and child health programme, in which immunization was also very important. The health of the child depended on that of the mother, and mothers in rural areas often suffered from anaemia; therefore, as part of India's antenatal programme, iron and folic acid tablets were distributed to mothers. Children, particularly of school age, had been found to have a dietary deficiency of vitamin A, leading to impairment of vision. India's maternal and child health programme therefore included a nutritional supplement of vitamin A for children. A number of Indian states had also adopted a midday meal programme for schoolchildren.

Immunization was also an important ingredient in India's child health programmes, because children in a tropical country, such as India, were exposed to communicable diseases. India was therefore stepping up its expanded immunization programme so that by 1989-1990 all children born in India would be covered. Infrastructure, including the cold-chain, would be the largest constraint in achieving that goal; India was therefore already tackling the cold-chain problem.

With regard to breast-feeding and breast-milk substitutes, he pointed out that in December 1983 his Government had adopted a resolution on the Indian National Code for Protection and Promotion of Breastfeeding. Echoing the message of the World Health Assembly, the Indian Government had affirmed in its National Code the right of every child to be adequately nourished, and had recognized that the health of infants and young children could not be isolated from the health and nutrition of women. Mother and infant formed a biological unit; breast-feeding was thus an integral part of the whole programme, and was also important from the standpoint of the reproductive process. Promotion of breast-milk substitutes and related products had been more extensive and pervasive than the promotion and dissemination of information concerning the advantages of breast milk and breast-feeding; that had contributed to a certain decline in breast-feeding. In the absence of strong intervention to promote breast-feeding, it could be anticipated that the decline would continue and that even larger numbers of infants and young children would be at risk of infections and malnutrition. Only when infants could not be breast-fed did other foods become necessary. In recognition of that basic fact, his Government had adopted the National Code and was framing legislation so that the Code could be put on the statute books and henceforth serve as a guideline regarding breast milk, breast-feeding and breast-milk substitutes. His Government had also taken administrative action to implement various provisions of the Code; no government media would give any publicity to, or accept any advertising for, baby foods or breast-milk substitutes. He was hopeful that in the not-too-distant future India would achieve the stage of development expected by WHO.

Dr HASSOUN (Iraq) expressed his admiration of the Director-General's report. He stressed the importance of proper nutrition for mother and child, but thought that in order to derive maximum benefit from such nutrition it had to be accompanied by other important elements in primary health care, such as clean drinking-water, proper drainage, expanded immunization against children's diseases, control of insects and, last but not least, health education for pregnant women to explain to them the importance of breast-feeding. His country had passed legislation to enable the working mother to take care of and feed her child during the most critical period of the child's life; the law stipulated that pregnant women should have 45 days' leave with full pay before delivery, as well as 6 months with full pay after delivery in order to raise standards of nutrition during childhood and to reduce the infant and child mortality and morbidity rates on the basis of primary health care in all its ramifications.

Dr PETROS-BARVAZIAN (Director, Division of Family Health) thanked delegates for their encouraging comments and their valuable suggestions, which would be an important guide for the Organization's further support to Member States' activities in nutrition and maternal and child health in the context of their strategy for health for all based on primary health care. She had carefully noted the updated information made available by delegates since the Director-General's report had been prepared; that information would be reflected in future reports to the Health Assembly, as requested by resolution WHA33.32. She had heard with great interest the wide-ranging activities initiated by Member States in infant and young child nutrition, which included maternal nutrition and health. The issues raised by delegates covered a wide range of subjects important to infant and young child nutrition including the overall socioeconomic situation; the status of women; intersectoral activities related to food and nutrition; education in general, and in particular of women; nutrition of mothers; prenatal care; childbirth; infancy; the integrated approach for the prevention of malnutrition and infection; and the importance of child spacing.
As reemphasized by all Member States, nutrition of the infant and young child could only be considered in a comprehensive and integrated manner with other elements of primary health care and with provision of appropriate technology to help the infrastructure to deliver those elements. All speakers had emphasized that, in child and infant nutrition, in addition to breast-feeding, maternal nutrition and nutrition during weaning and the second year of childhood were matters of great importance and concern. Maternal nutrition was very much a part of the development of appropriate prenatal technologies in support of Member States in connection with WHO's maternal and child health and nutrition programme; in particular more scientific knowledge was needed about energy intake and expenditure by women during pregnancy and its relationship to maternal nutritional status. WHO was convening a study group in 1985 to throw light on salient issues and to develop further action programmes in regard to nutrition during pregnancy and lactation. Meanwhile, as a practical guide, educational materials had been prepared — and Member States were adapting them — in relation to workload and energy expenditure against nutritional intake during pregnancy, and the prevention of infection, which had a deleterious effect on nutritional status and the outcome of pregnancy. Many delegates had stressed the close and important link between maternal health and child health, and the importance of the prenatal environment affecting the outcome of pregnancy, including birth weight, immediate survival and long-term morbidity.

In respect of weaning, in recent years the Organization had initiated an action-oriented research programme in support of many Member States. In 1983 the Organization had convened a Meeting on Determinants of Infant and Young Child Feeding and Care, not only as regards biological and food aspects but also behavioural aspects, family food distribution, decision-making by women at the family level and the availability of immunization, environmental sanitation, education, and all the various integrated elements affecting children's nutritional status. That activity was part of the of the programmes of nutrition and maternal and child health, including family planning, under the Seventh General Programme of Work.

In reply to the question on the draft model scheme for the evaluation of infant-food marketing prepared by the Regional Office for Europe, she said that the scheme had been prepared to be adapted and used by Member States of that Region who so wished in the context of their national priorities and national policies and that it would be made available to any interested delegates.

Careful note had been taken of many comments on specific nutritional deficiencies, such as vitamin A deficiency and nutritional anaemia in pregnant women. As regards comments on the statistical presentations in the report, additional information from Member States, including information on birth weight, which was one of the indicators of progress in achieving health for all, would permit future reports to reflect the situation more accurately. The present report had been based on the information so far available and the Organization would be pleased to receive any additional information which Member States wished to provide.

During the past year WHO had benefited greatly from close contact with professional groups and various organizations and bodies of the United Nations system, in particular UNICEF and UNFPA, as well as with the infant-food industry and scientific and nongovernmental organizations concerned with infant and young child nutrition. She appreciated their collaboration and hoped that it would continue throughout the coming biennium, as well as support Member States in their broad strategies for primary health care and its nutrition and maternal and child health components.

The CHAIRMAN drew the Committee's attention to the draft resolution on prevention and control of vitamin A deficiency and xerophthalmia, which read as follows:

The Thirty-seventh World Health Assembly,
Recalling resolutions WHA22.29, WHA25.55 and WHA28.54 on the prevention of blindness;
Recognizing the continuing great human suffering, and the considerable burden to both the individual and to society that is caused by nutritional blindness;
Considering that, in Asia alone, more than ten million children are affected by vitamin A deficiency and xerophthalmia, that more than one million of these become blind every year, that as many as 70% of this number die in the weeks immediately following the onset of blindness, and that the remainder are permanently blind;
Conscious that even mild cases of vitamin A deficiency and xerophthalmia contribute to increased morbidity and mortality in young children in many developing countries;
Considering that vitamin A deficiency and xerophthalmia are highly prevalent in Africa, Asia and the Western Pacific, and in limited areas of the Americas;
Aware that safe, effective and relatively inexpensive techniques exist to control vitamin A deficiency and xerophthalmia, in particular through periodic mass distribution
of large doses of vitamin A, the fortification of certain foods, and increased consumption of local foodstuffs rich in provitamin A;

1. THANKS the Director-General for the updated information on selected global and regional trends in nutritional status and related indicators included in his report;¹

2. URGES all Member States to give high priority to the prevention and control of vitamin A deficiency and xerophthalmia wherever these problems exist through appropriate nutritional programmes as part of primary health care;

3. REQUESTS the Director-General:
   (1) to give all possible support to Member States, as and when requested, in assessing the most appropriate approaches, in the light of national circumstances, needs and resources, to preventing and controlling vitamin A deficiency and xerophthalmia;
   (2) to collaborate with Member States in the monitoring of the incidence and prevalence of vitamin A deficiency and xerophthalmia;
   (3) to prepare suitable materials, for adaptation and use at the national level, for training health workers in the early identification and treatment of vitamin A deficiency;
   (4) to coordinate with other intergovernmental organizations, and appropriate nongovernmental organizations, the launching and management of intensive and extensive international action to combat vitamin A deficiency, including the mobilization of financial and other resources required for such actions;
   (5) to report to a future Health Assembly on progress in this area.

Professor SAGHER (Libyan Arab Jamahiriya), introducing the draft resolution, said that it appealed for help to all countries and agencies concerned in the humanitarian cause of saving millions of children from blindness. There were 10 million children in the world who were destined to lose their sight; that was a preventable catastrophe. The draft resolution spoke for itself; he hoped that the Organization would adopt it and provide assistance in its implementation.

Dr CORNAI (Switzerland) said that the strengthening and improvement of the control of vitamin A deficiency was an important goal, and her delegation supported the draft resolution. Apart from the gravity of the problem of xerophthalmia, there was another reason for her delegation's support: the relative simplicity of treatment, which should be made available to all endangered populations. The control of vitamin A deficiency included both prevention and treatment. Although treatment produced an immediate effect, preventive measures having long-term effects and requiring repeated action over a considerable period should nevertheless not be neglected and should even be given priority, particularly since they did not necessarily impose a heavy economic burden. For that reason she wished to propose two amendments to the text of the draft resolution, apart from an editorial change which concerned only the French text, and would bring it into line with the English version. The first substantive amendment concerned the sixth preambular paragraph, in which she proposed that the increased consumption of local foodstuffs rich in provitamin A should be mentioned first, so that the paragraph would read, after the word "xerophthalmia": "in particular through increased consumption of local foodstuffs rich in provitamin A, periodic mass distribution of large doses of vitamin A, and the fortification of certain foods;".

Her second amendment had the same aim of stressing the importance of the production and promotion of foodstuffs rich in vitamin A; she therefore proposed that paragraph 3(3), from the words "health workers", be amended to read: "health and development workers in the prevention of vitamin A deficiency - in particularly through education in nutrition and by promoting the production of local foodstuffs rich in provitamin A - and in its early identification and treatment".

Dr FERNANDO (Sri Lanka) said that his delegation also wished to be a sponsor of the draft resolution. He had no objection to the amendments proposed by the Swiss delegation.

Professor SAGHER (Libyan Arab Jamahiriya) said that the original sponsors of the draft resolution were pleased to accept the Swiss amendments.

Dr G. TRAORÉ (Mali) said that in view of the massive campaign against blindness being undertaken in his country, which included not only the surgical and medical treatment of eye disease but also prevention, his delegation also wished to sponsor the draft resolution.

¹ Document WHA37/1984/REC/1, Annex 5.
The draft resolution, as amended, was approved.1

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

3. ACTION PROGRAMME ON ESSENTIAL DRUGS AND VACCINES: Item 22 of the Agenda
(Resolutions WHA35.27 and EB73.R15; Document EB73/1984/REC/1, Annex 7)

The CHAIRMAN drew attention to the draft resolution proposed by the Executive Board in its resolution EB73.R15 as well as to the draft resolution on the rational use of drugs, proposed by the delegations of Algeria, Australia, Belgium, Botswana, Denmark, Finland, Ghana, Iceland, Kuwait, Mexico, New Zealand, Nigeria, Norway, Panama, and Sweden, reading as follows:

The Thirty-seventh World Health Assembly,
Recalling resolutions WHA24.56 and WHA31.32;
Recognizing the progress achieved in the development of the WHO Action Programme on Essential Drugs and Vaccines and the Organization's programme on drug information;
Concerned by the high proportion of health budgets spent on drugs, particularly in developing countries, thereby limiting the remaining funds available for the provision of adequate health care to the whole population through primary health care;
Realizing the problems of excessive and inappropriate prescription and use of drugs;
Aware of the need for developments in clinical pharmacology for the improvement of prescription practices, with regard to effects, adverse reactions and the possible interaction of drugs;
Realizing the need for further analysis of the basic knowledge of drug prescription and use required for the training of health personnel;
Recognizing the importance of objective and complete information about drugs to physicians, pharmacy staff, other health workers and the general public;
Aware of the need for better information on drug marketing procedures and practices;
Recognizing the achievements of local drug and therapeutic committees established in many Member States;
Noting with satisfaction the growing interest shown by governments, the pharmaceutical industry, consumers' organizations and health workers in information about, and the marketing of, drugs;
Convinced of the need for cooperation between all interested parties in order to achieve a more rational use of drugs;

1. URGES Member States:
   (1) to support the development and dissemination of unbiased and complete information on drugs;
   (2) to collaborate in the exchange of information on the use and marketing of drugs through bilateral or multilateral programmes and WHO;

2. REQUESTS the Director-General:
   (1) to continue to develop activities at national, regional and global levels aiming at the improvement of prescription practices and the provision of unbiased and complete information about drugs to the health profession and the public;
   (2) to foster the exchange of information among Member States on drugs and marketing practices;
   (3) to convene a meeting of experts during 1985 with the participation of all concerned parties, including governments, pharmaceutical industry and consumers' organizations, as well as other organizations, to discuss the role of marketing practices and means and methods for increasing the knowledge of the proper use of drugs, especially in developing countries;
   (4) to submit a report on the results of the meeting of experts to the Thirty-ninth World Health Assembly.

Dr KHALID BIN SAHAN (representative of the Executive Board), introducing the item, said that the Thirty-fifth World Health Assembly, in its resolution WHA35.27, had requested the Executive Board to continue to monitor the evolution of the Action Programme on Essential Drugs and Vaccines and to report to the Thirty-seventh World Health Assembly. At its

1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA37.18.
seventy-third session, the Executive Board had considered a progress report presented by its Ad Hoc Committee on Drug Policies on the Action Programme (document EB73/1984/REC/1 Annex 7). It would be recalled that the Board had reported to the Thirty-fifth World Health Assembly on the progress of the Action Programme, analysed problems in its implementation, and developed a plan of action for 1982-1983.

Among the problem areas then identified as requiring further attention were:
(a) administrative and legal complexities and difficulties, e.g., in pool procurement by groups of countries; (b) shortage of trained personnel; (c) lack of technical expertise in developing countries; (d) inadequate provision or unbalanced allocation to, and expenditure within the health sector; (e) political, social and commercial implications and determinants of drug policies; (f) the unfavourable attitude of many physicians to the concept of essential drugs; and (g) the high level of technology and investment needed to set up local production of drugs.

The plan of action for 1982-1983 had recommended appropriate actions at country, regional and global levels in the areas of development of national drug policies, drug procurement, manpower development, mobilizing financial resources, and programme monitoring and evaluation.

Introducing the progress report by the Executive Board Ad Hoc Committee on Drug Policies, he said that during 1982-1983 additional countries had adopted the concept of essential drugs while those already committed to that concept had made significant progress in implementing their national drug policies. There was now a greater awareness and understanding of the problems of essential drugs, both at country and international level and between consumers and producers, with increased possibilities of mutually beneficial cooperation. The progress made during the past two years was encouraging.

With regard to training and manpower development in the areas of drug selection, procurement, distribution and usage, the programme had already started active collaboration with governments, institutions, industry and other WHO programmes. Activities had included preparation of training materials, training workshops and seminars, and the identification of a number of well-established drug programmes as foci for further collaboration. Universities, particularly schools of public health, schools of medicine and pharmacy, and departments of economics and other social sciences, could play an important role in promoting the concept of essential drugs and its practical application.

Bangladesh, Kenya, Peru, the United Republic of Tanzania, Zambia, and other countries were successfully implementing national programmes on essential drugs. Three demonstration workshops to present the Kenyan experience to nationals from 25 other developing countries had been held in 1982 and 1983. Guidelines, handbooks, reference material and manuals had been developed and disseminated. Subjects covered included selection of drugs, drug policies and legislation, drug supply, and training in pharmaceutical technology and quality assurance. A publication entitled The use of essential drugs (WHO Technical Report Series, No. 685) had been distributed in 1983.

On the question of drug procurement, the advantages of large-scale, multi-year contracts based on international tender with assured financing had been demonstrated when in 1983 the United Republic of Tanzania had called for tenders for about 40 essential drugs for its primary health care programme for a period of three years, the financing being provided by DANIDA. The tender had been executed by UNICEF, while WHO had provided technical support. However, pool procurement on a large scale for a number of countries together had not yet taken place. Many countries did not consolidate their drug procurement and thus did not take advantage of possible lower drug prices. Consolidated and pooled procurement should stimulate competition among suppliers and thus lead to advantageous drug prices.

TCDC activities in the Action Programme had mainly focused on quality assurance, including reference standards, information and manpower development. There were also indications that Member States were now interested in joint production of essential drugs. Burundi was studying the feasibility of enlarging its production capacity in order to supply drugs to two other countries, while the Caribbean countries were preparing a subregional formulary and the Regional Office for the Americas was assisting in implementing the Andean subregional pharmaceutical policies. A number of collaborative activities had taken place among the countries members of the Association of South-East Asian Nations (ASEAN).

Contact and collaboration with nongovernmental organizations and the pharmaceutical industries had been strengthened.

The International Federation of Pharmaceutical Manufacturers Associations (IFPMA), as part of its collaboration in the Action Programme, had offered to supply 250 drugs and vaccines (150 of those listed in the publication The use of essential drugs) at favourable prices. The IFPMA offer of 1982, however, had not yet been applied. IFPMA had also offered expert assistance in drug management and distribution, training in quality control and collaboration in pilot projects for individual least developed countries. Technical assistance had been provided by certain companies to a number of Member States.
In 1981, IFPMA had established a voluntary Code of Pharmaceutical Marketing Practices and had officially stated its willingness to report to WHO on the application of that Code. The Organization had collaborated with IFPMA by submitting to it information relating to infringements of the Code. There had been considerable discussion in the Board on whether WHO should participate in monitoring the IFPMA Code, on the effectiveness of the Code, and whether there should not be an international code of pharmaceutical marketing practices sponsored by WHO. In his intervention, the Director-General had stated that there were two separate action programmes in WHO relating to drugs, one of which dealt with essential drugs; the focus in that programme was on ensuring access to such drugs and their proper use in the context of the health-for-all strategy. The other programme related to the wider issues of certification of drugs, quality control and so on. Though the two programmes were interrelated, delegates might wish to take note of that distinction when discussing the document before the Committee so that the primary objective of the Action Programme on Essential Drugs and Vaccines could be achieved.

The report contained a proposal for a monitoring and evaluation system for the Action Programme. The establishment of that system was considered essential to facilitate monitoring of progress.

The Board felt that the present policy and strategy for the Action Programme was basically sound. Significant additional progress had been made in the past two years, but for more effective implementation of the Programme, the Board had identified a number of critical issues that needed to be further considered by it in the future. Those related to the further development of national political will and technical "know-how", on such issues as estimating drug requirement and quality control, national drug formularies, supply mechanisms and structures, including drug storage and distribution, manpower training, good prescribing and dispensing practices, mass production of essential drugs, and research and development.

The Board was recommending that the Health Assembly should adopt the draft resolution contained in its resolution EB73.R15. He also drew the Committee's particular attention to paragraph 61 of the Ad Hoc Committee's report.

Dr. LAURIDSEN (Programme Manager, Action Programme on Essential Drugs and Vaccines), updating the report of the Ad Hoc Committee on Drug Policies (January 1984), said that most countries already implementing essential drugs programmes were making good progress with or without international collaboration. Highlighting additional countries which were now developing drug legislation, policies and implementation of plans along the lines of the Action Programme, he said that Sierra Leone had formulated a national drug policy and lists of essential drugs for all levels of health care had been established and approved; the programme was receiving technical and financial support from the World Bank and WHO. Zambia was being supported by SIDA and WHO in formulating its essential drugs programme and it had requested inclusion in the UNICEF/WHO procurement consortium now under development. Kenya had accelerated the implementation of its essential drugs programme. Full national primary health care coverage was scheduled for the end of 1984—beginning of 1985, one year ahead of schedule. A recently completed cost and financial analysis showed that the present system was more cost-effective than the previous system. The average cost of drugs per patient per year had been reduced to about US$ 0.25.

Zimbabwe had expressed interest in developing its essential drugs programme and a WHO support mission, probably in collaboration with DANIDA, was expected to take place by the third quarter of 1984. Ethiopia had formulated its national essential drugs programme in collaboration with WHO and UNICEF and implementation would take place during 1984 with financial support expected from Italy and possibly Sweden. Upper Volta and Mali were developing their programmes and were negotiating with the World Bank. Italy was expected to support Upper Volta and the French Government would make a grant available to Mali for its primary health care infrastructure, including an essential drugs programme. Djibouti, with WHO technical support, was developing drug legislation which would serve as the basis for a national drugs policy including revision of drug lists for different health care levels.

In Burundi, a pilot project implemented in collaboration with three Swiss companies would be expanded with a Sw.fr. 450 000 grant from the Swiss Directorate for Cooperation in Development and Humanitarian Aid. Equatorial Guinea was receiving substantial technical and financial support from Spain, while Nicaragua was developing its national programme with the Regional Office for the Americas and WHO headquarters support. The Democratic Yemen was analysing its drug sector and plans of operation were being developed with a WHO team of experts. The World Bank was financing primary health care activities, but additional external support was required for development of the infrastructure, local formulation of oral rehydration and intravenous fluids and for training.

Yemen had developed an essential drug project as a component of its health resources review. Oman was considering its drug policy and would be visited by a WHO team in
September. Bhutan had requested support from WHO for the improvement of its drug supply system and had secured initial financial support from Finland.

So far as the pharmaceutical industry was concerned, discussions and negotiations with IFPMA and individual member companies had been stepped up in an improved climate of collaboration. Technical and financial support for the Action Programme was increasing, and it was expected that that trend would continue. Both Bangladesh and Haiti were under consideration for support from IFPMA under its offer of drugs at favourable prices.

With regard to dissemination of experience and information, a four-day international Conference on Essential Drugs in Primary Health Care, sponsored by UNICEF, USAID, SIDA, WHO and IFPMA member companies, held in Boston, United States of America, had attracted more than 160 participants, including 60 from developing countries. The purpose of the Conference had been to develop problem-oriented teaching and training material for use in schools of public health. The Conference had been very well received by most participants and it was planned to arrange four similar conferences the following year in developing countries. The London School of Hygiene and Tropical Medicine was teaching essential drugs principles and had held a public hearing on essential drugs on 30 April 1984. The National School of Public Health in Rennes, France, had begun a test project, supported by the French Government, for training multidisciplinary groups from developing countries in the field of essential drugs. Numerous schools of medicine and pharmacy were being canvassed for possible interest in a collaborative scheme to teach essential drugs principles. Existing information concerning essential drugs was being adapted for use within national programmes. Thus, draft drug information sheets for primary health care drugs which had been reviewed by the Expert Committee on the Use of Essential Drugs in December 1982 were available for country application. Members of the Secretariat had also held discussions with and visited nearly all interested collaborating bilateral development agencies.

The Committee of Ministers of the Council of Europe had considered the report and recommendations listed in document EB73/1984/REC/1, Annex 7, paragraphs 60-61, and had informed WHO that:
The Committee of Ministers has had a preliminary exchange of views on Recommendation 969 on the sale of pharmaceutical products in the countries of the Third World, and agreed to transmit it to the governments of Members States...

The Committee of Ministers has also decided to ask the Committee for Public Health and the European Public Health Committee to give an opinion on Recommendation 969, particularly on the advisability and feasibility of making practical proposals and for coordinating action by Council of Europe Member States.

WHO and UNICEF had undertaken studies and consultations to develop programmes to assist developing countries to procure essential drugs and were currently formulating a plan to set up an international procurement fund to provide developing countries with short-term credit for financing the purchase of essential drugs. UNICEF and WHO's supply services would provide technical support when needed. That facility would enable countries to benefit from UNICEF's low prices through large-scale procurement without having to provide convertible currency in advance. A list of indicative prices for about 140 essential drugs was available and would be circulated to Member States through the UNICEF country offices during May 1984. The preliminary proposal provided for an amount of some US$ 10 million to be raised jointly by UNICEF and WHO for initial operations. Matching funds from other sources would be solicited. WHO would work with countries in establishing needs for essential drugs and vaccines and that information would be passed to UNICEF for early programming into the procurement process. The proposed joint WHO/UNICEF fund would, it was hoped, facilitate the transition between the policy and programme formulation stage and the actual supply of essential drugs and vaccines to the countries involved. An outline of the proposed international procurement scheme had been presented to the 1984 session of the Executive Board of UNICEF for information and UNICEF and WHO would develop the details of the plan during the coming five to six months for submission to the respective organs for approval. If the plan was approved, it was expected that the fund would become operational early in 1985.

Following discussions by the Executive Board Ad Hoc Committee on Drug Policies, the Director-General had decided to establish a small global advisory group along the pattern of the Expanded Programme on Immunization. The first meeting was planned to take place at the beginning of 1985.

He was pleased to inform the Committee that extrabudgetary contributions had been received or were committed from Sweden, Denmark, Finland and Canada, and that the Swiss Directorate for Cooperation in Development and Humanitarian Aid had announced the previous day that a substantial grant would be made available. Negotiations were under way with other bilateral agencies for increased collaboration.

The meeting rose at 11h05.
EIGHTH MEETING
Tuesday, 15 May 1984, at 14h30

Chairman: Professor F. Renger (German Democratic Republic)

ACTION PROGRAMME ON ESSENTIAL DRUGS AND VACCINES: Item 22 of the Agenda (Resolutions WHA35.27 and EB73.15; Document EB73/1984/REC/1, Annex 7) (continued)

Professor MATEJČEK (Czechoslovakia) said that increasing interest throughout the world in improving drug supply systems underlined the need for WHO to play an appropriate role in that field. WHO's strategy on the selection of essential drugs and vaccines was moving along the right lines, taking into account all available knowledge on pharmacological and biological aspects, the possibilities of reducing risk-benefit ratios, and economic and ethical considerations. The Action Programme was an important tool for Member States in carrying out their activities, and its implementation should take into account both the specific social conditions pertaining in individual States and knowledge concerning the rational use of drugs.

His delegation supported the recommendation encouraging developing countries to establish their own lists of essential drugs and revise existing lists, and endorsed the work of the Executive Board's Ad Hoc Committee on Drug Policies (document EB73/1984/REC/1, Annex 7).

In Czechoslovakia drug policy activities were an integral part of the country's comprehensive national health programme. Czechoslovakia was also providing financial, technical and moral support to many developing countries to assist them in implementing drug formulation and production programmes. The Czechoslovak pharmaceutical industry was also involved in those activities.

Dr Fernando (Sri Lanka), recognizing the importance of the Action Programme, said that Sri Lanka had identified a list of essential drugs for primary health care, which was now in use. Requirements and utilization patterns, which had been assessed previously, were being reviewed. It was essential for a developing country at least to formulate its own essential drugs. Currently, that was not the case in Sri Lanka, except for a very few items formulated by the private sector. Drug manufacturers did not readily undertake manufacture or formulation of essential drugs because of the low profit margins, so that such activities generally had to be run by the Government. Sri Lanka was negotiating with a friendly country to set up a formulation plant for tablets and capsules of essential drugs, and it was hoped to finalize the project soon. Negotiations were also under way with an organization regarding the formulation of sterile fluids. WHO had given technical assistance at all stages and levels in both those projects.

Sri Lanka was attempting to control the quality of drugs by allowing the import only of specific drugs from approved manufacturers. Unfortunately, the measure did not ensure that only good quality drugs were reaching the country. Although Sri Lanka had a quality control laboratory, it was inadequate at present to cope with the workload. An international organization was looking into the possibility of upgrading that laboratory. Even with an upgraded quality control laboratory, it was still essential to have an external quality control laboratory that could be consulted when necessary. Sri Lanka always purchased drugs with a quality control certificate both from the manufacturer and from an independent laboratory. However, in cases where the quality of a drug was in doubt the report of an independent laboratory was not always accepted by the manufacturer. If developing countries were to receive good quality drugs, a quality control laboratory that would not be contested by drug manufacturers was needed. Logically, the only suitable arrangement would be a regional quality control laboratory associated with WHO; its certification could not be challenged and, furthermore, it would not be in the interests of drug manufacturers to receive a poor report from such a laboratory. As at previous Health Assemblies, he urged the consideration of such an arrangement at the regional level.

The difficulties of pool procurement outlined in the report of the Board's Ad Hoc Committee were not insurmountable. Adequate quantities of good quality essential drugs were a prerequisite for the attainment of health for all by the year 2000. The quantity of drugs
imported would naturally depend on the finance available, always limited in developing countries. Pool procurement provided a means of obtaining drugs of good quality at prices that were much lower than those currently charged to individual countries. WHO should actively review means of pool procurement. If regional procurement was not viable, other means would have to be sought.

Sri Lanka had started to manufacture oral rehydration salts and the salts were now available to all primary health care workers and health institutions. He was confident that deaths from diarrhoeal diseases would be dramatically decreased in the future through that measure.

Dr SEPÚLVEDA (Mexico) said that the drugs policy of the Mexican Government had two aspects: the supply of drugs to public institutions (i.e. the State sector), and supply to the private sector - each sector covering about 50% of the population. Annual expenditure on drugs was more than US$ 1000 million. In accordance with a presidential decree of 9 June 1983, an interinstitutional committee to determine basic health sector inputs had been set up. The committee had drawn up a list of essential drugs on the basis of the following criteria: guarantee of maximum efficiency with minimum risk; elimination of unjustified drug combinations; elimination of unnecessary duplication of drugs; and the adoption of generic names. The criteria conformed with the general lines laid down by WHO.

The committee had also drawn up a basic formulary which contained 329 generic drugs, 484 pharmaceutical formulations and vaccines. The formulary contained general information on each drug, as well as indications, contraindications, necessary precautions for use and interactions with other drugs. The basic formulary had been published in January 1984 and was an indispensable therapeutic guide for doctors and other health workers. Its use was obligatory for institutions in the public sector, in which some 40 000 doctors were employed.

The production and marketing of drugs for the private sector, for use by the general public, was regulated by a presidential decree of 23 February 1984, which extended and consolidated government policy established in 1978. The decree outlined standards for the promotion and development of the national pharmaceutical industry, with the aim of reducing dependence on imports. It included the following marketing regulations: strict price-fixing criteria; rigorous monitoring of quality control by state laboratories; regulations for the marketing of a group of priority drugs, included in the basic formulary, at preferential prices; provision for the registration of new drugs only if they represented real progress in therapy and would benefit the health of the general public; and obligatory printing of the generic name on all packaging in the same type size as the proprietary name. Further, purchases of drugs by the federal administration were to be subject to tender according to the regulations laid down. The decree defined the legal bases for the operation of the basic formulary, and now formed a part of the general health law in Mexico — coming into force on 1 July 1984 — to which the President of the Thirty-seventh World Health Assembly referred in his inaugural address.

The selection of a drug for inclusion on the essential drugs list was only the first stage of a long and complex process. Other stages included procurement, storage, distribution and rational use. Each stage produced its own problems, which would have to be solved if the basic formulary was to be used properly. The rational use of drugs necessitated the cooperation of both medical personnel and users; to obtain this, a continuous and effective education and publicity campaign would be necessary. There would no doubt be some resistance to the introduction of the basic formulary. However, provision had been made for that, and the Government of Mexico had the political will and was well prepared to overcome such resistance and ensure the proper use of the basic formulary.

Mr JÆRGENSEN (Denmark), speaking also on behalf of Finland, Iceland, Norway, and Sweden, welcomed the Ad Hoc Committee's progress report on the Action Programme, which provided an excellent and up-to-date survey of the situation. The report was a balanced one, which dealt with both the progress achieved and the problems encountered in implementing the Programme. The report had dealt realistically with the question of cooperation with both the pharmaceutical industry and consumer groups. It was important to take a realistic and pragmatic view in considering the essence of the programme - an assured supply of essential drugs for those who needed them. Each country - or group of countries within a region, in cooperation - should establish and take responsibility for its own drug policy and should develop the important elements of such a policy, namely, selection, procurement, control and distribution.

Primary health care was an important part of the strategies for health for all by the year 2000. Experience had shown that the existence of essential drugs and vaccines gave credibility to primary health care units and was a motivating force for people to attend those units.
The idea behind the Action Programme had gained widespread support, and the development in the past two to three years, the forces brought into play and the commitment shown could only be described as unique. There had been some anxiety that the specifications for the Programme were inadequate to produce proper action. However, developments had shown that anxiety to be unfounded. The Programme was now on the right course, with a reasonable balance between the interests and concerns prevailing in all countries in the field of drug supply.

The Action Programme alone could not ensure sufficient development. As the Nordic countries had underlined several times, support for it would have to be combined with bilateral support to implement drug supply policies in countries which had started to tackle the problem on the basis of WHO's philosophy and with WHO's assistance. The Nordic countries were cooperating on a bilateral basis with a number of other countries in the field of essential drugs; WHO's technical support and coordination were essential to the success of that cooperation. They viewed the strengthening of the Action Programme as a logical consequence of and natural follow-up to their bilateral activities, and felt that they had contributed substantially to the Programme.

He urged other countries, in particular those with a comparatively large pharmaceutical industry, to provide increased financial support for the Action Programme. The Nordic countries had been early supporters of the idea of the Programme because they had found it both necessary and basically sound. Everyone now realized that implementation of the idea was vital and, therefore, more countries should take part in the financing of the Programme, in accordance with the principle of burden sharing.

The Action Programme concerned everyone, including those who had easy access to drugs. However, some thought should be given to the questions of whether the quantity of drugs consumed was reasonable and whether drugs were used correctly to obtain the maximum benefit in relation to costs. To a large extent those were questions of information.

It was of vital importance to concentrate efforts on supplying essential drugs to all people throughout the world at reasonable prices, ensuring that the drugs reached their destination and were used in the correct way. The objectives and aims of the Action Programme should not be compromised by concentrating discussions or efforts on matters that shifted the focus from the actual problems and the real challenge.

Mr SANSOM (Netherlands) welcomed the Ad Hoc Committee's extensive and encouraging progress report on the Action Programme. It was most encouraging to note that during the biennium 1982-1983 a further 83 countries had adopted the concept of essential drugs, and that those already committed to it had made significant progress in the implementation of their national drug policies. His delegation associated itself with the conclusion drawn in paragraph 148 of the report that the present policy and strategy for essential drugs were basically sound.

In its report the Ad Hoc Committee had identified a number of critical issues to which it would give further consideration in the future. His delegation subscribed to the importance of those issues, which ranged from such subjects as national political will to the mass production of drugs and research and development. However, it was difficult to see how they should be dealt with within the framework of the Action Programme which, in the words of the Director-General to the Board at its seventy-third session, was primarily concerned with the fact that so many people had no regular access to essential drugs (document EB73/1984/REC/2, page 197). His delegation fully agreed with the Director-General that there would be no public confidence in any health care delivery system unless the most important essential drugs were available. He asked whether his delegation was right in thinking that the Director-General considered the progress of the Action Programme as a political priority of the first order. Perhaps that should be more explicitly reflected in the internal organizational arrangements of WHO. There was no indication in the Ad Hoc Committee's report that the priorities identified within the Action Programme were in fact reflected in the efforts of the Organization, both at headquarters and in the European Region, in the wider field of the quality, safety and efficacy of drugs. At the national level, essential drugs policies could not be implemented without reference to legislation, to quality, safety and efficacy standards, to logistics, including the structure of the distribution systems, and to cost. An integrated approach to those issues was necessary. Accordingly, if WHO was to provide maximum support and impetus to Member States in the development of their essential drugs policies, it would seem appropriate to pool existing resources within the Organization. The study of the issues identified by the Ad Hoc Committee should be undertaken against that background.

Reference was made in the report to the Recommendation adopted at the thirty-fifth ordinary session of the Parliamentary Assembly of the Council of Europe concerning the sale of European pharmaceutical products in countries of the Third World. The Recommendation was
important because it showed increasing political awareness of the needs of developing countries in that field. On the other hand, optimal results could only be achieved if governments of developing countries availed themselves to the full of the facilities offered by both WHO and exporting European States to ensure that the drugs obtained were of satisfactory quality. Increasing use of WHO's Certification Scheme on the Quality of Pharmaceutical Products moving in international Commerce, to which the Netherlands had recently acceded, was of paramount importance in that respect.

Regarding the Code of Pharmaceutical Marketing Practices established by the International Federation of Pharmaceutical Manufacturers Associations (IFPMA) (paragraph 51 of the report), he noted comments made by several members of the Executive Board which seemed to indicate that they would prefer to monitor and evaluate the functioning of that Code outside the scope of the Action Programme; he was inclined to share that view. The ongoing discussion on that topic within the framework of the Action Programme deepened the misapprehension at both national and international levels that the functioning of the Code was part and parcel of the Action Programme. It was in fact a marginal problem in the context of the procurement, distribution and use of essential drugs and should, therefore, be dealt with as part of WHO's current programme on diagnostic, therapeutic and rehabilitative technology. That did not mean that his delegation regarded the problem of unethical sales practices as unimportant. On the contrary, the subject deserved continuous attention by the Executive Board and the Health Assembly. He noted IFPMA's offer to make situation reports on the implementation of the Code available to the Health Assembly on a regular basis and welcomed the active approach of IFPMA in searching for cases of alleged breaches of the Code. His delegation had no objection to WHO cooperating with IFPMA in drawing attention to cases reported by governments or consumer groups. It was a matter for satisfaction that the procedure set up by the Netherlands association of pharmaceutical manufacturers to deal with one of the six cases so far treated was working well. The continued vigilance of the International Organization of Consumers Unions and affiliated national organizations in that respect was important.

His delegation had taken note with great appreciation of paragraphs 36 and 37 of the report, describing the collaboration between WHO and UNICEF regarding drug procurement and the standardization of the labelling of essential drugs. The development of a logo was welcome: it would certainly help to increase professional and public confidence in essential drugs. His delegation had noted that WHO was continuing to look into the possibility of devising revolving funds or credit lines for long-term procurement, and would welcome more details on that topic in a future progress report.

Observing that the report made no mention of WHO collaboration with UNDP, UNCTAD and UNIDO, he asked whether that should be interpreted as indicating that cooperation on a structural basis with those three bodies was considered not necessary, or that it left something to be desired. In that connection, he drew attention to the fact that in the draft resolution proposed by the Board, in its resolution EB73.R15, collaboration between WHO and UNICEF was mentioned in the fifth paragraph of the preamble, but no reference at all was made to UNDP, UNCTAD or UNIDO. His delegation was, however, fully prepared to support the proposed draft resolution; it was convinced that the Action Programme was operating at maximum capacity with the available resources. The purpose of his comment was merely to elicit more information.

A few days previously the Second Chamber of the Netherlands Parliament had adopted a motion requesting the Government to promote the development of an export code for "dangerous products" - a term which covered pharmaceutical products. The WHO Certification Scheme, to which 110 countries now adhered, provided a sound basis for safeguarding the legitimate interests of importing Member States. The recent suggestion by IFPMA that the certificate should also provide information on dosage, contraindications and precautions merited further consideration; his Government would support initiatives to expand the scope of the WHO Certification Scheme, which was to be discussed at the Third International Conference of Drug Regulatory Authorities to be held at Stockholm.

Turning to the draft resolution on the rational use of drugs, he said that the request made to the Director-General in operative paragraph 2(3) to convene a meeting of experts in 1985 gave rise to difficulties of interpretation. It seemed to his delegation that the experts, who would be specialists in science and technology, would find themselves confronted with issues of policy rather than of science and technology. In addition, the technology for disseminating knowledge of the proper use of drugs was already available to WHO and many Member States and was at the disposal of any developing country wanting it. Adaptation of that technology to specific national needs must be made at the national level. If the meeting proposed in the draft resolution was to be successful it would have to be very carefully managed. The subject matter referred to in operative paragraph 2(3) was highly sensitive, and adequate precautions would have to be taken to avoid destructive controversy.
There were two possible courses of action: to delete operative paragraph 2(3), or to reword it in such a way as to make the mandate for the meeting and its membership clear. His delegation favoured the second course, because deletion of the paragraph would deprive the resolution of all practical meaning. His delegation proposed, therefore, that the question be dealt with in the framework of the international conferences of drug regulatory authorities where much of the subject matter mentioned in the draft resolution was already under discussion. His delegation had considered the possibility of amending the draft resolution recommended by the Executive Board in its resolution EB73.R15 in such a way as to take care of the issues dealt with in the draft resolution on the rational use of drugs, but felt that that might compromise the Board's proposed resolution, which seemed likely to receive the unanimous support of the Health Assembly. His delegation was therefore consulting delegations of other countries of the European Economic Community with a view to working out an alternative wording for paragraph 2(3) of the draft resolution on the rational use of drugs.

Dr WILLIAMS (Nigeria) stressed the constantly rising cost of drugs; in developing countries expenditure on drugs was a major item in national and family budgets. Most developing countries lacked the "know-how" and capacity to produce drugs locally, and where drug formulation plants did exist they relied on imported raw materials or active ingredients to make their insignificant contribution towards meeting the total demand. The prices of the drugs available in the developing countries were grossly exaggerated and bore no relationship to the cost of production. Furthermore, most of those drugs had little therapeutic value and their importation resulted in a waste of scarce foreign exchange. It was the aim of his Government to intensify local production of essential drugs of acceptable quality to attain self-reliance.

His delegation fully endorsed the Action Programme and hoped that its implementation would be speeded up.

The Nigerian Federal Military Government had taken a number of measures to promote more rational and economic use of drugs. It had, for example, introduced licensing for drug importation. That measure would enable the authorities to screen drug imports and ensure that drugs which were considered to be harmful or inessential and which continued to act as a drain on scarce foreign exchange were swiftly removed from the market. In addition, a pooled procurement system was being introduced which would make it possible to take advantage of low, bulk-purchase prices without sacrificing quality. The consolidation of procurement would also enable the Government to introduce low-cost essential drugs, develop better storage, ensure more effective distribution, and alleviate the problem of occasional shortages.

The Government had introduced the essential drugs principle into its primary health care scheme, and health workers in that scheme had been trained in the use of low-cost essential drugs. A national drug policy was in the process of formulation and the first draft of the national formulary had been prepared.

In his address to the Health Assembly the Nigerian Minister of Health had mentioned the problem of counterfeit drugs circulating in the markets of developing countries and had urged international action against that pernicious practice. There was also a need for international action to stop the dumping of useless drugs in developing countries and to curtail the misleading claims of manufacturers concerning the efficacy of drugs. His delegation called on WHO to step up the dissemination of unbiased information on medical products in countries of the Third World and to provide those countries with regular information on the prices of drugs and the behaviour of various drugs in different climatic conditions; such information would help developing countries in making their procurement decisions.

In conclusion, he urged all countries to support the Action Programme.

Dr ARNOLD (International Federation of Pharmaceutical Manufacturers Associations (IFPMA)), speaking at the invitation of the Chairman, reaffirmed the pharmaceutical industry's support for the Action Programme, which took the form of supplying drugs to less developed countries at favourable prices, organizing projects in selected less developed countries to improve systems for the delivery of drugs required for primary health care, and training in quality control techniques for candidates proposed by their government health authorities. Considerable progress had been made in all three aspects in the past 12 months.

A UNICEF tender for the supply of basic drugs for the United Republic of Tanzania had resulted in the lowest prices recorded for many of the products, the majority from companies that were members of IFPMA member associations. More recently, IFPMA had been involved in the promotion of a tender for the supply of basic drugs to Bangladesh, and had sought offers through its member associations for the supply of basic drugs for Haiti.
Regarding drug delivery systems, he referred to a project in the Gambia arranged by "Africare" in conjunction with PMA (Pharmaceutical Manufacturers Association) - the United States member association - and to a feasibility study being carried out for another scheme in Sierra Leone at the instigation of PMA. In Senegal and certain other French-speaking countries of the sub-Saharan region a major United States company had been involved in an ambitious project to create joint therapeutic commissions and establish a substantial education programme designed to improve the quality and efficiency of primary health care. In Burundi a pilot study in 1980 had led to a major project being carried out by three international Swiss companies, involving many aspects of the procurement, distribution and supply of essential drugs; it was due to be completed in 1987. In the United Kingdom a number of British companies, through the member association ABPI (the Association of the British Pharmaceutical Industry), had allocated more than a quarter of a million pounds for a pilot project to be established in a less developed country.

Considerable progress had been made in providing training in quality control for nominees from governments of less developed countries. A total of 33 candidates from 21 countries had received training or were currently undergoing training within the WHO/IFPMA programme; in addition, a considerably larger number of people from developing countries had also been trained by individual companies.

The cost of these various activities already amounted to several million dollars; however, the effectiveness of the pharmaceutical industry's activities in improving primary health care in less developed countries was a more important basis for assessment than the cost. It underlined the fact that the pharmaceutical industry's role in the implementation of the Action Programme was not the same as that of an aid agency or a government in providing financial resources. In carrying on its normal business of research, manufacture and sale of medicines in the developed and developing world it was able to support the Action Programme through the provision of human resources, technical skills and products which were essential if satisfactory primary health care was to be available for all.

During 1983 IFPMA had decided to publicize the results of the consideration of all complaints made under the IFPMA Code of Pharmaceutical Marketing Practices. Two reports had been issued, and were available to delegates. In all cases where complaints had been upheld the companies concerned had agreed to take remedial action, thereby demonstrating that the Code was an effective tool for maintaining and improving ethical standards in the marketing of pharmaceuticals. Any cases of marketing activities by the industry considered to be in breach of the Code should be drawn to the attention of IFPMA, which welcomed reasonably based complaints from whatever source - WHO, doctors, other health care professionals, consumer groups or members of the general public. IFPMA firmly believed that the extent of supposed improper marketing practices had been greatly exaggerated, but wished to ensure that the industry's conduct should stand up to critical examination and that where there were lapses effective remedial action was taken.

In conclusion, he referred to the proposals made by the industry in 1983 for reinforcing the WHO Certification Scheme. Those proposals suggested that pharmaceutical companies should provide additional information under the Scheme, with the aim of giving further reassurance to developing countries regarding the suitability and quality of the products they imported.

Mrs TCHEKNAVORIAN-ASENBAUER (United Nations Industrial Development Organization (UNIDO)) said that UNIDO fully supported the Action Programme. She would circulate a statement prepared in advance of the Assembly and respond to some of the comments of delegates.

UNIDO had been requested to prepare technological and economic evaluations for the production of low cost drugs in the developing countries. Over the past six years UNIDO had been systematically studying and assessing the economics and technology of production of the developing countries' pharmaceutical industries.

The delegate of Nigeria had raised the question of how a pharmaceutical industry could be considered to be cost-effective if everything had to be imported. The problem had been discussed within UNIDO which had attempted to provide a solution in cooperation with the industry. She was pleased to state that UNIDO enjoyed cordial and harmonious cooperation with the pharmaceutical industries. She drew attention to the UNIDO papers prepared for consultations on the pharmaceutical industry which could assist developing countries' health programming and their national or public sector pharmaceutical industries, for instance, in formulating a more economic purchasing policy or attaining a more cost-effective production. In particular, the UNIDO Directory of sources of supply of 26 essential bulk drugs, their chemical intermediates and the raw material would assist those responsible for the health programming of developing countries in the purchase of bulk drugs and intermediates. UNIDO had also prepared industrial profiles for the establishment of dosage forms with the full cooperation of the Italian pharmaceutical industry.

At the request of the developing countries UNIDO had established a programme for the industrial production of biologicals in connection with the WHO Expanded Programme on
Immunization. The aim was to produce in the developing countries the vaccines needed for their activities under that Programme. All the relevant programmes were in accordance with the specific goals and objectives laid down by WHO with which UNIDO enjoyed full cooperation.

Finally, with regard to the suggestion by the delegate of the Netherlands regarding a meeting to discuss the rational use of drugs, she drew attention to UNIDO's second consultation on the pharmaceutical industry, held in November 1983, and attended by 260 delegates from 65 countries, at which the matter had been partially discussed. A further consultation would be organized in 1986 at which topics more relevant to WHO programmes might be included.

Dr BORGÖÑO (Chile) said that his country had had considerable experience with such programmes. Since 1964, its national formulary, the first in Latin America, had been continually renewed and updated, and the necessary infrastructure and distribution network had been established.

In order to guarantee the continuing success of the Action Programme, a concerted, realistic effort was needed by all countries, international and nongovernmental organizations, the pharmaceutical industry and the community as a whole to ensure that it was genuinely relevant to the realities and needs of the countries and populations concerned.

The Director-General's progress report and the further information supplied by Dr Khalid and Dr Lauridsen gave grounds for a certain satisfaction with the progress made and for some optimism regarding its future development. In that connection it was vital that countries should be clearly informed of the specific nature of the existing coordination between the Action Programme and other units of the Secretariat dealing with drugs and vaccines, as well as outside the Secretariat. For how could the programme exist without quality control, or without channelling of financial resources for the programme between multilateral and bilateral donors and receiving institutions?

He endorsed the views of the delegate of the Netherlands and others concerning the need for a political will, deeds rather than words, and the legal and material framework to implement the action undertaken. The revolving fund of US$ 10 million referred to by Dr Lauridsen was indeed a step forward, but in his view its capital was insufficient. The US$ 4 million fund in the Americas for the procurement of vaccines was proving inadequate, yet it concerned that Region alone; the aims of that fund should be expanded to provide a minimum of basic assistance to those countries that needed it. It was important for WHO, and the WHO Regions, to stimulate cooperation among developing countries in that field. There were good examples of bilateral and multilateral cooperation of that kind in Latin America. The regions had a leadership role to play and the Action Programme should find in them a response that would facilitate the catalytic role of their organizations in promoting and achieving multilateral and bilateral cooperation between developing countries.

His delegation fully endorsed the draft resolution contained in resolution EB73.R15 of the Executive Board.

In regard to the draft resolution on the rational use of drugs, he endorsed the comments of the delegate of the Netherlands and suggested that paragraph 2(3) be either deleted or amended. As it stood, it conflicted with paragraph 4(2) of the draft resolution proposed by the Board, which requested the Board itself "to study major outstanding issues ...". The subject to be discussed at the meeting of experts proposed in paragraph 2(3) of the former draft resolution was such an issue, rather than one for experts. The Organization had the necessary machinery for deciding on a policy matter of that kind. Any amendment of paragraph 2(3) would have to be very carefully phrased and so should be referred to a drafting group, but he would prefer the very large sum which the meeting would cost to be spent on the Action Programme itself.

Professor ORDONEZ CARCELLER (Cuba) welcomed the Ad Hoc Committee's progress report, commending the effort being made by WHO to correct the economic and technological disparities between developed and developing countries which prevented broad sectors of the world's population from having access to essential drugs and vaccines. Whatever the efforts made, however, it was important to bear in mind that the transnational corporations had ways of utilizing programmes of that kind for their own benefit and introducing distortions into plans for cooperation between countries. He was convinced that essential drugs was one of the areas most conducive to the application of appropriate technology and technical cooperation among developing countries. It was vital that all national or multilateral plans to assist developing countries in producing drugs locally should be seen in the socioeconomic context of each country and should not detract from the aim of promoting national self-reliance, if they were to satisfy appropriately the basic needs of the population. Such plans should not be restricted by costly economic ties outside the field of appropriate technology.
He noted with satisfaction that more countries were implementing national drug policies in response to the Action Programme, demonstrating that a political commitment by governments existed. Referring to paragraph 63 of the progress report concerning collaborative national drug programmes pursued by WHO, he requested further details about WHO's role and the benefits which had resulted from such programmes for the countries concerned.

In the Region of the Americas, recent studies had shown that there were many products on the market that were not consistent with the health needs or financial situation of the populations concerned. That was largely due to the production and marketing practices of pharmaceutical companies which encouraged a preference for brand-name drugs among physicians and the public. It was for Member States of WHO, particularly the least developed ones and those most seriously affected by the world economic situation, to play a decisive role in controlling conditions of sale, use and promotion through drug registration. In that connection he welcomed the recommendations of the Committee of Ministers of the Council of Europe concerning the marketing of European drugs in developing countries and the formulation of a code of marketing practice. Member States might consider the possibility of close collaboration between WHO and UNIDO in monitoring that code.

While there was clear enough recognition of the need for a list of essential drugs to be adopted as part of national health programmes, in the majority of WHO Member States those drugs still failed to reach broad sectors of the population who could not afford to buy them, even if they were generic and generally speaking, cheaper. Distribution in rural areas was poor and drug safety and efficacy was not always guaranteed. Those factors should be borne in mind in the new procedure for monitoring progress made in implementing the Action Programme, and should be taken into account in any recommendations made.

The dialogue of WHO and other United Nations organizations with the pharmaceutical industry on improving the availability of drugs and appropriate technical assistance should be strengthened for one reason, among others - that expenditure on drugs in most countries was channelled through the open market. In that connection it should be born in mind that the activities of the major pharmaceutical companies in their countries of origin were subject to increasingly strict regulation, whereas in Third World countries those companies had almost entirely free and complete access to the market. There was ample evidence of that unsatisfactory state of affairs. He would not go into detail but would merely point out that, in the continuing dialogue between WHO, UNIDO and other organizations of the United Nations system, on the one hand, and the pharmaceutical industry, on the other, it was necessary to take greater account of five important factors: first, the participation of pharmaceutical firms in more structured training programmes for laboratory workers; second, an analysis of the possible financial contribution of those firms on a percentage basis of their profits to Third World countries; third, the formulation of programmes of direct support to establishing pharmaceutical information centres in those countries which needed such centres; fourth, the development of joint research programmes with Third World countries, providing for the true transfer of technology, which would enable those developing countries to acquire in-depth scientific and production capabilities; and fifth, the active participation of the community in such matters.

With reference to primary health care and the objective of health for all by the year 2000, emphasis should be placed on the need for least developed countries to acquire the capability of assimilating the technological and scientific progress of the more developed countries, making proper use of such progress in the context of their specific socioeconomic conditions.

Health for all by the year 2000 also required the solution of the problem of underdevelopment in the field of drugs, whence the urgency of breaking the various ties of scientific and economic dependence that served the interests of the giant pharmaceutical corporations.

Referring to the indicator for the evaluation of health-for-all strategies specifying that supplies of drugs and health care facilities should be available to local communities (number 7), he informed the Committee that those functions were fulfilled in Cuba by the basic unit of health care which was the local health centre or polyclinic. One of his country's major achievements was to have established some 400 such health centres, each serving some 30 000 people in an average area of two square kilometres. His country was also carrying out a drug development strategy in the context of its development possibilities. Some 200 essential drugs were available, 95% of them at local level, while a national formulary had been prepared. The pharmaceutical industry of Cuba was producing some 85% of the drugs needed by its people. Priority was also given to health education and medical training, oriented towards the rational use of drugs.

Cuba was a country of the Third World, confronted with current international economic realities. But its main concern was the human being and that was why it had health indicators which placed it on an equal footing with the developed countries.
In spite of its limited resources, his country was helping some 27 other Third World countries at their request, supplying technical advice, experts and essential drugs at the lowest possible prices. Cuba was ready to cooperate with all nations.

Dr JEANES (Canada) said that, in his opinion, the availability and proper use of safe and effective drugs and vaccines was a major component of primary health care and for the attainment of the objective of health for all by the year 2000. His delegation had noted the concern expressed at the Health Assembly about the great difficulties countries encountered in obtaining appropriate drugs at affordable prices. His delegation therefore supported the Action Programme and took the view that it centred on six key issues, namely: national will, technical knowledge, distribution and logistic support, manpower training, improvement of prescribing and dispensing practices, and mass production of essential drugs.

Canada had already paid the first instalment of its contribution of C$ 500 000 in support of that Programme which was gathering momentum under Dr Lauridsen's direction. However, the Programme would succeed only if WHO, the pharmaceutical industry and all Member States fully cooperated in its implementation.

His delegation would support the draft resolution proposed by the Executive Board, although it had some reservations in that connection. They related, however, more particularly to the draft resolution on the rational use of drugs. He agreed with the delegate of the Netherlands that it was not clear how the proposals in the latter draft resolution would further current WHO policies and programmes. It would be helpful to have an explanation of how those proposals would relate to the Action Programme's existing mandate and that of the Executive Board Ad Hoc Committee on Drug Policies.

Dr MORK (Norway), speaking on behalf of the sponsors of the draft resolution on the rational use of drugs, said that it dealt with some of the specific issues identified in resolution WHA31.32, that is to say: the prescribing habits of physicians, the drug information made available to health workers and consumers, and marketing practices especially in developing countries.

There were problems worldwide arising from excessive and inappropriate prescription and consumption of drugs and from insufficient information. Physicians and their health personnel often lacked adequate knowledge of the effects, side-effects, and possible interaction of drugs. As for consumers, most drugs were taken at home, supplied on prescription by a physician, or bought in a pharmacy without prescription and even in general stores, or else the patient obtained the drug from members of his family or friends. Even when a physician had clearly explained how a particular drug should be taken, the patient still did not always use it correctly or, sometimes, he did not take it all. Yet the rational use of drugs was an essential component in both the prevention and treatment of illness.

He was glad to note the growing interest shown by governments, the pharmaceutical industry, consumers' organizations and health workers in that problem, which existed in both developed and developing countries. That growing interest was reflected in the establishment in 1981 of the IFPMA voluntary Code of Pharmaceutical Marketing Practices, as well as in the activities of the International Organization of Consumer Unions and other nongovernmental organizations.

The time was now ripe for a broad exchange of views and experiences among all the interested parties based on their stated common goal which was to secure the rational use of drugs. Such discussions should take place under the auspices of WHO and would lead to a better understanding between the pharmaceutical industry, consumers and other interested parties.

Discussions about that problem both within international organizations and elsewhere had so far focused too much on a possible code of marketing practices; the rational use of drugs covered a much wider field than that. The proposal made in paragraph 2(3) of the draft resolution seemed to have given rise to some misunderstanding. In view of the importance of the contribution that the industry and the consumer's organizations could make in the broad dialogue on drug policies and management, he could not share the view of the delegate of the Netherlands that the meeting should be governmental, the pharmaceutical industry, consumers and other interested parties attending as observers only. He wished to make it clear, on behalf of the co-sponsors, that they intended it to be the prerogative and the responsibility of the Director-General to convene that meeting at a time and place he considered most convenient and to invite to it those participants he considered most relevant and representative of numerous parties with interests and experience in the many aspects relating to the rational use of drugs. The purpose of the proposed meeting would not extend beyond exchange of views and experiences. In accordance with paragraph 4 of the draft resolution, it would be for the Thirty-ninth World Health Assembly to review and decide on any recommendations or proposals made at that meeting and to take the relevant decisions.
Recalling the discussions on drug information and marketing at other international forums, such as UNCTAD VI, he felt that such matters should be discussed in the wider framework of health for all within WHO, which was the appropriate United Nations body with the constitutional role of providing leadership in the field of health.

He pointed out that the draft resolution was sponsored by both developed and developing countries and that reflected the global nature of the problem, even if the implications of the current unsatisfactory situation were more serious for developing countries. The sponsors hoped that it would therefore be adopted by consensus.

Dr AL-SALLAMI (Democratic Yemen) welcomed the Action Programme as a realistic and rational means of providing safe and effective drugs at reasonable prices. Steps had already been taken in his country in collaboration with WHO to develop a comprehensive and effective drug policy in line with the Action Programme. A survey had been carried out early in 1984 to identify and assess medical drug requirements and steps were now being taken to improve the procurement, storage, distribution and utilization of drugs. The national programme would also provide for the establishment of a quality control unit in conjunction with the intravenous fluids and oral rehydration salts production unit and for the training of health personnel in drug management. A standing committee had been set up to approve and revise the list of essential drugs on the basis of the relevant WHO publications, such as drug information sheets, the Drug Information bulletin and WHO Technical Reports. Implementation of the concept of essential drugs would not only cut out unnecessary expenditure on drugs but also provide a wider coverage of the population with the most urgently needed drugs, thus contributing to better disease management.

Dr BELLO (Venezuela) drew attention to the fact that implementation of the Action Programme involved serious difficulties for the developing countries. In his country, for example, no clearly defined drug policy had been promulgated until recently. The newly-elected Government, bearing in mind that high drug prices bore most heavily on the poorest 80% of the population, had decided to draw up a national drug policy to meet the requirements of the people and a study commission had been set up for that purpose.

The turnover of the pharmaceutical industry in Venezuela, consisting of 35 national companies and over 45 international corporations, had amounted to Bs 1527 million in 1981 - possibly a conservative figure. The main characteristic of the drug market had been its response to the private sector's preference for proprietary products, which promoted product differentiation at the expense of products comprising unimportant modifications to particular compounds, supported by enormous promotional efforts to induce the doctor, pharmacist or consumer to give preference to one drug over another. All that had greatly increased the final price to the consumer. Analysis showed that more than 200 different companies were in operation producing more than 3000 pharmaceutical preparations, a situation which was again reflected in high production and sales promotion costs. The public sector share of the market, on the other hand, apparently only accounted for slightly under 30% of the total, although it was difficult to estimate accurately in the absence of reliable statistics and with no centralized procurement system.

Although it was for the most part the national companies that supplied the public sector - Social Security, Ministry of Health and Social Welfare and other government agencies - which ordered drugs under generic names, the spirit of that operation was rendered practically ineffective and the public sector had to bear the costs prevailing in the proprietary drug market because the national companies used proprietary names and sold to the public sector on the same terms as to the private sector, i.e., price to the public less 40.5%. Production and sales promotion costs were of course lower for generic drugs, since the only difference that could exist between them was the name of the manufacturer which guaranteed their quality.

In other countries, such as the United States of America and Canada, and in Europe, governments had taken various stringent measures to reduce health costs, including encouraging use of generic drugs. In Venezuela, unlike other countries, pharmaceutical products were protected by patents lasting up to 17 years. Thereafter any pharmaceutical laboratory, provided that it complied with legal and health requirements, could manufacture any drug whatsover. Yet most companies increased their capacity by becoming manufacturers of, or agents for, proprietary drugs, which again contributed to intensified competition, promotion and sales drives and considerable increases in drug costs.

Presidential Instruction No. 16, issued in 1975, on drug procurement by the public administration, the purpose of which was to activate drug procurement for the public sector, gave Venezuelan companies the exclusive right to supply pharmaceuticals to that sector. It was a tentative measure to stimulate the use of generic drugs. It also provided for the establishment of a single list - that of the Social Security at the time - for compulsory use
in public sector procurement. However, the latter purpose had not been served owing to failure to keep the list up to date. In the generic drug market competition was based on price - marketing and promotion costs being minimal - which permitted the maintenance of quality at reasonable prices.

Venezuela was a developing country with a large proportion of the population in low income groups which, far from being able to pay the high market prices for proprietary drugs, had to receive free medical care. His delegation therefore warmly welcomed the WHO Action Programme. In his country ways and means were being worked out at the national level - and it was hoped to promote them at the regional level among the Andean countries in particular - of facilitating procurement of drugs at advantageous prices from the national industries. That would both open up new horizons for all national industries and help in the formation of national companies. Morbidity levels were being studied so as to determine the relationship between drug availability and requirements, and procedures devised for ensuring quality control; the WHO list of essential drugs was being adapted to local circumstances, attention being given to combining the highest efficacy with the lowest risk, and arrangements were being made for updating. Basic training was being given to personnel involved at different levels in drug procurement and distribution and protocols for basic medical treatment had been drawn up for the most common causes of morbidity in order to ensure uniformity in prescribing and in the use of generic names.

The drug manufacturing division of the Ministry of Health and Social Welfare was being reorganized to improve its organizational, functional and administrative capacities, to reduce costs and to increase productivity. Standards were being prepared on the supply of drugs so as to assist health establishments in programming their needs and planning the procurement, acceptance, storage, control and distribution of medical supplies. University medical and pharmacy faculties, the pharmaceutical industry, consumer organizations and health workers had been invited to participate in workshops and seminars in order to drive home the vital importance of essential drugs in health care programmes.

His delegation fully supported the draft resolution on the rational use of drugs. As it was WHO policy to recommend and promote effective community involvement in the application of health programmes, there could be no better way of doing so than by fostering the participation of consumers' organizations and other institutions in the Action Programme.

Professor NÁJERA (Spain) said that he was convinced that the Action Programme was one of the most important and promising of all the Organization's programmes and he was greatly encouraged by the progress that had been made. The situation had been clearly and succinctly set out in the excellent report by the Ad Hoc Committee and he fully supported the draft resolution proposed by the Executive Board, as well as that on the rational use of drugs; his delegation would like to be included among the co-sponsors of the last-mentioned.

(For continuation, see summary record of the ninth meeting, section 3.)

The meeting rose at 17h25.
NINTH MEETING

Wednesday, 16 May 1984, at 9h10

Chairman: Dr K. AL-ALJOUNI (Jordan)

1. SECOND REPORT OF COMMITTEE A (Document A37/35)

Mrs MAKHWADE (Botswana), Rapporteur, read out the draft second report of the Committee.

The report was adopted (see document WHA37/1984/REC/2).

2. INFANT AND YOUNG CHILD NUTRITION (PROGRESS AND EVALUATION REPORT; AND STATUS OF IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES):

Item 20 of the Agenda (Resolution WHA33.32; Documents WHA34/1981/REC/1, Annex 3, Article 11.7 of the Code, and A37/6) (continued from the seventh meeting)

The CHAIRMAN drew attention to the draft resolution submitted by the delegations of Bahrain, Egypt, Kuwait, Qatar, Swaziland, Uganda and the United Arab Emirates, on infant and young child nutrition, which now read as follows:

The Thirty-seventh World Health Assembly,
Recalling resolutions WHA27.43, WHA31.47, WHA33.32, WHA34.22 and WHA35.26, which dealt with infant and young child feeding;
Recognizing that the implementation of the International Code of Marketing of Breast-milk Substitutes is one of the important actions required in order to protect healthy infant and young child feeding;
Recalling the discussion on infant and young child feeding at the Thirty-sixth World Health Assembly, which concluded that it was premature to revise the International Code at that time;
Having considered the Director-General's report,1 noting with interest its contents;
Aware that many products unsuitable for infant feeding are none the less being promoted for this purpose in all parts of the world, and that some of these products may not be considered to be covered by the International Code;

1. ENDORSES the Director-General's report;
2. URGES continued action by Member States, WHO and nongovernmental organizations to put into effect measures to improve infant and young child feeding, with particular emphasis on the use of foods of local origin;
3. REQUESTS the Director-General:
   (1) to continue and intensify collaboration with Member States in their efforts to implement and monitor the International Code of Marketing of Breast-milk Substitutes as a minimum measure at the national level;
   (2) to take steps to monitor the inappropriate promotion and use of foods unsuitable for infant and young child feeding;
   (3) to submit to the Thirty-ninth World Health Assembly a report on the progress in implementing this resolution, together with recommendations for any other measures needed to further improve sound infant and young child feeding practices.

---

1 Document WHA37/1984/REC/1, Annex 5.
He had been informed that the delegations of Cameroon, Congo, Ghana, Madagascar, Mozambique, Pakistan, Rwanda, Senegal and Zaire wished to be included among the sponsors of the draft resolution.

Dr ADOU (Djibouti) and Mrs MATI (Kenya) requested that their delegations should also be included in the list of sponsors.

Dr BORGOÑO (Chile) said that the last preambular paragraph seemed out of context in regard to the operative part of the resolution, which related only to the Code; it could perhaps be clarified. Then, in paragraph 3(1), the last phrase, "as a minimum measure at the national level", should be deleted, as it imposed unnecessary minimum requirements on the Director-General in the performance of his duties. Furthermore, paragraph 3(2), should be reworded as it was inappropriate to ask the Director-General to monitor the application of the Code. Article 11.2 of the Code specifically stated that such monitoring was the responsibility of governments acting individually or collectively through WHO; that point was also clearly made in resolution WHA34.22, which stated that monitoring of the Code should be undertaken by the regional committees, the Executive Board, and the Health Assembly. Finally, paragraph 3(3) should simply request the Director-General to report to the Thirty-ninth World Health Assembly on the progress in implementing the resolution and not ask him to make recommendations.

Dr CORNAZ (Switzerland), pointing out that certain infant foods, such as cereals, were being promoted as being suitable for infant feeding from the first week of life, suggested that, in order to make the aim of the resolution clearer, the last preambular paragraph should be amended. She proposed deleting the words "none the less" and adding, after the words "all parts of the world", the phrase "and that some infant foods are being promoted for use at too early an age, which can be detrimental to infant and young child health;". The last phrase of the existing text should then be deleted. In line with that amendment, paragraph 3(2), should be amended to read: "to take steps to examine the problem of the promotion and use of foods unsuitable for infant and young child feeding and the promotion of the inappropriate use of infant foods;". Finally, she proposed replacing the word "minimum", in paragraph 3(1), by the word "important".

Mr VAIDYANATHAN (India), while supporting the draft resolution as a whole, agreed with the delegate of Chile that the Director-General should not be asked to monitor the inappropriate promotion and use of foods unsuitable for infant and young child feeding since the Code itself placed that responsibility on Member States themselves. The Director-General and the Secretariat could certainly provide assistance to countries in setting about the task of monitoring. He proposed that, in paragraph 3(2), the phrase "to take steps" be replaced by "to prepare guidelines to enable Member States".

Dr QUAMINA (Trinidad and Tobago) also considered that the draft resolution placed too many responsibilities on the Director-General. She therefore supported the amendments proposed by the delegate of Switzerland.

She pointed out that the role of monitoring infant foods was the responsibility of another organization of the United Nations system. The Director-General was responsible for advising mothers and health personnel on the use of infant foods, but their marketing and quality was the responsibility of another organization and another technical group. The Committee should therefore request the Director-General and ministers of health to focus on their main role in connection with infant feeding, namely, that of education and providing information.

The CHAIRMAN proposed that, as the suggested amendments overlapped, a working group composed of the sponsors and the delegations of Chile, India and Switzerland, and any others who wished to participate, prepare a revised text for consideration at the next meeting of the Committee.

It was so decided. (For continuation, see summary record of the tenth meeting, section 2.)
3. ACTION PROGRAMME ON ESSENTIAL DRUGS AND VACCINES: Item 22 of the Agenda (Resolutions WHA35.27 and EB73.R15; Document EB73/1984/REC/1, Annex 7) (continued from the eighth meeting)

The CHAIRMAN said that the Committee would next resume its discussion of item 22. He had been informed by the Vice-Chairman, who had chaired the previous meeting, that various proposed amendments to the draft resolution on the rational use of drugs had been suggested. Several delegations had let him know informally that they would welcome the establishment of a working group in order to harmonize the various viewpoints. That would save the time of the Committee and would enable a synthesis of the different ideas to be prepared. He therefore proposed that a working group should meet immediately before the Committee reconvened in order to try to determine whether a consensus could be reached. He proposed that the following delegations should be members of the working group: Algeria, Chile, India, Netherlands, Nigeria, Norway, Sweden, and any others that might wish to participate. He requested delegates who had asked to speak on the subject not to propose amendments to the draft resolution at the current meeting, but to submit them to the working group.

It was so agreed.

Professor ROOS (Switzerland) said that the role of drugs and vaccines in the promotion and protection of health was important and undeniable; vaccines were rightly grouped together with essential drugs. Two years ago, his delegation had emphasized the importance that it attached to WHO's Action Programme on Essential Drugs; moreover, as Dr Lauridsen had announced the previous morning, the Swiss Government was prepared to contribute to the financing of that Programme. The goal which the Health Assembly had set was ambitious, namely to ensure a supply of drugs that were safe to use, had a minimum of undesirable effects, were of satisfactory quality, were available in sufficient quantities to the populations of the different countries, and met their needs. To reach that goal, the collaboration of a number of partners was necessary, obviously including industry, but also governments, health authorities, and health personnel, together with patients' organizations and research institutes. Each partner had its own role to play. With regard to the draft resolution proposed by a number of delegations, he stressed that each partner had to recognize its responsibilities and do its best to fulfill them.

One of the fields where several partners were involved was research and the development of drugs which met the priority needs of the Third World. Industry had a leading role to play in that area. The other partners were, of course, the research institutes and WHO, in particular the Special Programme for Research and Training in Tropical Diseases.

With regard to information on the effects, indications, contraindications and directions for use of drugs, his delegation attached great importance to improving the flow and exchange of objective and complete scientific information. There, too, industry, governments, scientific associations, universities and others were involved.

As far as the training of health personnel and the education of the general public was concerned, education had in many cases to be improved and strengthened in respect of drug use, description and management. The responsibility for that education was shared by the health authorities, the educational authorities and private organizations. Many important problems and difficulties had to be overcome, not only technical, medical and pharmacological, but also economic, social and political. Marketing, for all its importance, should not obscure those other problems. His country was happy to know that WHO was paying attention to those other aspects, in particular quality control and management training.

His delegation supported the three main proposals contained in the draft resolution on the rational use of drugs, namely the promotion of activities aimed at improving prescription methods and the flow and exchange of complete and objective information, and the holding of a meeting at which qualified representatives of all parties concerned would participate on an equal footing. WHO's responsibility for organizing that meeting clearly rested with the Director-General; such a meeting could not and should not define solutions but should help to clarify the understanding of each partner of the factors involved, not only as they concerned that partner alone but also the others. Such a sharing of views might provide a better basis for action, whether jointly or separately. Such a dialogue was all the more necessary in that the present situation was characterized by certain prejudices. What was at stake certainly justified yet another meeting if it made it possible to define more precisely the factors and the principles involved. He was sure that the Director-General would keep the costs at a reasonable level, and that, in the choice of subjects and the preparation of the discussion, as well as in the choice of participants, he would show the discernment necessary to give the meeting the best chance of success.
That said, his delegation had certain amendments to proposed to the draft resolution which would clarify the aims and form of the proposals without changing their substance; those amendments would be submitted when the resolution was discussed in detail. In conclusion, he stressed that the purpose of the actions taken should be to promote the rational use of drugs and the improvement of drug prescription, thanks above all to the availability of complete and objective information to everyone concerned.

Dr MÜLLER (German Democratic Republic) agreed that the agenda item under discussion was very important in the achievement of the overall goal of health for all. The Action Programme on Essential Drugs and Vaccines was one of the essential components of the primary health care system and, as experience had shown, was of great importance for developing countries in particular. The correctness of WHO's drug strategy had been confirmed by the experience of the last 35 years in the establishment and development of the national health system in his country. Based on the new political and socioeconomic conditions, the German Democratic Republic had been able to establish a national drug industry to produce essential drugs that was currently able to satisfy the requirements of the population. In addition, all drugs were supplied free of charge. In his country particular attention was given to the designation of drugs on a scientific basis. The Ministry of Health possessed a central institute at which experts tested all new drugs and were responsible for selecting a range of effective ones. In the light of the comments made by many delegates to the effect that drugs were sold by pharmaceutical firms at high cost and were often of unsatisfactory quality, his delegation believed that an international codex of essential drugs would be extremely important in health policy in reaching the goal of health for all by the year 2000. He therefore supported the draft resolution.

Dr MPITABAKANA (Burundi) said that his country attached special importance to the Action Programme for a number of reasons, among which was the fact that Burundi was a landlocked country with limited resources, with all the complications which that implied for drug supply. His country had supported WHO's policy on essential drugs as well as its policy of pooled drug procurement, which he hoped would be put into effect as soon as possible since it would enable certain countries, including his own, to obtain more drugs at lower cost. Thanks to bilateral cooperation, his country had been able to procure drugs and to pay for them in local currency.

In accordance with the essential drugs policy, his Government had set up a national committee on essential drugs composed of doctors and pharmacists. Each year the regional health authorities met in a national committee to draw up the list of essential drugs to be imported, based on the policy of decentralization and, above all, on the diseases prevalent in the country. That arrangement had made it possible to increase the importation of drugs. Thanks to the collaboration of WHO, Interpharma and the Swiss Government, Burundi had been able to carry out activities in drug supply, storage and management, as well as in training. Drugs that were not used were returned to the central pharmaceutical supply depot, from which they could be redirected to the other hospitals that might need them most. That activity had been going on for three years and had been described in reports issued jointly by WHO, Interpharma and the Government of Burundi under the title: WHO Action Programme on Essential Drugs: Burundi Pilot Project. Those reports were available to delegations that wished to consult them.

In the field of technical cooperation between developing countries, Burundi had also had experience of cooperation between the countries of the Economic Community of Countries of the Great Lakes, namely, Burundi, Rwanda, and Zaire, whose Heads of State had signed an agreement to undertake the joint manufacture of drugs; a drug manufacturing industry would be established at Bujumbura. Feasibility studies were in progress, thanks to financing from WHO and UNDP.

Essential drugs and vaccines were rightly among the essential components of primary health care. Drugs were used in both prevention and cure, and their usage and sale should therefore be entrusted solely to professionals. He entirely agreed that information on drugs should be disseminated, but would prefer such information to be circulated exclusively to the scientific and professional press, since the non-scientific press sowed confusion between health professionals and drug users. He also hoped that a dialogue would be maintained between Member States of WHO and the pharmaceutical industries, so that new drugs might be developed for the serious diseases that were rife in the developing countries, where the level of technological research unfortunately did not allow the development of new drugs. He also looked forward to further collaboration between Member States, nongovernmental organizations, WHO and the pharmaceutical industries.
Professor SZCZERBAŃ (Poland) recalled that WHO had created the Action Programme to support national drug policies by ensuring a regular supply of safe and effective drugs of adequate quality at the lowest possible cost; that was indispensable for the proper functioning both of the primary health services and of hospital care. The Action Programme was thus a logical consequence of primary health care and should be directed towards meeting the needs of developing countries. Important economic interests came into play in drug supply; the policy of the multinational firms concerned was obviously directed towards achieving their own goals. Thus the activities of the Action Programme had to be considered in the light of increasing the independence of smaller developing countries faced by trading conditions that were weighted against them.

Improvement of the drugs supplied in the developing countries required a multi-sectoral approach and covered a number of related activities: support for national drug policies; assistance in the improvement of local drug supply systems, especially in countries relying mainly on imports; assistance in the improvement of drug distribution systems; and also a related training component and assistance in the exchange of relevant information and experience. Quality assurance was also of primary importance in the drug field, and an appropriate interface was required between the activities of the Action Programme and other regular WHO activities in that area.

The supply chain of pharmaceuticals began with the production or importation of drugs. Poland satisfied its own drug requirements, especially in respect of the most widely used drugs, by local production, supplemented by imported drugs. Poland also exported pharmaceutical raw materials and dosage forms, thus participating in the international pharmaceutical trade in both directions. Drug manufacturers in Poland fully understood the need to ensure that their products reached an appropriate quality level, and Poland was participating in the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce, established under resolution WHA28.65. Appropriate quality certificates were issued by the Polish Ministry of Health and Social Welfare. The level of drug consumption depended on the degree of health services development, but had also to be correlated with the economic realities of a country; the sign of a successful drug policy was the achievement of harmony between them. In Poland, one of the tools of drug policy was the limitation of the list of pharmaceutical products widely used in general medical practice so as to avoid unnecessary multiplication of similar products. That limitation was achieved by the system of drug registration, which took into account both health factors, such as the safety and effectiveness of the products, and economic factors. The list of marketed drugs was thus kept stable, but not unchanged; when new and more effective products appeared they replaced those considered to be obsolete.

For a number of years there had been a steady increase in the use of large-volume parenteral infusions used to modify electrolyte balance, for parenteral nutrition, and for other purposes, and that had caused various problems. Because the products were voluminous and heavy, their decentralized production seemed advisable, so as to avoid transportation and distribution problems. However, there were technical difficulties, involving the availability of large quantities of water of adequate quality, problems of sterilization and the selection of adequate containers and seals. Modern pharmaceutical technology offered a number of approaches for the solution of individual problems, but the high level of consumption of large-volume parenterals made it imperative that the solutions adopted should make the enterprise economically viable. The problem was becoming so important in so many countries that WHO should convene a study group to review the techniques of purifying the water for use in infusion fluids, sterilization procedures and quality requirements for containers and seals, both for single and for multiple use. Such an unbiased review would facilitate the selection of technical approaches by health authorities who had to decide on the extension of local production of large-volume parenterals.

The activities of the Action Programme deserved full support; Poland was willing to assist, through its experts and consultants, in questions of drug supply, drug distribution, and drug quality assurance and in specific technical matters.

Dr WARD-BREW (Ghana) found encouraging, the progress made in the field of essential drugs and vaccines at the global and regional levels, as indicated in the report of the Executive Board Ad Hoc Committee on Drug Policies (document EB73/1984/REC/1, Annex 7), as was the further progress at country level reported by Dr Lauridsen.

As the leader of his delegation had noted in his address to the plenary meeting, the Government of the Provisional National Defence Council had been concerned about acute shortages of essential drugs and vaccines, which occurred rather frequently in Ghana. The Government had received a document from the Regional Office for Africa which proposed the bulk purchase of essential drugs for Member States of the African Region. Although Ghana now had a drug policy and had decided on its list of essential drugs for primary health care, legislation on the subject had not yet been enacted. He was particularly interested in the
UNICEF procurement policy and the price list being prepared by WHO and UNICEF for the international procurement scheme. He acknowledged with gratitude the good work done by the International Federation of Pharmaceutical Manufacturers Associations (IFPMA) and the financial support to the programme given by Sweden, Denmark, Switzerland and Canada, among others.

He was deeply concerned about the marketing of some drugs by certain industrialized countries; too much money was being wasted in some developing countries on non-essential drugs of doubtful therapeutic value which were being promoted by drug firms of questionable reputation. The delegate of Nigeria had already drawn attention to the export of useless drugs to Third World countries.

It was for that reason that his delegation wished to become a sponsor of the draft resolution on the rational use of drugs. The operative paragraphs of the draft resolution were self-explanatory and the draft resolution deserved the support of all delegates. He understood that the delegate of the Netherlands, while supporting the draft resolution, would like to add some operative paragraphs to it and he was sure that the sponsors of the draft resolution would consider that proposal objectively.

Dr HEDAYETULLAH (Bangladesh) said that one of the basic elements of the primary health care approach was to make good-quality essential drugs available to all people at an affordable cost. Unfortunately, most developing countries were still far from achieving that objective. In view of the fact that the health care delivery system of most countries was biased towards curative medicine, both doctors and patients were used to the excessive and inappropriate prescribing and using of drugs. Such over-prescription caused harm to the vital organs of the users and had a detrimental effect on scarce financial resources, particularly in developing countries. He thanked the Director-General for providing leadership to Member States in evolving a sensible essential drugs programme.

His country, with a population of 95 million and a high morbidity rate, was a major market for drug manufacturers and hence a very large part of its scarce financial resources was being wasted on drug bills in both the Government and private sectors. In 1982 his Government had taken steps to stop that drain of resources which could be used for essential national development programmes. The salient features of the Government's drug policy were to remove all harmful, useless, ineffective and non-essential drugs from the market; to ensure a supply of good-quality essential drugs at a cost which people could afford; and to ban combination drugs.

Of the drugs which had been on the market before the promulgation of the drug policy, 1700 had been declared harmful, useless, ineffective or non-essential by an expert committee; 300 of those drugs had been considered harmful and had been withdrawn from the market immediately. The remaining 1400 drugs considered to be useless or non-essential were withdrawn in phases over a period of 6-12 months.

A new drug list of 150 essential generic drugs had been drawn up and drugs had been identified for use at each tier of the government health system, 12 at the lowest level, 45 at an intermediate level, 150 at the central level and an additional 100 drugs for use by specialists only.

Following the promulgation of the Drugs (Control) Ordinance in 1982, the Ministry of Health of his Government had published a paper on the drug policy of Bangladesh which, inter alia, emphasized the need to ensure local production, procurement, quality control, distribution and utilization of generic drugs under unified legislative and administrative control. After some initial resistance from interested quarters, that policy was taking effect. A total of 1700 drugs had been banned between June 1982 and December 1983 and their withdrawal from the market had been uneventful. Although some of the banned drugs were still available, their prices were very high, which indicated their scarcity, and it was believed that they would soon disappear completely. As a result of the non-availability of harmful, useless and non-essential drugs, the prescribing habits of doctors were becoming more rational.

Prior to the promulgation of the drug policy, some eight multinational companies used to manufacture about 75% of drugs whereas the 130 national companies manufactured only 25%. Those proportions had been reversed. The prices of essential drugs had been considerably reduced and good-quality essential drugs were readily available. Both doctors and the population were acquiring confidence in the local products.

His Government had taken a bold step in introducing a drug policy in conformity with the policy and strategy of WHO, and he urged other Member States to streamline their drug policies in the same way as an essential instrument for achieving health for all by the year 2000.

Finally, he urged aid agencies to provide financial and technical support to develop and strengthen his country's drug manufacturing facilities and government quality-control laboratories.
His delegation fully endorsed the Executive Board's recommendations in resolution EB73.R15 relating to the Organization's essential drugs programme.

Dr NJIE (Gambia) expressed his appreciation of the Ad Hoc Committee's report. Over the preceding two years, his Government had been realigning its national drugs policy to ensure ready access by the population to essential drugs. In the midst of the near chaos which had existed in some countries in respect of the sale and distribution of drugs, there was a temptation to adopt restrictive legislation. He raised that point because much time had been spent in the Gambia in developing legislation and policies in line with the realities of the country. Clearly, in a country like his, which had only three pharmacists, all of whom were located in the capital, it would be quite unrealistic to insist by law that only qualified pharmacists could dispense drugs. That would have meant that 98% of the population could have no access to essential medical supplies. Hence, in a new Act which had been recently passed, the Government had tried to develop a tier system whereby various schedules of drugs would be handled by different officers, the range of drugs in those schedules depending on the level of competence and training of the officers concerned. The situation was still somewhat chaotic and there was a need for control procedures.

The restrictive features of the Act would mean that for the first time drugs to be imported would be subject to registration. The national list of essential drugs would form the basis of the list of drugs to be imported and any other items would require specific application and justification before they could be approved for import. Under the registration procedure, there would be a legal requirement for any company importing any product into the country to provide a certificate from the appropriate authority — in other words, there would be a requirement similar to those of the WHO Certification Scheme. The national list of essential drugs had been drawn up taking into account the country's epidemiological profile and relevant economic considerations, but it was not intended that specific items should be excluded, unless they failed to meet the requirements of the Act.

It was not enough merely to develop policies and enact legislation; it was also necessary to implement programmes and strategies if progress was to be made. In the Gambia, a unique collaborative project had been developed, as mentioned the previous day by the representative of IFPMA. From its inception, that project had been designed, not to flood the country with drugs over a brief period so as to leave it with an insatiable appetite which would be impossible to satisfy, but rather to review the management system of drug supply in the public sector. In essence, every stage of the system was scrutinized, from the compilation and quantification of orders through funding, receipt, storage and distribution, and monitoring. The project had rightly received wide publicity — although in dollar terms it was a small one — because its value to the country was inestimable.

A programme had been developed whereby technical expertise would be provided by pharmaceutical companies and every stage of the drug supply system reviewed. He wished to emphasize the fact that the drugs supplied to the project had been paid for from the national budget; thus, almost 20% of the national budget for essential drugs had been invested in that project, and those funds were jointly managed by the project representative and the Ministry of Health, Labour and Social Welfare. That had made it possible to rectify problems which had become apparent within the system, and which otherwise would have taken a long time to resolve by normal procedures. With regard to practical issues, such as requirements for calculators, typewriters and air conditioners, the funds generated from local resources in exchange for the drugs donated had been used to solve such minor but significant problems.

The Gambia had a system which, in the foreseeable future, could be managed within the limits of national resources, since there had not been an injection of any supplies over and above what the country could absorb. It was essential to take full account of the risks of any situation in which there was easy access to large quantities of drugs over a short period, but where the supply could not be maintained after a project had been completed. The system developed in his country should, all things being equal, ensure easier access by every member of the community to essential drugs.

With regard to procurement, the Gambia was faced by the hard currency problems shared by many other countries. Although it had been possible to persuade the Government to increase the national allocation for drugs, the present economic situation, together with a 25% devaluation of the national currency, had allowed the existence of a level of supplies to be maintained. His country followed an open-tender system, having in the past used 50 different suppliers from all over the world. However, as a result of the hard currency problems, the number of suppliers tendering had dwindled, with a consequent reduction in flexibility and benefits. His country accordingly welcomed the efforts being made by WHO to review the options available for assisting countries such as his own to overcome that major obstacle, since the long-term commitment in hard currency needed for bulk procurement was a major problem. However, even the reimbursable procurement system developed by WHO and UNICEF, in
which the Gambia was participating, suffered from important constraints, since it was limited to the amount of local currency which the organization concerned could spend within the country. Thus, although that help had been of inestimable value, it only met less than one-sixth of country requirements. He also drew attention to the unduly long period of time, amounting to five or six months, between payment and delivery under that scheme, as opposed to four to six weeks with normal commercial supplies. His country would accordingly welcome efforts to streamline procedures in that regard.

The option of buffer stocks had been investigated at the national level. One possibility would be for capital to be made available by the Ministry of Planning to the Ministry of Health, Labour and Social Welfare so that buffer stocks covering up to two years' supplies could be built up and released only when all payments for the current year, including those in hard currency, had been made. That process would call for disciplined endeavours, but his country was determined to establish a system which would avoid fluctuations in supplies.

Although it was true that, as stated in paragraph 49 of the progress report before the Committee, 13 United States companies had provided technical assistance to the Gambia's drug management and distribution systems, together with buffer stocks of drugs, not more than four or five items had, in fact, been provided. While his country was in no way unappreciative of that gesture, it was nevertheless true that the priority need for buffer stocks had not as yet been met.

The Gambia had developed its own list of essential drugs for all tiers of service, 11 drugs being provided at the village level. Although the criticism had been made that mainly illiterate workers were responsible for administering those drugs, experience had shown that the most rational use of essential drugs was made in that sector, possibly because the workers had received special training to deal with the restricted range available to them. At higher levels, doctors and nurses were gradually being weaned away from the use of a large variety of drugs, and the economic situation provided the justification for reducing the number of items on the drug inventory. He stressed the need to embark progressively on a national in-service training programme to ensure the most rational use of drugs and other medical supplies.

Decentralization of supplies had proved of advantage, since past experience had shown considerable expenditure on fuel used in collecting supplies. Regional medical stores had been established, which distributed supplies at fixed times to local centres. Wastage of drugs, as a result, for example, of deterioration during storage, called for special attention, and stock levels had been determined for each centre; they were replenished as the need arose.

He supported the draft resolution submitted by the Executive Board, as well as the draft resolution on rational use of drugs, although it was his view that the operative paragraphs should be strengthened.

Mr ZHI Junbo (China) said that his delegation fully supported the report submitted by the Executive Board, which represented an important indicator in the implementation of the Global Strategy.

His country accepted the principle of the Action Programme on Essential Drugs and Vaccines, and had organized production of those drugs to supply all the various needs.

Starting in 1979, the Ministry of Public Health and the State Pharmaceutical Administration had collected lists of various kinds of medicines submitted by provinces, autonomous regions and municipalities. After examination and selection by experts, as well as broad consultations, 279 drugs of 28 categories had been classified as national essential drugs for western medicine. In 1982, the national essential drugs list had been published. In 1983, documents were published, for the guidance of medical and health personnel, describing the pharmacological and toxicological properties as well as the clinical application of those drugs.

In order to ensure that those essential drugs were of the required quality, 2471 pharmaceutical plants throughout the country had been inspected and reorganized. After they had been inspected and their products reviewed and approved, they were issued with pharmaceutical production licences. Furthermore, the Ministry of Public Health had eliminated 127 drugs and preparations as being unsuitable. Those measures had contributed to the effectiveness and safety of medical practice.

Chinese medicine constituted a valuable cultural heritage. On the basis of national experience in traditional medicine and also of modern scientific methods, thorough studies had been undertaken and remarkable results obtained, which had led to rapid developments in the production of new forms of Chinese medicines. A total of 26 new forms, including crystals, powders, injections and sprays, were available, as well as over 500 new types of drugs, which were proving more effective and easier to administer.
In keeping with the Expanded Programme on Immunization, China had revised its national regulations governing the procedures for the immunization of children and had drawn up an action programme for immunization. At the same time, a planned network of institutions covering immunization at the central, local and basic levels, had been established, with regular personnel. WHO teaching materials had been used to hold 10 531 workshops at senior, intermediate and beginner levels, at which 750 000 individuals had been trained. Furthermore, the media had been used to provide information and education on immunization. Since China possessed vast territories and a large population, while transportation and communications were inadequate, the task of extending the immunization programme to cover all cities and rural areas and of installing a comprehensive cold chain was indeed formidable. His country was, however, determined to meet WHO's requirements, particularly in regard to biological standardization, and would make every effort to achieve the goals of the Action Programme.

Dr HOLLANDER (Zimbabwe) said that, following independence, Zimbabwe had taken action to ensure the regular supply of safe and effective drugs and vaccines, at the lowest possible cost, to the entire population, through health systems based on the fundamental principle of primary health care.

The national drug and therapeutic policy committee had been established in 1981, with a view to formulating an appropriate national drug policy relevant to needs, reviewing the entire pharmaceutical sector in the country, and improving the procurement, distribution and use of drugs. A proposed essential drugs list, based on WHO guidelines, had been distributed on a trial basis to the government, mission and private health sectors, as well as to pharmaceutical companies. In the light of their comments, a revised document had been prepared by the above-mentioned committee, listing 376 items, as compared with the 2000 drugs, the majority imported, marketed before independence. It was planned to establish a national formulary following discussions with the public and private sectors. Quality control would be strengthened, and monitoring improved. Workshops would be held at provincial and district levels to provide information and training for health workers, and flow charts would be designed for lower level health cadres, who would also be provided with treatment regimes. Training of pharmacists and pharmaceutical assistants would be continued. The former were being deployed to central and provincial hospitals, and the latter to district hospitals, where they were encouraged to play an educational and promotional role as well, including support to 3000 village health workers, who were given six essential drugs as part of their equipment.

As part of the educational strategy, it was planned to incorporate information on the role of drugs in health in talks and seminars at schools and training institutions for young people, as well as for health and general community workers. It was thus hoped to develop appropriate responses in the community in an area of health activity susceptible to considerable abuse.

Drug distribution was currently being effected by decentralizing medical stores to the provincial level, a measure that should significantly improve the availability of drugs and make them more readily accessible to rural health facilities, where they could be most effective.

Her delegation supported the draft resolution recommended in resolution EB73.R15. It also supported the draft resolution on the rational use of drugs, and, in particular, paragraph 2(3), and would like to be included among the co-sponsors.

The meeting rose at 10h50.
The CHAIRMAN announced that the working group on the draft resolution on infant and young child nutrition had met and completed its work. The working group on the draft resolution dealing with the rational use of drugs had also met. He therefore suggested that the Committee continue the discussion of item 22 of the agenda for the time being and at an appropriate moment consider the draft resolution on infant and young child nutrition, presented by the working group, under agenda item 20 and a draft resolution on the role of universities in the strategies for health for all under item 19.

It was so agreed.

1. ACTION PROGRAMME ON ESSENTIAL DRUGS AND VACCINES: Item 22 of the Agenda (Resolutions WHA35.27 and EB73.R15; Document EB73/1984/REC/1, Annex 7) (continued)

Mr VAIDYANATHAN (India) said that the objective of a national drug policy was to make available to the population drugs of the right kind, the right quality, in the required quantity, at the desired time and at reasonable prices. There must be an adequate infrastructure and adequate facilities to ensure that that objective could be met. For instance, there must be a mechanism to assess what drugs were needed, the quantities, and the time at which they would be required. There must also be a regulatory mechanism - including an adequately staffed and equipped inspectorate and control laboratories - to ensure drug quality, so that people could be certain that they did not consume substandard drugs. In order to ensure the timely and adequate supply of drugs, Member States should develop their own manufacturing capabilities so as not to be entirely dependent on imports. Price regulation could best be ensured by governments: if indigenous manufacture was in the private sector, the government could determine drug prices in such a way that profit margins were fixed at a reasonable level; if it was in the public sector, the government could directly establish prices at levels which would serve the best interest of consumers.

The guidelines laid down in resolutions WHA28.66 and WHA31.32 were adequate but the Ad Hoc Committee's report (document EB73/1984/REC/1, Annex 7) indicated that not all Member States had formulated drug policies; his delegation therefore supported the Board's recommendation that they should be encouraged to introduce and implement drug policies in accordance with the Health Assembly's resolutions.

In the late 1940s his Government had enacted a Drugs and Cosmetics Act which provided the legal framework for implementation of the national policy on drugs. Under that Act the Drug Controllers of India and of its component states were vested with powers to license the import, manufacture and use of specific drugs. The programme of indigenous manufacture was the responsibility of the Ministry of Petroleum and Chemicals, and the Ministry of Health and Family Welfare was responsible for drug quality control. There was also a competent government department to examine costing and determine the price of drugs.

His Government had taken a policy decision to ban drugs considered injurious or harmful, and had indeed banned a number of such drugs. It had also decided that single-ingredient drugs should be marketed under generic, not trade names. Some affected parties had, however, gone to court against that decision, and the verdict was still awaited.

Aware of the need for technical cooperation among developing countries, India had been helping other developing countries to build their own capabilities. Details of its training facilities had been circulated to the WHO Regional Office for South-East Asia and to the Members of the Region and approximately US$ 500 000 had been earmarked for training purposes. India had also supplied medicines to certain developing countries which had been unable to obtain them on the open market at affordable prices. Its capacity, however, was not unlimited; his delegation therefore urged the developed countries to assume greater responsibility for helping the less developed countries, and suggested that at future sessions of the Health Assembly the developed countries should be called upon to indicate what they had already done and what they proposed to do in the future in that regard. WHO
might also consider the possibility of compiling details of the help afforded by the developed countries, for circulation to Member States.

It was important that full information on drugs should be disseminated to all Member States in order to enable them to decide, in the light of their own requirements, which drugs they needed, which drugs had to be imported and which could be manufactured indigenously. In that connection, he welcomed the WHO quarterly bulletin, Drug Information. The Indian delegation also appreciated the initiative taken by UNIDO to prepare project profiles for the benefit of developing countries.

The rational use of drugs and the availability of essential drugs at affordable prices could be ensured provided all Member States took concerted action along the lines suggested by the Health Assembly.

Professor BENHASSINE (Algeria) said that the Action Programme had resulted in a general awareness, at the medical, economic, management and educational levels of the importance of the problem of essential drugs. The success of the Programme was such that in time its scope would certainly be expanded.

Regarding the future perspective of the programme, as outlined in paragraphs 148 to 150 of the Ad Hoc Committee's report, the question arose whether aid, however generous, was always the best form of assistance. Needs were created, but their future satisfaction was not guaranteed. In the opinion of his delegation the best form of assistance was that which, in cases where the necessary will and means existed, promoted the transfer of technology for the production of essential drugs. The projects prepared by UNIDO on the subject were realistic because they were to be implemented in stages: first, the formulation and packaging of products imported in bulk; then, the manufacture of drugs using natural resources; and, finally, the production of drugs by synthesis or fermentation. WHO could further increase its cooperation with UNIDO in that sector.

It was interesting to note the increase in the use of generic drugs, the efficacy of which had generally been proved, and the cost of which was usually lower for consumers in both developing and developed countries. Nevertheless, generic drugs were often spurned by both doctors and patients, in favour of "innovations" often of little therapeutic value, promoted by advertising campaigns which sometimes increased the price of the product by as much as 15%. Paradoxically, that meant that the consumer financed the "barrier" between him and cheaper products. That was especially true in many Third World countries which had no official structure for the medical information of doctors. That function was therefore performed by the pharmaceutical industry which, in many cases, had called into question national nomenclatures based on the international nonproprietary names. Even in developed countries competition was so fierce that powerful pharmaceutical companies had been obliged to stop the manufacture of generic drugs. Thus the action taken by certain WHO regional offices to circulate objective information on drugs to doctors and pharmacists was excellent, and should be encouraged.

Greater emphasis should be placed on the question of morality in the marketing of drugs. In that connection, his delegation appreciated the attitude of the Parliamentary Assembly of the Council of Europe which, in September 1983, had invited the governments of European countries to lend their full political support to the development of an effective code of practice for the marketing of pharmaceuticals. WHO could not remain indifferent to that initiative, which reflected the concern of both consumers and governments with the question of essential drugs. Consumers were disturbed by prescription abuse and by the fact that drugs which had been proved to be harmful and had therefore been banned in some countries were freely available in others. Governments for their part were concerned because they were anxious to protect the health of their populations and to curb the rising cost of drugs.

However, it was not merely through objective information or a code for the marketing of pharmaceuticals that a rational use of drugs would be achieved. WHO must also take into consideration the need to improve training in clinical pharmacology for those issuing prescriptions, and the need to increase public awareness of the question of drugs in general and the dangers of self-medication in particular.

The rational use of drugs was a complicated matter which must be dealt with in a global manner within a framework of constructive discussion between all competent parties concerned. That was the aim of the sponsors of the draft resolution on the rational use of drugs, who wanted to ensure that all would have access to effective care at a reasonable cost.

Dr HYZLER (United Kingdom of Great Britain and Northern Ireland) said that the progress made in the relatively short time since the launching of the Action Programme was a source of satisfaction. The examples of activities undertaken at various levels demonstrated the effect the programme was having in stimulating original ideas, encouraging individual and
cooperative initiatives, and developing practical ways of achieving its central objective. The examples showed, moreover, that rational drug policies attracted a wide measure of support. Most encouraging of all was the evidence of the greater acceptance the Programme was gaining in many countries and the trust, good will and cooperation that was growing up amongst those who had key roles to play if it was to be successfully implemented.

There were, however, still problems to be overcome. At its seventy-third session the Executive Board had highlighted some of the more pressing problems and drawn attention to the need for greater efforts to help Member States develop expertise in drug management; to improve the quality and flow of information; to refine methods for estimating drug requirements; to develop better prescribing and dispensing practices; and to encourage wider participation in the Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce and the international drug monitoring system.

The Ad Hoc Committee's report gave examples of ways in which the Programme was being supported. His Government, for instance, offered training facilities to health workers from developing countries in a wide range of disciplines, including drug management and quality control. It disseminated information on national drug licensing decisions and on adverse reactions to drugs, as well as source documents for detailed information on quality control. Copies of the British National Formulary were dispatched to all 68 national regulatory authorities, and further information would be supplied to any country requesting it. Quality assurance for exports was provided through the WHO Certification Scheme and his delegation joined in the calls that had been made for greater participation in that Scheme. In the past year useful discussions had been held with WHO and with representatives of consumer groups and the pharmaceutical industry in the United Kingdom with a view to exploring new ways of deploying resources in support of the Action Programme. In a wider context his country's support for the Programme included many complementary and interrelated activities directly and indirectly contributing to furthering its aims, ranging from the promotion of research and development of new drugs and vaccines still needed to combat the diseases that continued to account for millions of deaths each year, right through to the provision of technical cooperation in its many forms.

On the basis of the Ad Hoc Committee's report and the discussions which had taken place in the Executive Board and the present Committee, he believed that the policies and strategy being pursued were basically sound. He wished to place on record his appreciation of the contribution of the Director-General and his staff to the Programme.

With regard to the draft resolution on the rational use of drugs, his delegation appreciated the concerns it raised, but was not fully convinced that the course of action proposed was necessarily the most appropriate one. A delegate had said that the Director-General should be free to decide the place of the proposed meeting. In fact, it was not a question of the siting or timing of the meeting - but, more fundamentally, of finding the most appropriate ways of tackling the whole problem. He would like to hear the views of the Secretariat before reaching a final conclusion on the draft resolution. He would prefer to leave the Director-General as free as possible to adopt the course of action which, in his opinion, would most constructively carry forward the many helpful and practical suggestions made during the debate.

It was understandable that the subject under discussion should arouse strong and passionate feelings. However, in his view, it should always be kept firmly in the overall context of primary health care, with all its components.

His delegation supported the draft resolution proposed by the Board in its resolution EB73.R15.

Dr NIGHTINGALE (United States of America) commended WHO for its work on the Action Programme. The Ad Hoc Committee's report showed that considerable progress had been made at the global, regional and country levels, and that industry had made significant contributions to the effort. He strongly supported the draft resolution proposed by the Board in its resolution EB73.R15.

One item in the report (paragraph 27) highlighted the progress made to date: he referred to the international Conference on Essential Drugs for Primary Health Care held at the Harvard School of Public Health (Boston, United States of America) in April 1984. The Conference, which he had himself attended, had brought together government officials, representatives of industry and consumer organizations, and students, and would lead to the development of teaching materials on essential drugs which could be used at universities throughout the world.

As noted in paragraph 59 of the report, the United States Food and Drug Administration (FDA) had responded to specific requests for assistance within the Action Programme by providing consultants in Asia and South America on drug registration information, quality control, and good manufacturing practices. He believed that the
information obtained from those initial projects, in addition to its value to the countries concerned, would have worldwide applicability and would be of use in meeting future requests for assistance.

The FDA had collaborated closely with WHO regarding the exchange of technical information, the monitoring of adverse reactions to drugs, and the WHO Certification Scheme, in which the United States was participating. It had co-sponsored the first meeting of drug regulatory authorities in Annapolis, Maryland, in 1980. The group had met once since then in Rome in 1982, and would meet in June 1984 in Saltsjöbaden, Stockholm; it had now been established on a firm biennial basis and an advisory committee would meet early in 1985 to plan for the 1986 meeting. In addition the FDA had collaborated with WHO in preparations for an international conference of veterinary drug regulatory authorities and was now working with WHO headquarters, PAHO and the Regional Office for Europe on the planning and co-sponsorship of a first international meeting of medical device regulators. International meetings of that kind, particularly through the valuable contacts made, facilitated the communication of important information on the safety, efficacy and quality of products.

He considered that drug regulation and regulatory bodies in all countries were essential for effective drug registration and the labelling, advertising and promotion, and quality control of drugs. Central to the Action Programme was national legislation and regulations and their effective implementation at the national level. Distribution and supply systems were superfluous or even counter-productive if they were simply vehicles for ineffective or sub-potent drugs which did not treat endemic diseases or did not have a favourable risk-benefit ratio in a particular country.

The United States Government was developing a strategy to establish the most effective cooperation with the Action Programme, and was preparing an inventory of skills and functions within its Public Health Service in order to identify the expertise appropriate for the various components of the Programme. USAID was already contributing approximately US$ 14 million a year for essential drugs for primary health care programmes.

He drew attention to a potential problem which had been raised during the Executive Board's discussions on the Action Programme. Many of the Action Programme's activities were included in the "Pharmaceuticals" (Drug and Vaccine Quality, Safety and Efficacy) programme and he asked for clarification on the relationship between the two programmes. Perhaps lack of clear demarcation of roles had been partly responsible for the introduction of the draft resolution entitled "Rational use of drugs". With regard to that resolution, the concept of establishing a demarcation area of pharmaceuticals was sound; but, he was puzzled by the resolution's title. Drug labelling and physician prescribing were clearly components of the Action Programme. Those and other important matters mentioned in the preamble, however, were normally covered by the "Pharmaceuticals" programme; in fact, he believed that everything in the resolution came within the terms of reference of the "Pharmaceuticals" programme.

He did not agree with the statements in the fifth and sixth preambular paragraphs concerning the need for "developments in clinical pharmacology" and for "further analysis of the basic knowledge of drug prescription and use" in order to improve prescription practices. The greatest need was to disseminate current knowledge and available materials more widely and, where necessary, to create materials appropriate for each level of the national health care system. Nor would he give priority to the "need for better information on drug marketing procedures and practices", as stated in the eighth preambular paragraph. He did not agree with the contents of the tenth preambular paragraph.

Operative paragraph 2(1) was directed at prescription practices and was within the province of the "Pharmaceuticals" programme. He strongly supported that very helpful and useful function of WHO. In operative paragraph 2(2), as in the eighth preambular paragraph, he found the term "marketing practices" puzzling. He saw no need for WHO to be involved in commercial practices which were outside its area of responsibility, and he considered that such references should be deleted from the resolution. He strongly endorsed the Director-General's warning that WHO should not get involved in controversial and contentious issues.

Operative paragraph 2(3) caused him great concern; he wondered why a meeting was needed, and what it would discuss. The "Pharmaceuticals" programme was already dealing with drug regulatory authorities from both developing and developed countries concerning those matters. He believed that the kind of meeting proposed would be unproductive and, even worse, disruptive to the Action Programme. A meeting of such a mixed group of participants with imprecise terms of reference could indeed be counter-productive. The decision on whether a meeting was needed should be left to the Director-General, who should also decide on the participants, the venue and the agenda. He considered that the draft resolution should be withdrawn, and agreed with the delegates of the United Kingdom and Canada who had requested clarification. He supported the proposal for the establishment of a small working group which could prepare an amendment to the draft resolution proposed by the Executive Board, if that was felt to be appropriate.
Dr SAVEL'EV (Union of Soviet Socialist Republics) said that he wished to associate himself with the views expressed by the delegates of Cuba and Norway. The USSR had fully supported the Action Programme since its inception. The conflicting interests of Member States and transnational pharmaceutical companies represented a basic problem, and WHO's efforts and authority in that respect were particularly important.

He stressed the special importance of the sections of the Add Hoc Committee's report dealing with the dissemination of experience and information, technical cooperation among developing countries, and programme monitoring and evaluation.

The price of drugs largely depended on the quantity produced but the report was not very clear in that respect. He wondered if there was a mechanism to determine the long-term needs for a particular drug in a particular country, and whether a methodology for planning had been established. Only one country was mentioned in the report as having called for bids for a three-year period. The matter was important, because if a mechanism existed it would be possible to group orders on a long-term basis, which would lead to a lowering of the cost. The cost of drugs and the scale of their production should be taken into account in the establishment of the list of essential drugs in order to avoid including drugs produced in limited quantities by a limited number of companies, with a consequential high price.

With regard to manpower development, paragraph 48 stated that 32 people from 19 developing countries had been - or were being - trained. The question arose whether the training programme was adequate for the scope of the Action Programme. Particular attention should be given to the training of specialists on drug use, the organization of distribution systems, stockage and marketing, legislation and quality control. It would also be advisable to train personnel to deal with the financial aspects.

Lastly, there was the question of coordination. Bearing in mind the emphasis on the development of State monitoring measures for the quality control of drugs, it would be wise to have closer cooperation between WHO's Action Programme and its other programmes concerning pharmaceuticals. Expert assessment was essential. In the Soviet Union and other socialist countries the question of drug supplies was kept under constant review; a special discussion at the twenty-third meeting of Health Ministers of the socialist countries had established plans for further improvement.

In conclusion, he had no objections to the draft resolution proposed by the Board in its resolution 130/48, or to the draft resolution on the rational use of drugs; he felt that a working group could combine the two resolutions without much difficulty.

Ms VON WARTENSLEBEN (United Nations Conference on Trade and Development (UNCTAD)) said that UNCTAD had been active in the field of pharmaceuticals since 1976 when its Committee on the Transfer of Technology had requested the secretariat to undertake studies on the problems of the transfer of technology in specific sectors with a view to strengthening the technological capacity of developing countries in those sectors. The UNCTAD Conference discussed the same issue in 1976 and, inter alia, called for cooperation among the developing countries in the establishment of subregional, regional and interregional centres in specific sectors of particular interest to developing countries, such as pharmaceutics. At the same time, the Conference established UNCTAD's Advisory Service on Transfer of Technology (ASTT) to provide technical and operational assistance and advice to the developing countries on a continuing basis, its work including the pharmaceutical sector.

UNCTAD's activities in the pharmaceutical sector did not take place in a vacuum, but were closely related to those of WHO towards the implementation of the strategy for health for all by the year 2000, particularly with regard to the supply of the right drugs at the right price to all people needing them. There was an urgent need to develop and implement strategies for facilitating the supply of pharmaceuticals, in particular essential drugs, to the developing countries. A number of initiatives and actions at the national, regional and international levels had an important bearing on a comprehensive and integrated approach to pharmaceuticals. For example, the fifth and sixth Conferences of Heads of State or Government of Non-Aligned and Other Developing Countries had both given detailed attention to the question of pharmaceuticals and had adopted resolutions on the subject. A number of aspects of those resolutions called for action by UNCTAD. The UNCTAD Group of Governmental Experts on the Economic, Commercial and Developmental Aspects of Industrial Property had dealt with the pharmaceutical sector in 1982, and the Fifth Ministerial Meeting of the Group of 77, in its Buenos Aires Platform, adopted in April 1983, called upon UNCTAD "to explore the possibility of preparing international measures, norms or standards on marketing, promotion, distribution, trade and technology in the pharmaceutical sector so as to provide the basis for appropriate action by governments". That had led to a decision at sixth session of the Conference on Trade and Development, held in Belgrade, in June 1983, requesting UNCTAD to report to the twenty-eighth session of the Trade and Development Board on UNCTAD/WHO collaboration in that sector. The issue had been discussed at the
twenty-eighth session of the Board (March 1984), and a draft resolution had been tabled by the Group of 77 requesting UNCTAD to circulate the IFPMA Code of Pharmaceutical Marketing Practices as well as the Health Action International draft proposal on pharmaceuticals to Member States of UNCTAD for their comments. The Board's debate was to be continued at its twenty-ninth session.

UNCTAD's research programme on the economic, commercial, legal, technological and developmental aspects of pharmaceuticals was continuing. UNCTAD also provided training programmes, advisory services, and technical and operational assistance to developing countries concerning trade, imports and distribution of pharmaceuticals, particularly under generic names, as well as on strategies, plans, policies and regulations concerning the transfer, utilization and development of technology in that all-important sector. Many developing countries had availed themselves of the expertise of UNCTAD's Advisory Service in evolving, systematizing and implementing programmes, policies and control systems at the national level. While national action had so far been given priority, there might also be legitimate concern among producers, consumers and governments to harmonize such action as far as possible. If in the future governments considered it desirable to formulate universal standards on pharmaceuticals, the modalities to be adopted would have to be the subject of agreement among them, and would have a decisive influence on the role of international organizations such as WHO and UNCTAD. In that respect she looked forward to the outcome of the deliberations of WHO and expressed UNCTAD's continued readiness to cooperate with WHO on all matters relating to trade, technology and developmental aspects of pharmaceuticals.

Professor FORGÁCS (Hungary), expressing appreciation of the Ad Hoc Committee's report, said that the introduction of an essential drugs list in some developing countries was an encouraging sign for the future and that the elimination of non-essential drugs from domestic markets was in the interests of countries with limited economic resources.

His country had supported the Action Programme in several ways, including the development of basic tests for quality control in developing countries. In Hungary the health authorities kept the exporting pharmaceutical industry under rigorous control, and strict conformity with the WHO Certification Scheme was ensured; the pharmaceutical quality assurance system made no distinction between drugs produced for export and those designed for domestic use.

Students from developing countries were regularly trained in Hungary, and Hungarian experts were sent to such countries as advisers.

The report referred to collaboration between WHO and other international organizations. There were many UNIDO programmes on pharmaceuticals, and it was important to ensure full coordination.

Mrs MATI (Kenya) expressed her country's appreciation of the Action Programme. The establishment of a list of 160 essential drugs in 1981 and the mandatory registration of imported or locally manufactured drugs as from 1982 in her country had led to improvements in drug procurement, distribution and prescription, with a subsequent radical effect on the health system as a whole.

One of the most serious problems had been the chronic lack of drugs in rural areas. Thirty-nine drugs that were in common use in rural health centres had been identified, and steps were being taken to ensure that they were available at all times. Procurement was effected through a tendering system, and the drugs were packed locally and dispatched directly to each health unit. That programme was operational in more than half the country, and countrywide coverage was expected by the first quarter of 1983. Beneficial effects included new confidence of the population in rural health facilities, a markedly lower intake in district hospitals, awareness by health workers that they required only a small number of drugs for their work, and regulation of the prescription pattern of health workers.

Credit for the success of the Kenyan experience was due to the cooperation of SIDA, DANIDA and WHO. Kenya would continue to share its experience with other Member States at their request.

Ignorance about drugs was a problem which the Kenyan Government was endeavouring to resolve; since 1 November 1983 medical practitioners, dentists and pharmacists had been required to inform patients about drugs prescribed or dispensed.

Her delegation wished to co-sponsor the draft resolution on the rational use of drugs, and expressed the hope that the good intentions behind the resolution would not be compromised by trade interests.

Dr GAUDICH (Federal Republic of Germany) welcomed the recent progress made in many Member States in implementing the Action Programme, as reflected in the Ad Hoc Committee's comprehensive report.
The Federal Republic of Germany contributed to the achievement of the objectives of the Action Programme by supporting local production of essential drugs; public laboratories' quality control of drugs and examination of domestic medicinal herbs; stockpiling of drugs in the public sector to ensure better distribution to basic health services; and primary health care and hospital services - to ensure a better application of drugs by training the personnel and informing the public. It also supported projects for research on and the production of traditional therapeutic substances and medicinal herbs, and sent essential drugs to Third World countries to meet urgent needs. It collaborated in the activities of many international organizations aimed at improving drug supplies in the Third World, including research on drugs and their application for the control of the six major tropical diseases covered by the Special Programme for Research and Training in Tropical Diseases, and for the control of onchocerciasis in seven West African countries; so far it had made available DM 42 million for those programmes.

The Federal Republic of Germany was willing to help the drug-importing countries to assess drugs by providing information on the conditions concerning the sale of any specific drug on its own market. Restricting imported drugs to those that were essential would improve supply to deprived areas and would be conducive to a more rational use of limited financial resources. There was, however, the risk that restrictions might be made on scientifically and therapeutically sound drugs for political reasons. Research by the industry was absolutely essential, but would only be able to develop successfully if it was free from fundamental State intervention and financially secure. It would also have to spread beyond the currently small circle of industrialized countries if dependence was to be abolished.

She consequently took the view that the Action Programme, which she supported fully, should preferably not be addressed to all Member States but should serve primarily as a guide for those countries in which the drugs most urgently needed were not available in sufficient quantities.

Dr DIALLO (Mali) was concerned at the reservations expressed in the Committee concerning the draft resolution on the rational use of drugs.

When the pharmaceuticals reform which instituted a list of 240 essential drugs, was undertaken in Mali, the Department of Health had asked the national school of medicine to take part in a public information campaign. Those responsible for the campaign realized that resistance would be encountered from physicians, consumers and the pharmaceutical companies. Mali's pharmaceutical industry was in its infancy, producing only some 50 drugs. It was therefore puzzling to hear the reservations expressed by delegates of some of the industrialized nations with the largest pharmaceutical companies. He did not see why the convening of a meeting of experts, as recommended in paragraph 2(3) of the draft resolution should be in dispute, and would like some reassurance on the subject.

Dr GURMUKH SINGH (Malaysia) said that Malaysia had noted with satisfaction the progress made by many countries in carrying out the Action Programme as outlined in the Ad Hoc Committee's report, but he agreed with the delegate of Chile that there was still room for further progress.

High priority was being given to the Action Programme in Malaysia, where measures were needed to counter the aggressive marketing policies of the pharmaceutical industry. Legislation would soon be introduced under the Sales of Food and Drugs Ordinance to tighten the control of the marketing of drugs, providing for the registration of drugs prior to marketing, for labelling, for quality control, and for good manufacturing practices. An effective national drug control laboratory had been set up.

In addition to national measures, there was a need for an international code to control the movement of drugs between countries. Such a code would greatly help the developing countries while they were preparing their own national control measures. The fact that many developing countries had to pay far more than necessary for the drugs they needed was also a matter for concern. The pharmaceutical industry should endeavour to form a clearer view of its role and accept its share of responsibility for ensuring the attainment of the goal of health for all by the year 2000, and drug-producing countries had a moral responsibility to assist developing countries to obtain good quality drugs at fair prices.

His delegation greatly appreciated the excellent work WHO was doing, and urged that it continue to give the Action Programme the priority attention it merited. It supported the draft resolution proposed by the Executive Board in its resolution EB73.R15.

Mr CARUANA (Malta) said that considerable attention had been paid in Malta to the matter under discussion, especially with a view to ensuring that essential drugs were available to all, at reasonable prices.
Malta was actively engaged in the formulation of a comprehensive national drugs policy, and, as a first step, consideration was being given to the drugs used by government-run hospitals and primary health care centres. A formulary had been drawn up containing a list of such drugs, and a committee had been set up to consider requests by physicians for additions to that list and for supplies of unlisted drugs.

However, Malta was a small country, with a small population, and that gave rise to certain constraints. Drugs were purchased by means of open international tenders, but Malta's relatively small orders excluded the possibility of concessionary prices. Furthermore, Malta's therapeutic standards were aligned on European and, particularly, United Kingdom standards. Consequently, the formulary included drugs that were not generally considered essential, and Malta had been unable to join with other countries in making bulk purchases. It was far from certain, therefore, that Malta was obtaining its drugs at the lowest possible prices.

Furthermore, laboratory facilities and opportunities for quality testing were necessarily limited in Malta. Large-scale manufacture would not be cost-effective, and only a small number of drugs were produced in the country: most of the drugs used in Malta were therefore imported.

Diabetes had assumed the proportions of a national disease in Malta and priority was being given to efforts to control it. A national diabetes project had been launched five years ago under WHO auspices. The project involved the procurement of drugs and glucose testing equipment, the printing of educational material and the training of medical and paramedical personnel. That had led to a severe drain on the country's limited foreign exchange resources.

He hoped that Malta would also be included in future among the countries to which assistance was being extended by a number of organizations and drug manufacturers' associations.

He expressed his delegation's appreciation of the Ad Hoc Committee's comprehensive report, and its full support for the Action Programme. It wished to be included among the sponsors of the draft resolution on the rational use of drugs.

(For continuation, see section 4 below.)

2. INFANT AND YOUNG CHILD NUTRITION (PROGRESS AND EVALUATION REPORT; AND STATUS OF IMPLEMENTATION OF THE INTERNATIONAL CODE OF MARKETING OF BREAST-MILK SUBSTITUTES): Item 20 of the Agenda (Resolution WHA33.32; Documents WHA34/1981/REC/1, Annex 3, Article 11.7 of the Code, and A37/6) (continued from the ninth meeting, section 2)

Dr AL-JABER (Qatar), Chairman of the working group, introducing the revised draft resolution on infant and young child nutrition, said that the working group had reached agreement on the following text:

The Thirty-seventh World Health Assembly,
Recalling resolutions WHA27.43, WHA31.47, WHA33.32, WHA34.22 and WHA35.26, which dealt with infant and young child feeding;
Recognizing that the implementation of the International Code of Marketing of Breast-milk Substitutes is one of the important actions required in order to promote healthy infant and young child feeding;
Recalling the discussion on infant and young child feeding at the Thirty-sixth World Health Assembly, which concluded that it was premature to revise the International Code at that time;
Having considered the Director-General's report,1 and noting with interest its contents;
Aware that many products unsuitable for infant feeding are being promoted for this purpose in many parts of the world, and that some infant foods are being promoted for use at too early an age, which can be detrimental to infant and young child health;

1. ENDORSES the Director-General's report;

2. URGES continued action by Member States, WHO, nongovernmental organizations and all other interested parties to put into effect measures to improve infant and young child feeding, with particular emphasis on the use of foods of local origin;

1 Document WHA37/1984/REC/1, Annex 5.
3. REQUESTS the Director-General:
   (1) to continue and intensify collaboration with Member States in their efforts to implement and monitor the International Code of Marketing of Breast-milk Substitutes as an important measure at the national level;
   (2) to urge Member States in examining the problem of the promotion and use of foods unsuitable for infant and young child feeding, and ways of promoting of the appropriate use of infant foods;
   (3) to submit to the Thirty-ninth World Health Assembly a report on the progress in implementing this resolution, together with recommendations for any other measures needed to further improve sound infant and young child feeding practices.

He proposed the further amendment: the word "support" should be substituted for "assist" in paragraph 3(2).

Mr BOYER (United States of America) said that he appreciated the good intentions of those who had prepared the draft resolution under discussion, but his delegation still had serious reservations. He was disappointed that the draft resolution, which was the first on that subject for two years, ignored the bulk of the work which WHO was doing to promote improvements in infant and young child feeding, and gave the impression that the Assembly considered WHO's primary task to be the regulation of marketing practices of the private sector, an impression widely circulated since the adoption of the International Code of Marketing of Breast-milk Substitutes in 1981. Yet the excellent report of the Director-General provided extensive details of the efforts of WHO to encourage breast-feeding, to strengthen educational programmes for mothers, to encourage appropriate weaning practices and to undertake other important tasks in that field, and they were not mentioned in the resolution.

It seemed inconceivable to him that the Assembly could adopt a resolution on infant and young child feeding which ignored "breast-feeding" and even that the word did not appear in the draft resolution, which either implicitly or explicitly focused almost exclusively on the need for more controls on private sector marketing practices. It once again pushed WHO into the arena of international controversy in spite of the Director-General's warning against dealing with controversial issues which diverted attention from the true role of WHO, and thus reduced international support for the Organization. The draft resolution before the Committee would appear to aim at re-opening the breast-milk controversy within WHO, in order to renegotiate and to broaden the scope of the International Code, which had been carefully limited to products marketed as breast-milk substitutes; that Code had generated controversy enough.

The draft resolution under discussion would extend WHO's involvement to the marketing practices of food products in general for young children. As a father of a four-year-old child he knew young children would eat almost anything, whether or not it was good for them. Therefore, he wondered whether WHO really wished to become engaged in battle with the food industry over such foodstuffs as ice cream, biscuits, soft drinks and the like, and initiate a new and damaging controversy.

He believed that there was a constructive and positive way to deal with the use or misuse of foodstuffs, by, for instance, requesting the Director-General in paragraph 3(2) to assist Member States in encouraging the proper use of food products, in developing appropriate weaning foods and in avoiding the use of inappropriate products.

It was not necessary for the draft resolution to attempt to address the marketing practices of the corporate sector throughout the world. He wished to make it clear that he was not in favour of unlimited marketing practices, and that he took the view that every Member State had the sovereign right to regulate marketing practices in its territory. What his Government opposed was the involvement of the organizations of the United Nations system in efforts to impose uniform commercial marketing standards, whether they applied to infant foods, pharmaceuticals, alcohol, tobacco or any other product, particularly when they went beyond the legitimate responsibilities of those organizations. He was not proposing to call for a vote on the draft resolution despite his strong reservations about the direction being taken in the matter under discussion. He did, however, wish to have the concerns that he had just expressed clearly placed on record and to express the hope that the Secretariat in addressing the resolution would keep firmly in mind the proper role of WHO.

Professor ORDÔNEZ CARCELLER (Cuba) said that the draft resolution aimed at consolidating and promoting certain principles which formed part of the Global Strategy for Health for All.

It seemed to him that in the Health Assembly a problem of communication, of terminology, of semantics and of the interpretation of concepts arose in the discussion of the texts that came before it. There was a tendency in discussing technology to lose sight of its
scientific, and in particular, epidemiological bases, although the two were inseparable. If the technology developed was oversophisticated, the fault lay in the scientific analysis of the problem. The draft resolution before the meeting was properly aimed at securing respect for a scientific approach to the solution of the problem: for some three-quarters of the world's children the problem was not whether or not they ate suitable food products, but whether they had anything to eat at all. That was why he considered that WHO should support - and not merely conform to - the Strategy it had defined - that is to say the Strategy aimed at ensuring health for all - in which those scientific principles were paramount. The peoples of many countries represented in the Committee had life-styles which had harmed their health. As a result of the liberal introduction of certain food products, the indigenous peoples of developed countries, who used to enjoy good health were also suffering from that state of affairs and currently experiencing hypertension, heart trouble, decaying teeth, which they had never previously known.

The real problem was to find the best ways and means of strengthening the WHO Global Strategy for Health for All by the Year 2000, and so far as concerned infants and young children the real problem was to ensure that they had enough food and of the right kind. That was one of the aims of the International Code of Marketing of Breast-milk Substitutes. In an international forum, such as the Health Assembly, no attempt should be made to restrict that scientific and technological approach. Although scientific principles were, of course, universal, when it came to applying them at country level many social and cultural factors intervened to limit their applicability, in that connection he pointed out that every Member State was at liberty to apply the International Code or not to do so. What he opposed was a technocratic approach which sought to impose on Member States a certain view of reality.

His delegation had therefore endorsed the previous draft of the resolution under discussion and had no objection to the merging of that draft resolution into the text currently under consideration.

The CHAIRMAN asked whether there were any further comments or objections.

The draft resolution, as amended, was approved.  

3. GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000: REPORT ON MONITORING OF PROGRESS IN IMPLEMENTING STRATEGIES FOR HEALTH FOR ALL: Item 19 of the Agenda (Resolutions WHA34.36, WHA35.23, WHA36.34, EB73.R3 and EB73.R6; Documents EB73/1984/REC/1, Annex 1, A37/4, A37/5 and A37/INF.DOC./6) (continued from the sixth meeting, section 1)

The role of universities in the strategies for health for all

The CHAIRMAN invited comments on the draft resolution proposed by the delegations of Australia, Greece, Iceland, Malta and the Netherlands, which read:

The Thirty-seventh World Health Assembly,
Appreciating the outcome of the Technical Discussions held at the Thirty-seventh World Health Assembly on "The role of universities in the strategies for health for all";
Mindful of the important role assigned to universities and other higher learning institutions, including colleges for postgraduate medical training, in the Global Strategy for Health for All by the Year 2000, and of the significant contribution that the fulfilment of such a role could make to human development and social justice;
Aware of the prestige that universities carry and the influence they have in developing the minds of young people and in preparing them for their role in society as well as in forming public opinion;
Recalling the functions of universities in providing education and training in the field of health and in a wide variety of social, economic and technical disciplines having a bearing on health, as well as their outstanding contributions to research in these areas;
Keeping in mind the growing involvement of universities throughout the world in grappling with social challenges and in providing services to the communities in which they are situated;
Convinced that there is an increased need for collaboration between governments and universities in order to deal adequately with health and related socioeconomic problems;

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA37.30.
Appreciating that governments and universities are becoming increasingly aware of the vast untapped resources in the universities that could be mobilized in furtherance of health and socioeconomic development;

1. Urges Member States:
   (1) to encourage universities and other higher learning institutions to include the social and technical concepts of health for all in the education and training of all categories of students and postgraduates and to acquaint the general public with these concepts;
   (2) to support universities in orienting the education and training of workers in health and related fields towards the attainment of health for all;
   (3) to involve appropriate faculties in universities, wherever applicable, in the preparation of policies for health for all and in the formulation and implementation of strategies to give effect to these policies;

2. Invites universities throughout the world:
   (1) to ensure that students and postgraduates in all faculties are adequately acquainted with the goal of health for all by the year 2000 and the measures for attaining it;
   (2) to provide the kind of education and training for students and postgraduates in the health and related disciplines that will prepare them technically and attune them socially to meet the health needs of the people they are to serve;
   (3) to conduct scientific, technological, social, economic and behavioural research required to prepare and carry out strategies for health for all;
   (4) to offer to increase their collaboration with governments for the preparation of policies and formulation and implementation of strategies for health for all;
   (5) to place themselves at the disposal of communities to the maximum of their capacity for the promotion of health and provision of health care;
   (6) to participate in creating awareness in the general public of the action people can take to promote their health and the health of the communities in which they live;

3. Requests the Director-General:
   (1) to publish a report on the Technical Discussions and ensure its wide distribution among governments, universities and other institutions of higher education, and other interested parties;
   (2) to ensure in all appropriate forums WHO's advocacy of the proper role of universities in the strategies for health for all and of the related collaboration required between governments and universities;
   (3) to provide governments and universities with information that will facilitate the assumption by universities of their role in strategies for health for all;
   (4) to support governments on request in increasing the involvement of universities in national health development efforts;
   (5) to collect and disseminate information on the involvement of universities in the strategies for health for all and on joint endeavours of governments and universities to this end;
   (6) to carry out the above within available resources, and to report on developments in his biennial reports to the Health Assembly.

Professor ORDÓÑEZ CARCELLER (Cuba) said that his delegation supported the draft resolution, but considered paragraph 2(1) to be somewhat passively worded. He would like to point out that what one heard could be easily forgotten, but what one did remained in the mind: he believed that universities and their students, both undergraduate and postgraduate, should be more active and positively oriented towards health for all. He therefore proposed that the paragraph be amended to read: "(1) to ensure that students and postgraduates in all faculties are adequately acquainted with the goal of health for all ... and actively support the measures for attaining it". That would also reflect the agreement reached in the Technical Discussions.

With regard to paragraph 2(3), he said that all research activities were scientific, and that was also the case for technological, social, and economic research and for research in the epidemiological, social, biomedical, and behavioural fields. All those activities formed an integral part of the scientific method. He therefore requested the insertion of a reference to epidemiological research, so that the paragraph would begin: "(3) to conduct biomedical, epidemiological, technological ... research ...".

He wished to make it clear that his delegation supported the draft resolution, but considered it necessary to pinpoint those issues with greater precision.
Dr AL-SAIF (Kuwait) said that his delegation supported the draft resolution but would like to amend the reference to governments and universities for instance in the sixth and seventh preambular paragraphs and in paragraphs 3(1) to (5). Since some universities were financed by governments, while others were private, it would be desirable to make a clear distinction between governments and universities, but not to such an extent as to put them in two different worlds. He therefore suggested replacing the words "governments" by some such wording as "ministries and other bodies concerned" as appropriate, in those paragraphs.

Dr REID (United Kingdom of Great Britain and Northern Ireland) proposed the insertion of a new paragraph 3(6) to read as follows:

(6) to establish the necessary mechanisms at headquarters and regional levels to ensure that all appropriate actions are taken, coordinated, monitored and evaluated;

the existing subparagraph (6) to be renumbered (7).

Dr CORNAZ (Switzerland) proposed the insertion of the word "evaluation" in paragraph 2(4), which would then read "formulation, implementation and evaluation of strategies for health for all".

Dr RAY (Secretary) read out the proposed amendments.

The draft resolution, as thus amended, was approved.1

4. ACTION PROGRAMME ON ESSENTIAL DRUGS AND VACCINES: Item 22 of the Agenda (Resolutions WHA35.27 and EB73.R13; Document EB73/1984/REC/1, Annex 7) (resumed)

Mr CASCiano (Brazil) emphasized that the supply of essential drugs to the population was among the indicators for the provision of primary health care and would be one of the tests of the success of the health-for-all strategy. Essential vaccines - against rabies, meningitis, measles, diphtheria/pertussis/tetanus - including BCG vaccine were being manufactured in Brazil and the local manufacture of poliomyelitis vaccine would be starting in 1984. All the stages in the manufacture of yellow fever vaccine, an essential biological product, were carried out in the country. Brazil was able and prepared to collaborate with other countries, at their request, in the training of personnel in specialist technologies and on quality control of imported drugs and biologicals.

In its full commitment to the goals of the Organization, the Federal Government had established, in "Finsocial", a system whereby 5% of the gross income of all enterprises was invested in social programmes, especially those concerned with essential drugs and biological products.

A national list of essential drugs had been drawn up a few years previously and the quality control of biological products was carried out centrally by the National Institute for Quality Control.

Mrs BOROTHO (Lesotho) said that her country had first tackled the problem of the availability of essential drugs in 1979 with the establishment, in collaboration with the private health sector and with assistance from the Netherlands, of the Lesotho dispensary association and the national drug storage organization (LDA/NDSO). The former was currently manufacturing about 40% of all the essential drugs consumed in the country and exporting to neighbouring countries, such as Swaziland, Botswana, Zambia and Mozambique. The latter, which was part of the Ministry of Health, was responsible for the procurement, distribution and overall management of drugs for health institutions both in the public and private health sectors. In 1982 her Government had hosted two workshops on the subject for countries within the subregion. LDA had also received, in a spirit of technical cooperation among developing countries, health workers from two other countries in the Region who had studied and observed its operations.

The LDA/NDSO project also included the construction of drug storage facilities in hospitals throughout the country, which also served clinics under their jurisdiction within the area health service structure.

LDA/NDSO and the Ministry of Health had initiated a training programme to meet the needs of essential drug management and procurement staffs, while distribution and management

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA37.31.
procedures had been explained to health workers at various meetings throughout the country. Pharmacy technicians were being trained at the national university, special emphasis being placed on the reorientation of their functions in connection with primary health care.

One of the more serious problems facing Lesotho was inadequate estimation of national drug requirements. It was not unusual for consumption to exceed the estimated requirement to such an extent as to necessitate the placing of emergency orders which then had to be met at a higher cost, especially as LDA was not yet producing at full capacity. Another area in which her country would greatly appreciate assistance was the formulation of legislation to control drug imports and distribution and to ensure rational prescribing practices by doctors and other health workers. The public had also to be educated to accept the value of medical advice rather than insisting on the prescription of drugs even where they were not required. A study might perhaps be made to assess the seriousness of that problem in developing countries. She suggested also that the WHO/UNICEF project on pool procurement might be prepared to consider the possibility of strengthening and improving drug manufacturing ventures in developing countries to enable them to participate as suppliers so as to benefit from the resulting economies of scale, as most such ventures initially operated below capacity.

Her delegation would like to be included among the co-sponsors of the draft resolution on the rational use of drugs.

Mrs MATANDA (Zambia) said that her Government attached great importance to the subject of essential drugs for a variety of reasons which included the provision of free health care and limited resources in convertible currencies.

The first national formulary, which had been drawn up in accordance with WHO guidelines in 1981, was currently under review and a revised edition would be issued early in 1985. In 1983 a pilot scheme, financed by SIDA through WHO, had been started in one district to study the feasibility of supplying all rural health centres directly from medical stores, rather than from the nearest hospital or zonal rural health centre. Initial results had indicated that such a system would benefit the population in rural areas and it was intended eventually to extend the scheme to all parts of the country.

Efforts to rationalize drug supply had so far been confined to the public sector, since the Ministry of Health had limited control over drug procurement and distribution in the private sector. Negotiations were however proceeding as a result of which it was hoped that in the not too distant future the Ministry would exercise complete control over the importation of medical supplies.

Draft legislation was also being prepared, which would bring Zambian practices up to the most stringent international standards in regard to manufacturing plant, quality control, good manufacturing practices and the registration of drugs. The pharmaceutical industry in Zambia, however, was still at an early stage of development and self-sufficiency had only been achieved in the manufacture of intravenous fluids. Local plants were at present capable of meeting about 25% of the national tablet and capsule requirement and 75% of the demand for mixtures and topical preparations. Projects already in hand and due for completion by the end of 1984 would add considerable capacity to the pharmaceutical industry and should increase tablet and capsule production so as to meet approximately 60% of national needs, but the country was likely to remain dependent on imports for the supply of injectable products for some time to come. Her country would welcome further support in expanding the local industry.

Her delegation would also like to be included among the co-sponsors of the draft resolution on the rational use of drugs.

Mr FEKIH (Tunisia) said that his country had always understood very well the importance of essential drugs in public health policy. A number of important measures had been taken earlier on, such as the restriction of drug nomenclature, the obligatory registration of imported products, the setting-up of a faculty of pharmacy, the institution of group purchasing in conjunction with Algeria, as recommended by WHO, and the local manufacture of drugs, especially those deemed to be essential for public health.

Welcoming WHO's commitment to an essential drugs policy, he singled out three factors which in his experience were of particular importance for its success at the national level. First and foremost the firm determination of the Government to achieve success was indispensible, a determination that had to be manifested in effective regulations and follow-up measures. Secondly, quality control was all-important, backed up by pharmacokinetic studies, to provide support for a purchasing policy that could turn international competition to good account in the purchase of both finished products and the raw materials for national industries which were just starting up. Unfortunately, fraudulent practices did occur in the pharmaceutical as in other industries, so that unless a
procurement policy was supported by a properly staffed and equipped quality control organization, the results could be the reverse of what was originally intended.

The third important factor was the full participation of the medical profession in the essential drugs policy. In all civilized countries the doctors were mainly responsible for prescribing drugs and unless they were fully involved and committed to the essential drugs policy there was always a serious risk that it might not succeed.

The WHO Action Programme should stress the promotion of quality control of drugs. WHO had already recommended that countries should set up quality control laboratories. Activities should be continued in order to help countries to choose the necessary equipment at the least cost. Many countries were not aware of the high costs involved, and, sometimes, financial assistance in that area was most useful.

Highly qualified personnel were required to undertake quality control activities, and assistance from universities or industrial institutions would be needed to enable them to undertake the necessary training. In that respect, he welcomed the proposal of the representative of the International Federation of Pharmaceutical Manufacturers Associations (IFPMA).

WHO should stress the need for real reforms in the teaching of medicine. Many physicians from developing countries were trained in countries where curative rather than preventive aspects were emphasized, and where the costs of health care were high. Even those undergoing training in developing countries were frequently taught on the European model, which generally did not conform with the other countries' needs.

WHO should also consider ways of persuading public health authorities to take the responsibility of keeping the medical profession informed about new developments in therapy and other matters, such as contraindications, which frequently were not known at the time of introduction of new drugs. The information supplied by WHO was also of great value, but it should be passed on to medical and pharmaceutical personnel and, if possible, to consumers. Continuous in-service training of physicians to increase their awareness of the usefulness of essential drugs was a fundamental and indispensable element in the success of health policies.

Dr MGILI (United Republic of Tanzania) said that a national drug policy had been established in his country in 1980. Although it was too early to present a cost-benefit analysis, the national action programme on essential drugs and vaccines was progressing steadily.

The critical role of drugs and vaccines in the attainment of the goal of health for all by the year 2000 had been eloquently described by many previous speakers. The developing countries were concerned that the attainment of health for all was being hampered by the malpractices found throughout the drug supply chain, from the producer to the consumer, which included excessive pricing of drugs sold to developing countries and the dumping of obsolete drugs. Members of the Committee were aware that the pharmaceutical companies were taking advantage of the lack of basic infrastructure and expert knowledge of the developing countries to supply them with drugs not acceptable elsewhere. Sometimes, such malpractices were not only a violation of human rights but were a serious crime against humanity and it was the moral duty of the Health Assembly to see that they ceased. It was not enough to gather annually to hear reports of such malpractices, practical action was required.

Despite the complexity of the situation, a solution should still be possible. In their countries of origin, pharmaceutical manufacturers did not have a free hand to operate as they liked, but were subject to licence and to regulations and standards and other conditions. Surely those countries could also exercise control over the ways such companies operated in the Third World, where countries did not have adequate control measures of their own.

The continued support for the Programme promised by the representative of IFPMA would be most welcome, as were the successful activities undertaken by that Association. The IFPMA representative had expressed his conviction that the voluntary IFPMA Code of Pharmaceutical Marketing Practices was an effective tool for maintaining ethical standards. However, the voluntary nature of the Code betrayed the claims being made for it. How should those claims be viewed in the light of the increasing marketing of potency drugs in African countries, including his own? The effectiveness of the Code left much to be desired. Further, it applied only to marketing practices and not to production. IFPMA should perhaps consider control of that aspect too; there was little point in producing drugs that were not desirable for marketing anywhere. Besides being inadequate, the IFPMA Code only served to delay the establishment of a WHO code that would set required international standards for marketing, production and transfer of technology, as well as other key areas. Developing countries were unlikely to be safeguarded from malpractices by relying on their national legislation alone, however tough that might be. Additional support and action at the international level, were needed characterized by the strong political will of all governments concerned. The IFPMA Code was no substitute for an appropriate and unbiased WHO
code. WHO should endeavour to elaborate such a code in collaboration with other organizations, such as UNCTAD, UNICEF and UNIDO, which had always shown a willingness to cooperate with WHO in that area, as in many others. He welcomed the inter-Secretariat collaboration between WHO and UNCTAD in the area of transfer of pharmaceutical technology and hoped that other relevant organizations would also make their expertise available.

His delegation supported the draft resolution on the rational use of drugs and wished to be included among the co-sponsors. He hoped that the meeting of experts would take place in 1985 as proposed, and that it would discuss the constraints facing the developing countries in the pharmaceutical sector.

He commended the report of the Executive Board's Ad Hoc Committee as well as the efforts of Health Action International which had continued to investigate the sometimes unscrupulous operations of the pharmaceutical industry.

Professor SYLLA (Senegal) commended the Executive Board's report.

His delegation supported the provisions of the draft resolution on the rational use of drugs, but regretted that the strength and scope of the proposed text had been diluted by repetitions and by the introduction of general ideas which had already been studied by WHO over the past five years, in the context of both the objectives of WHO and of policies for the supply of drugs, sera and vaccines in developing countries. His delegation wished to propose an amended text which he would submit directly to the working group in the hope that a text more in keeping with the interests of the Organization and of Member States might be drawn up.

Dr SHERIF ABBAS (Somalia) said that the Government and people of Somalia were actively pursuing the goal of health for all by the year 2000 through primary health care. The difficulties facing Somalia were aggravated by the arid nature of most of the country, the high proportion of the people who led a nomadic or semi-nomadic life, the high level of resettlement and rehabilitation following natural and man-made disasters, and the virtual absence of marketable natural resources. Although measures for the prevention and control of diseases were crucial to the attainment of health for all by the year 2000, for most people the real test of the usefulness of health services was whether they could provide adequate, individual medical care when illness struck. In most cases, that meant proper and adequate treatment with drugs at a reasonable cost to both the private and public sector. The Action Programme was therefore most timely.

While Somalia had always responded to the need for drugs for both individual cases and mass treatment, as well as for prophylaxis, it had become increasingly clear that there were many steps involved in ensuring an adequate supply chain if the drugs were to reach those in need. The Government of Somalia had therefore issued a policy statement which had included the following main points: legislation would be introduced to supplement earlier provisions for control of the range of drugs that could be imported and distributed in the country; only generic names were to be used; measures would be taken to establish local formulation from imported raw materials and price controls, and appropriate enforcement measures. The policy statement had subsequently been amplified into an action programme on essential drugs with several identifiable elements.

For several years, Somalia had sought to reduce its dependence on imported pharmaceutical products by setting up its own facilities for manufacture at the intermediate and final levels. Two months previously, an equipped production plant had been handed over to the Government which, in due course, would process imported materials to produce a range of essential drugs. Quality control facilities were available on the premises of the parastatal agency responsible for the distribution of drugs to the private sector. Such facilities would have to be extended as local production increased.

In his address to the plenary meeting, Somalia's Minister of Health had mentioned the quantification of needs for essential drugs at the primary health care level and of the logistics of drug procurement and distribution. A series of action-oriented programmes had been formulated with the assistance of the Government of Italy, UNICEF and WHO, and implementation would begin soon.

His delegation commended the report of the Executive Board's Ad Hoc Committee and welcomed the action already undertaken by WHO.

Dr WESTERHOLM (Sweden), with reference to the draft resolution on the rational use of drugs, said that her delegation found acceptable the amendments proposed by the delegations of Switzerland and India. The amendment proposed by the delegate of the Netherlands, requesting the Director-General to review the machinery within WHO concerning the dissemination of objective information relevant to the appropriate use of essential and other drugs and to introduce improvements where necessary, was also acceptable. However, the
The further amendment proposed by the delegate of the Netherlands, to have the review of the IFPMA Code placed on the agenda of the forthcoming International Conference of Drug Regulatory Authorities was not acceptable, since it completely changed the substance of the original text as it appeared in paragraph 2(3). Despite considerable efforts, a consensus on that point had not yet been reached and it might be necessary to put it to the vote. Delegates would have the opportunity of studying a new draft, incorporating the acceptable amendments, before a decision was taken, probably at the next meeting.

The United States delegate had argued that WHO should not concern itself with marketing practices. However, she recalled the Director-General, in paragraph 3(6) of resolution WHA31.32, had been specifically requested "to study how prices of pharmaceutical products are determined and possible strategies for reducing such prices, including the development of a code of marketing practices, with special emphasis on pharmaceutical products essential for the populations of developing countries".

Dr ADOU (Djibouti) said that, with the technical assistance of WHO, Djibouti had drafted legislation on pharmaceutical products which was presently being reviewed by the relevant authorities. Lists of products for use at various health service levels were also being drawn up. There was an ongoing training programme for health workers and a national seminar would be held soon, following a visit to a country where the programme was somewhat further advanced.

His delegation supported the draft resolution on the rational use of drugs in its original version and wished to be included in the list of co-sponsors.

Mr FORMICA (Italy) said that international cooperation in the pharmaceutical sector should be aimed at ensuring the availability of essential drugs. Drug policies should be oriented to give priority to essential drugs appropriate to the actual needs of populations and should be an integral part of the planning and development of health services as a whole. They should also be related to information systems and to user participation.

During 1983, Italy had experimented, successfully, with such a strategy in the implementation of a number of programmes in coordination with WHO, UNICEF and the governments concerned. Several programmes were now under study, involving a detailed analysis of the situation in the country concerned as regards legislation, distribution, information and production, followed by: the preparation of a list of essential drugs; review of drug supply and control systems; examination of the possibilities of starting or maintaining production lines; and the training of experts in accordance with the country's health policies.

The Government of Italy had participated in a meeting, held in Harare in 1982, of those responsible for the pharmaceutical services in African countries, and had determined a course of action taking account of the differing needs of those countries. The Government had approached WHO and UNICEF in order to carry out that course of action. A start had been made by reviewing the situations in Ethiopia, Somalia, Mozambique, Guinea-Bissau and Upper Volta. The Italian Government had donated US$ 15 million to the programme. Joint WHO/UNICEF meetings of experts had been held and, as a result, specific programmes had been developed for each country. In Upper Volta, a plant for the production of essential drugs was to be built. Upper Volta had been selected for the pilot project, since it was felt that neighbouring countries in the Sahel region would also benefit. Those programmes were highly regarded by his country, since they were directed towards the achievement of the final objective of drug policies in the Third World, namely, the increase of local production of drugs until self-sufficiency was achieved.

The meeting rose at 18h05.
ELEVENTH MEETING

Thursday, 17 May 1984, at 9h00

Chairman: Dr K. AL-AJLOUNI (Jordan)

1. THIRD REPORT OF COMMITTEE A (Document A37/38)

Mrs MAKHWADE (Botswana), Rapporteur, read out the draft third report of the Committee.

The report was adopted (see document WHA37/1984/REC/2).

2. ACTION PROGRAMME ON ESSENTIAL DRUGS AND VACCINES: Item 22 of the Agenda
(Resolutions WHA35.27 and EB73.R15; Document EB73/1984/REC/1, Annex 7 (continued)

Dr COHEN (Adviser on Health Policy, Director-General's Office), replying to specific questions, recalled that the delegate of Canada had asked how the proposals in the draft resolution on the rational use of drugs related to the mandate of the Action Programme as well as to that of the Executive Board's Ad Hoc Committee on Drug Policies, and how those proposals would enhance current policies. There were two interrelated proposals in the draft resolution: one related to marketing practices and the other to the proper use of drugs. Both issues were very relevant to the Action Programme. Two years previously the Health Assembly had given indications on the elements of national drug programmes, and they included ensuring the proper use of drugs and ethical standards concerning drugs. Many of those issues were also relevant to the WHO programme of Drug and Vaccine Quality, Safety and Efficacy, commonly called "Pharmaceuticals". As for the Executive Board's Ad Hoc Committee, the draft resolution was certainly also relevant to its mandate. One of the major issues identified for study in its report was good prescribing and dispensing practices. In the draft resolution proposed in resolution EB73.R15, which the Committee was about to consider, paragraph 4(2) requested the Board to study major outstanding issues and define principles for resolving them.

As for the more complex issue of how the proposal would enhance current policies, questions had to be asked about urgency and priorities with respect to other parts of the Action Programme. In January 1984, the Director-General had stressed to the Executive Board the urgency of getting essential drugs to those 90% of people in developing countries who were non-consumers and wished to become consumers. It was not even a question of the 200 drugs on the model list; if those non-consumers had even 20 drugs they would be delighted. To attend to that problem solid national programmes were required - the whole range of activities approved two years before by the Health Assembly, which included ensuring that the disadvantaged majority not only had access to essential drugs but could use them properly. The Director-General still hoped that the Organization would be able to build up experience as countries developed and implemented their essential drugs programmes, giving rise to relevant, sensitive, and consistent information, the wide dissemination of which
would permit decisions to be taken objectively on all the issues involved. He stressed that he was referring, above all, to decisions taken by countries. Information on decisions within countries could form the basis for concrete factually based proposals for international action in support of national action.

However, marketing and prescribing practices were clearly of particular importance and urgency to quite a number of Member States, who were demanding early international debate on those issues. The Organization would obviously have to act quickly, and in that perspective he evoked the proposed meeting in 1985. He had been told that the meeting should not be too difficult to organize, because it would be similar to the one held some years previously on breast-feeding and breast-milk substitutes. However, he begged to differ: the present issues were infinitely more complicated. The purposes of the meeting had been defined as the exchange of experiences and views, clarifying the position of partners and defusing tension and confrontation; the Director-General was being given a free hand in deciding on the location, the participants and, presumably, the agenda. One of the main aims would have to be to ensure that the meeting produced constructive results and that purposes did not become cross-purposes. Ways would have to be found of defusing confrontations, even though many of the views were polarized.

As the delegate of the Netherlands had pointed out, the marketing issues were more commercial and political than they were technical; similarly, it was doubtful that prescribing practices were simply a technical matter depending on improved clinical pharmacology. There were many other factors, such as: access to information on the large numbers of drugs on the market, if those drugs were not limited by an essential drugs policy; the questions of drug economics and drug ethics; and the influence of promotional activities on drug prescription. Another intangible but important factor was the tacit mutual identity of interest between patients and doctors. Patients expected drugs; doctors expected to have drugs expected of them, and a vicious circle continued, particularly in the more affluent countries. As the delegate of the Gambia had demonstrated the situation in primary health care in the developing countries was vastly different.

The delegate of Switzerland had suggested that the Director-General limit the meeting to a reasonable level; however, since health systems based on primary health care emanated from the social and economic systems of each country, there was bound to be wide national variation. The conditions in the developing countries, including the disadvantaged majority of non-consumers, would have to be taken properly into account at the meeting. Those conditions should not be eclipsed by the situation prevailing in the more affluent countries. There were also great differences between countries with market economies and those with centrally planned economies. All those factors would influence the agenda as well as the choice of the participants.

With regard to participants, the draft resolution recommended the Director-General to consult all parties concerned. The parties were very many, including about 70 national regulatory agencies and even State financial auditors or comptrollers. There were economists, political scientists, the International Federation of Pharmaceutical Manufacturers Associations (IFPMA), as well as other pharmaceutical industries, wholesale and retail distributors, pharmacists, prescribers, professional advertisers and experts in marketing legislation. He wondered who represented the non-consuming majority in the developing countries. If the proper use of drugs were to be considered, more participants would have to be added: general practitioners, nonprofessional community health workers, clinical specialists and pharmacologists, social and behavioural scientists to deal with the identity of interest between patients and doctors, and health educators and patients themselves. He had already arrived at a list of around 150 participants. A rough estimate of the cost of the meeting would be US$ 250 000. The Director-General had no budget line for that amount for 1985 and would have to solicit extrabudgetary funds; he (Dr Cohen) already appealed to those delegations that were able to do so to help provide the Director-General with the wherewithal to hold the meeting.

As regards the implementation of current policies, the Director-General would try to organize the meeting so as not to interfere with ongoing activities just when the Action Programme was gathering momentum and showing real progress in implementing national drug policies based on the principles of essential drugs. If there was any doubt of that, the reports of the developing countries at the present Health Assembly should be compared with those of any previous Health Assembly: there had never been such encouraging reports of real progress. Such progress had been achieved through hard work and, as far as possible, the keeping out of polemic. To maintain the momentum of national drug programmes, it would be necessary to devote the time of the entire staff of both programmes - the Action Programme and the programme on pharmaceuticals - to supporting countries.

The Director-General would therefore have to find additional human resources, quite apart from financial ones, to ensure the optimal preparation of the meeting. One of the
Director-General's intentions was to convene the Executive Board's Ad Hoc Committee on Drug Policies as soon as possible with a view to deciding on the venue and date, preparing a specific agenda, drawing up a list of participants, making more precise costing and identifying possible sources of funding.

Finally, the Director-General would at the same time intensify ongoing activities, in particular those aimed at supporting developing countries in setting up and implementing national drug policies along the lines adopted by the Health Assembly two years previously, as well as those aimed at mobilizing enlightened bilateral and multilateral support for those countries. The Director-General would thereby do his best to accelerate the implementation of the Action Programme which, to judge from the presentations at the current Health Assembly, nothing could now stop.

Dr LARULIDSEN (Programme Manager, Action Programme on Essential Drugs and Vaccines), dealing with the more specific issues which had been raised, assured delegates that the Action Programme was a high priority for the Organization. It was, for the time being, in the Director-General's Office and that was construed as constituting an attempt to pool all the existing resources of the Organization to achieve the objective of the Programme. The global, regional and country budgets had doubled for the 1984-1985 period, and that in a period of zero-growth budgets. The extrabudgetary resources received and sought would also be used to further the objectives of the Programme.

The accounts from many developing countries of their increasing efforts to improve the supply of essential drugs and vaccines not only illustrated the fact that activities were now too numerous to be fully accounted for in one progress report, but also indicated that the concept of essential drugs was gaining widespread acceptance and that countries were facing the problems and showing a definite political commitment to solving them. That was illustrated by the interventions by the delegates of Mexico, Nigeria, China, Malaysia, Ghana and several other countries.

As the delegate of the Netherlands had correctly pointed out, there was a discrepancy in the report between the priorities of the Action Programme and the actual achievements. The report attempted to recount progress as well as problems and constraints, but delegates would appreciate that the Programme was young and complex and had had some initial difficulties in determining priorities, approaches and activities. The Action Programme now operated on the basis of a well-defined medium-term programme in close collaboration with other related WHO programmes, in particular those on Diagnostic, Therapeutic and Rehabilitative Technology, Diarrhoeal Diseases Control and the Expanded Programme on Immunization.

Major attention was being and would continue to be given to the normative aspects of drug supply systems such as quality control, the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce, safety and efficacy, provision of unbiased information on drugs and their side-effects, in addition to the issues of procurement, storage, distribution and utilization of drugs. The Action Programme, however, must occasionally work in other problem areas identified by individual Member countries.

A pragmatic, down-to-earth approach, as mentioned by the Nordic countries, could not always be reconciled with an orthodox priority approach, and the Secretariat had perhaps been too rigid in that respect. It was essential to attack the worst bottle-necks first, but without losing sight of the overall objective; it was perhaps not too important where a country started provided it ended up with a comprehensive drug programme which regularly delivered a limited number of essential drugs and vaccines of good quality and acceptable price to its population.

Several delegations had requested clarification on the division of labour within the United Nations system. The role of WHO as the lead agency was fully recognized, and the role of the various organizations and bodies of the United Nations system was well understood. Collaborative efforts were being made at the country level. UNIDO and UNCTAD had already reported on their collaboration with the Action Programme. UNICEF was the Organization's closest collaborating partner, and the UNICEF representative might give the Health Assembly a brief account of its activities on essential drugs and vaccines including the proposed procurement scheme. UNDP had been less active in the field owing to its financial situation but, among other activities, it was supporting the Association of South East Asian Nations TCDC project mentioned in the Ad Hoc Committee's report. Apart from resource constraints, there were no structural obstacles known to the Secretariat preventing collaboration between the specialized agencies.

With regard to division of labour within WHO, following the reorganization of the Action Programme on 1 May 1983 and the comments by the Executive Board in January 1984, the division of labour between the Action Programme and the Pharmaceuticals unit in the Division of Diagnostic, Therapeutic and Rehabilitative Technology had been the subject of detailed discussions in the Director-General's Office. The Pharmaceuticals unit dealt with all the
normative aspects of drugs, and the Action Programme was the operational and managerial arm in support of country activities on essential drugs and vaccines. A short paper on the subject would be presented by the Director-General to the Executive Board at its session in January 1985.

As suggested by the delegate of Sri Lanka, various procurement schemes would be reviewed in the process of establishing a new procurement scheme and the UNICEF representative might also comment on that issue.

Several delegates had mentioned manpower and training. That was a very high programme priority. Teaching and training material, already field tested, was being developed for national adaptation. Rational prescribing and drug use was a key element in manpower training.

The delegate of Cuba had asked for clarification on paragraph 63 of the Ad Hoc Committee's report. There was possibly some editorial misunderstanding, but that paragraph was a preamble to the text as specified in paragraphs 64-91.

A delegate had mentioned the importance of good prescribing practices and the need for rational use of drugs. The Action Programme had addressed itself to those issues recently when a working group in Kenya had reviewed training material for essential drugs programmes. The main recommendation had called for improvement in drug utilization and the development of appropriate training/educational material for health workers and consumers, and that was now under way. Numerous academic institutions had been contacted to solicit comments on approaches to introducing curricula on the essential drug concept and rational drug use. Prescribing habits and rational use of drugs were, however, broad and complex issues which required concerted efforts by present and future health workers and consumers.

The delegate of Chile and others had emphasized the importance of TCDC and the subject had been dealt with in the Ad Hoc Committee's report. TCDC activities had also been mentioned by India, Kenya and Lesotho. The subject was an obvious area for increased activities and he assured the Health Assembly that such activities would continue to be supported as required.

The delegates of the Union of Soviet Socialist Republics, Algeria and others had raised the question of financing of drug procurement and dependence on foreign aid. That area was receiving increased attention under the Action Programme and attempts were being made to devise financing schemes at the national, regional and global levels.

Many countries were already addressing the question of cost recovery to ensure continued financing of regular supplies in drugs and vaccines. The organization was encouraging that effort and, together with the World Bank, would be willing to give technical assistance for the development of such schemes. The issue of long-term contracts for the procurement of drugs had also been raised, and the delegate of the Gambia had made a very relevant point when he had asked how a poor country could enter into long-term agreements, when it could hardly be assured of foreign exchange for the next quarter's procurement. Long-term contracts, however, could bring drug prices down and the proposed drug procurement fund was intended to address that issue. The proposed capitalization was modest, as pointed out by the delegate of Chile, but he hoped that in the not too distant future it would be possible to establish a much larger credit facility.

Dependence on foreign aid was, regrettably, not unique to drug supplies. An action programme did not require massive capital investment and all developing countries were already used to financing the recurrent drug budget, but many did not get full value for their money. The cost per person per year for essential drugs in primary health care was quite small and savings through improved procurement, reduced wastage and better drug utilization could be translated into savings in the national drug budget or could make more drugs available to more people. One country had demonstrated that a well managed drug supply system was more cost-effective than the system it was replacing. In the long run, countries must pay for their drugs and when foreign exchange problems became a major constraint to ministries of health it was hard to find alternatives to relying on international support.

That so few speakers had mentioned the problem of estimating future drug requirements, a question which had been raised continuously over the preceding years, had been the source of some surprise. He was pleased to report that field tests had been conducted in a number of countries and WHO was now working with the Evaluation and Planning Centre for Health Care of the London School of Hygiene and Tropical Medicine, the Health Management Institute (Geneva, Switzerland), and Management Sciences for Health (Boston, United States of America) to develop a more precise methodology in that very complicated but important area. He anticipated that that activity would receive funding from the Swiss Directorate for Cooperation in Development and Humanitarian Aid and Swiss pharmaceutical industries.

In conclusion, he said that the positive comments made had been much appreciated and would be studied in greater detail. The work of the Action Programme would be actively pursued and he hoped that further resources would be made available. Whatever credit was
given to the Action Programme must be shared with all its collaborating partners - country officials, regional advisers, other United Nations agencies, the pharmaceutical industries, consumer groups, nongovernmental agencies, institutions, universities and individuals.

The CHAIRMAN invited the Committee to consider the draft resolution contained in Executive Board resolution EB73.R15.

The draft resolution proposed by the Executive Board in resolution EB73.R15 was approved.1

Dr WESTERHOLM (Sweden) introduced a draft resolution on the rational use of drugs, which was a revised version, drawn up by the working group established at the ninth meeting of the draft resolution submitted at the seventh meeting. The revised text took account of amendments proposed by the delegation of India as well as the proposal by the delegation of the Netherlands concerning the review and improvement of machinery within WHO for the dissemination of information on the appropriate use of essential and other drugs. The new text, which was proposed by the delegations of Algeria, Australia, Belgium, Botswana, Denmark, Finland, Ghana, Iceland, India, Kuwait, Mexico, New Zealand, Nigeria, Norway, Panama and Sweden, read as follows:

The Thirty-seventh World Health Assembly,
Recalling resolutions WHA24.56 and WHA31.32;
Recognizing the progress achieved in the development of the WHO Action Programme on Essential Drugs and Vaccines, the Organization's programme on drug information and other WHO activities in this field;
Concerned by the high proportion of health budgets spent on drugs in many countries, particularly in developing countries, thereby limiting the remaining funds available for the provision of adequate health care to the whole population through primary health care;
Realizing the problems of inappropriate and excessive prescription and use of drugs;
Aware of the need for further studies, inter alia, in clinical pharmacology, to facilitate the improvement of prescription practices, with regard to effects, adverse reactions and the possible interaction of drugs;
Realizing the need for better knowledge of actual drug consumption and prescription practices;
Aware of the importance of training health personnel to ensure the appropriate use and prescription of drugs;
Recognizing the importance of unbiased and complete information about drugs to health authorities, physicians, pharmacy staff, other health workers and the general public;
Aware of the need for better information on drug marketing procedures and practices;
Recognizing the achievement of local drug and therapeutic committees established in several Member States;
Noting with satisfaction the growing interest shown by governments, registration authorities, the pharmaceutical industry, patients' and consumers' organizations and health workers in information about, and the marketing of, drugs;
Convinced of the need for cooperation between all interested parties in order to achieve a more rational use of drugs;

1. URGES Member States:
(1) to support the development and dissemination of unbiased and complete information on drugs;
(2) to collaborate in the exchange of information on the use and marketing of drugs through bilateral or multilateral programmes and WHO;
(3) to strengthen the national capabilities of developing countries in the selection and proper use of drugs to meet their real needs and in local production and quality control, wherever feasible, of drugs;
(4) to intensify action to introduce and implement comprehensive and rational drug policies;

2. REQUESTS the Director-General:
(1) to continue to develop activities at national, regional and global levels

1 Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA37.32.
aiming at the improvement of use of drugs and of prescription practices and the provision of unbiased and complete information about drugs to the health profession and the public;

(2) (a) to foster the exchange of information among Member States on drugs, including registration and marketing practices;
(b) to review the machinery within WHO concerning the dissemination of unbiased information relevant to the appropriate use of essential and other drugs; and to introduce appropriate improvements therein;
(3) to arrange in 1985 a meeting of experts of the concerned parties, including governments, pharmaceutical industries, patients' and consumers' organizations to discuss the means and methods of ensuring the rational use of drugs, in particular through improved knowledge and flow of information, and to discuss the role of marketing practices in this respect, especially in developing countries;
(4) to submit a report on the results of the meeting of experts and the implementation of this resolution to the Thirty-ninth World Health Assembly.

Concerning the financial implications of the meeting of experts referred to in paragraph 2(3), she repeated the offer made earlier on behalf of the Swedish Government; Sweden would be happy to be one of the co-sponsors of such a meeting.

Mr SAMSOM (Netherlands) recalled that his delegation had proposed an amendment involving the deletion of operative paragraph 2(3) of the original draft resolution and its replacement not only by a provision concerning the review of WHO machinery for the dissemination of objective information on the use of essential and other drugs, but also by a request to the Director-General "to arrange, as soon as possible, for the inclusion on the agenda of a forthcoming meeting of the International Conference of Drug Regulatory Authorities of a review of the effectiveness of the IFPMA Code of Pharmaceutical Marketing Practices and of its application in the Member States, taking into account the views of interested parties, including consumer organizations and the pharmaceutical industry, and to submit a report for consideration by the Executive Board." That proposal had been drawn up in consultation and agreement with the Member States of the European Economic Community and the United States of America. He repeated his earlier comment on the highly sensitive nature of the subject-matter alluded to in paragraph 2(3) of the original draft resolution.

The Health Assembly could not avoid facing up to the issue of unethical marketing practices for pharmaceutical products. The Ad Hoc Committee of the Executive Board had discussed that problem in its report, and IFPMA had explained the steps that it had taken to combat such practices. The problem was a persistent one that needed close attention at both national and international levels. In his opinion, neither the original draft resolution nor the revised text dealt with the issue adequately. Not only was much already known about marketing practices, but the subject, he would submit, had little to do with the proposed discussion on means and methods for increasing the knowledge of the proper use of drugs, especially in developing countries. He continued to question the need to convene a meeting of experts for that purpose, in the manner proposed. Apart from the fact that it would not address itself properly to the issue of a code of marketing practices, a single meeting that was not at government level—though it might enjoy wide publicity because of its controversial aspects—was unlikely to have any meaningful follow-up.

The delegate of Mali had questioned the proposed amended wording of paragraph 2(3), and had implied that it might be inspired by a wish to protect industry interests. That had certainly not been the case. He wished to make it absolutely clear that the delegation of the Netherlands had no quarrel with the sponsors of the original draft resolution concerning the strategy expressed with regard to the solution of the problem of unethical sales practices for pharmaceutical products. The question was one of tactics. It accepted that the IFPMA Code alone could not solve that problem, and that other measures, at the national and international levels alike, were necessary. It believed that discussion on such measures should be pursued within the WHO framework, together with issues indicated by the Ad Hoc Committee on Drug Policies. The subject matter of the Code was a matter of urgency but the convening of an expert meeting was not the best way to handle that issue. The IFPMA Code should be recognized as a sincere effort on the part of its member industries and, where appropriate, countries should contribute to its implementation. That Code existed already, whereas the WHO code did not. Indeed, it would take many years for a WHO code to be developed and for it to be implemented at national level through appropriate legislation.

The question was not one of choosing between the IFPMA Code and an eventual WHO code. What was required was a whole range of measures; he would submit that, for the time being, public interest was best served by monitoring the application of the existing IFPMA Code by industry in the Member States. Its introduction would provide an opportunity for exerting
formal or informal pressures to apply or improve it. Recognition and evidence of its inadequacies would indicate to the Health Assembly what measures needed to be taken.

The amendment proposed by the delegation of the Netherlands to paragraph 2(3) of the original draft resolution set up machinery for the development of a balanced judgement at the global level. By entrusting that mission to the International Conference of Drug Regulatory Authorities, the aim was to allow government representatives in the field of drug control to oversee the application of the Code in their own countries and to report their findings to the Conference, thus producing a global and independent assessment of the functioning of the Code. The findings could then be reported by the Director-General to the Executive Board. The Executive Board's ad hoc Committee on Drug Policies could then review the report and present appropriate recommendations to the Health Assembly for adoption. The Health Assembly could thus keep the matter under continuous review without wasting too much time on the matter. In view of the facts that the Conferences of drug regulatory authorities were organized by WHO, that their agenda was determined by an advisory committee whose composition was controlled by WHO, and that their published proceedings carried the WHO emblem, they could realistically be considered as a WHO activity. They were held on a secure biennial basis and financing was available for their continuation.

That being said, he acknowledged that the replies to a number of important questions raised during the debate had gone some way to removing his initial concerns. It was his understanding that if the draft resolution before the Committee were adopted by the Health Assembly, the Director-General would ask for guidance from the Executive Board, in particular concerning the organization of the meeting of experts. He trusted that consultation between the Director-General and the Board would also point the way to global approaches to a more structured solution for combating unethical marketing practices, and take account of his own suggestions in that connection. He was content to rely on the wisdom of the Executive Board. He had listened attentively to the comments by the delegate of Sweden at the previous meeting with regard to the various amendments proposed to the original draft resolution, including those by the delegation of the Netherlands, and accepted the revised version of the first part of his proposal. As far as the second part was concerned, the explanations provided by the Swedish delegate, together with those by Dr Cohen with regard to the implementation of operative paragraph 2(3) of the draft resolution as now submitted, did not entirely dispel his misgivings, but they relieved him of the necessity to call for a separate vote, and removed the obstacles to his delegation's support for the text as a whole. It would withdraw its proposals, and vote accordingly in favour of the draft resolution.

The CHAIRMAN said that, since the delegate of the Netherlands had signified the withdrawal of his amendment, the Committee need only consider the revised version of the draft resolution as presented by the delegate of Sweden. He asked whether there was any objection to its adoption.

Dr NIGHTINGALE (United States of America) stated that his delegation, which agreed with many of the comments in the preamble of the draft resolution, and could have supported the compromise text put forward by the Netherlands delegation, regretted that no consensus now appeared possible. Dr Cohen had made it very clear that the convening of a meeting of experts, which the United States delegation saw as the central element of the draft resolution, would be costly, complicated and disruptive of the work of the Action Programme and WHO's other activities. For those and other reasons previously expressed, his delegation could not support the convening of that meeting, and would be obliged to vote against the draft resolution.

Dr FLOURY (France) stated that his delegation had supported the amendment submitted by the Netherlands but acknowledged its withdrawal. Furthermore, it entirely shared the concern expressed regarding the difficulties of convening a meeting of the type proposed. The number of interested parties involved would be considerable, and the question of who would represent the "non-consumers", i.e. those without any access whatever to pharmaceutical products, was indeed most pertinent.

His delegation nevertheless placed its full confidence in the Director-General with regard to the organization of the proposed meeting and thought that the Executive Board Ad Hoc Committee on Drug Policies should meet in order to establish the agenda and list of participants, and to go into the possibility of holding the meeting within existing frameworks and more specifically under the auspices of the drug regulatory authorities.

The CHAIRMAN put to the vote the revised draft resolution.
The draft resolution was approved by 100 votes to 1, with 2 abstentions.\(^1\)

3. FOURTH REPORT OF COMMITTEE A (Document A37/39)

Mrs MAKHWADE (Botswana), Rapporteur, read out the draft fourth report of the Committee.

The report was adopted (see document WHA37/1984/REC/2).

4. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 10h25.

\(^1\) Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA37.33.
COMMITTEE B
FIRST MEETING
Tuesday, 8 May 1984, at 14h30
Chairman: Dr N. ROSDAHL (Denmark)


The CHAIRMAN expressed gratitude for his election and welcomed those present, in particular the delegates of the new Members of the Organization, Antigua and Barbuda, and Saint Vincent and the Grenadines, the representatives of the Cook Islands and Kiribati, and the observer from Brunei Darussalam. He drew attention to the third report of the Committee on Nominations (document A37/27) in which Dr E. Yacoub (Bahrain) and Dr B. P. Kean (Australia) were nominated for the offices of Vice-Chairmen of Committee B, and Mr B. Balakrishnan (India) for that of Rapporteur.

Due to administrative difficulties, Mr Balakrishnan was unable to accept nomination as Rapporteur, and one of the Vice-Chairmen was invited to act in that capacity pending further consultations.

Decision: Committee B elected Dr E. Yacoub (Bahrain) and Dr B. P. Kean (Australia) as Vice-Chairmen.

2. ORGANIZATION OF WORK

The CHAIRMAN, pointing out that the Health Assembly's schedule was a heavy one and that time was short, urged members to limit the length of their interventions to allow everyone who wished to participate in the debates to do so. Referring to the role of the representatives of the Executive Board in the work of the Committee, he pointed out that those representatives would express the views of the Board only and not the views of their respective governments.

He drew attention to the terms of reference of Committee B, and said that, since there was no proposed budget before the Health Assembly, Committee B would not be considering either casual income or the scale of assessments. He reminded the Committee of the Health Assembly's decision the previous year to amend Rule 52 of its Rules of Procedure; that meant proposals had to be circulated at least two days before they were discussed or put to a vote.

Finally, he suggested that, in accordance with the Health Assembly's earlier decision, the working hours of the Committee should normally be from 9h00 to 12h30 and from 14h30 to 17h30.

It was so agreed.

The CHAIRMAN explained that, under the arrangements approved the previous year concerning the Health Assembly's method of work, it would be possible for one main committee to meet concurrently with the debate in plenary on the reports of the Executive Board and the Director General's report on the work of WHO. Similarly, one main committee could meet on Saturday while the Technical Discussions were being concluded. At the present Health Assembly, Committee B would not meet on either Friday or Saturday of the first week, but could expect to meet almost continuously both morning and afternoon during the second week with only a few interruptions to allow for brief plenary meetings.

---

1 See document WHA37/1984/REC/2.
2 See decision WHA37(4).
THIRTY-SEVENTH WORLD HEALTH ASSEMBLY

3. REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION: Item 24 of the Agenda

Mr FURTH (Assistant Director-General), introducing the item, drew the attention of delegates to the financial report of the Organization for the full biennium 1 January 1982 to 31 December 1983, contained in document A37/8, and reminded the Committee that when the Health Assembly had decided to go over to biennial programme budgeting, it had also decided that at the end of such a budget period the Director-General would submit a financial report covering the entire budget period and that the External Auditor would submit a report on the accounts of the same two-year financial period. In 1983, the Director-General had submitted an interim financial report covering the first year of the period 1982-1983, but the recent increase in obligations incurred under extrabudgetary funds as a whole, and of the individual sources of financing, such as the United Nations Development Programme, had decreased from one biennium to the next. There had been similar trends with respect to the Voluntary Fund for Health Promotion and the Trust Fund for the Special Programme for Research and Training in Tropical Diseases. The overall increase of $40.3 million represented an increase of only 4.8% over the obligations incurred in 1980-1981, which compared unfavourably with the situation reported two years previously, when total obligations incurred for the integrated international health programme had increased from the biennium 1980-1981 to the biennium 1982-1983 by some US$ 40.3 million (from $832.9 million to $873.2 million), the increase had been entirely due to the increase in obligations incurred under the regular budget. There had been no increase in obligations incurred under extrabudgetary funds as a whole, and some of the individual sources of financing, such as the United Nations Development Programme, had decreased from one biennium to the next. There had been similar trends with respect to the Voluntary Fund for Health Promotion and the Trust Fund for the Special Programme for Research and Training in Tropical Diseases. The overall increase of $40.3 million represented an increase of only 4.8% over the obligations incurred in 1980-1981, which compared unfavourably with the situation reported two years previously, when total obligations incurred for the integrated international health programme during the biennium 1980-1981 had shown an increase of $121 million, or 17% of the biennium 1978-1979. The recent increase of 4.8% in obligations incurred was undoubtedly less than the rate of increase in the cost of living worldwide during the years 1982-1983, it was reasonable to assume that in real terms there had been no increase in WHO's programme delivery over the last two biennia. However, it was extremely difficult to measure on a worldwide basis with any degree of precision the impact of increases in cost of living and of currency exchange rate movements and similar factors, particularly in view of the diversity of activities taking place in many different geographical locations under programmes financed from WHO's various resources. Efforts had nevertheless been made to measure the percentage real increase in expenditure for 1982-1983 over 1980-1981 under the regular budget. As stated in paragraph 12 of the Introduction to the financial report, while in nominal terms the regular budget had increased by 11.43%, the estimated increase in regular budget expenditures in real terms had been put at just under 2%.

In the Introduction to document A37/8, the Director-General had highlighted a number of important points, the first being the status of collection of assessed contributions (paragraph 5 of the introduction). Whereas the overall rate of collection of contributions at the end of the biennium 1982-1983 had been more favourable than at the end of the preceding biennium, there had been no fewer than 68 Member States which on 31 December 1983 had not paid their 1982-1983 assessments in full, as against 51 Member States in a similar position at the end of 1981. Fourteen of the Members, as against three at the end of 1981, had made no payment at all. Fortunately, those shortfalls and delays in the payment of contributions had not seriously inconvenienced the financial implementation of WHO's programmes. However, the payment of assessed contributions on time was incumbent upon all Member States, and the Director-General would continue to remind Member States of their obligations in this connection.

One reason why the delay in the payment of contributions of those 68 Members had not unduly inconvenienced WHO had been the existence of a budget surplus of $15.552.000 for the biennium 1982-1983, which was slightly higher than the amount of contributions in arrears ($14.3 million) for the effective working budget. As stated in paragraph 6 of the Introduction, had that surplus not arisen, WHO would have had to use the whole of its Working Capital Fund and borrow some of the other internal resources available to meet its programme...
commitments. The largest part of the budget surplus, $ 12 113 000, had arisen as a result of favourable developments in the US dollar/Swiss franc relationship. In establishing the budgetary rate of exchange of 1.85 Swiss francs per US dollar for the 1982-1983 programme budget, the Health Assembly had three years previously requested the Director-General in the event of the exchange rate exceeding 1.85 Swiss francs per US dollar to transfer to casual income any net savings resulting therefrom. In fact, the average accounting rate of exchange during the past biennium had been 2.05 Swiss francs per US dollar, resulting in savings under the regular budget of $ 12 113 000. Additional savings of $ 3 438 000 had arisen both at headquarters and in the six regions from economies in programme implementation. The total budget surplus would be credited to casual income as and when arrears in contributions for the 1982-1983 financial period were received.

One particular aspect of the management of WHO's resources which had always been of interest to the Committee was casual income. It was available for appropriation by the Health Assembly principally in order to finance future programme budgets, and was derived from a number of sources, including the budget surplus. A comparative statement of casual income received and utilized over the four-year period 1980-1983 was given on page 26 of the financial report. That statement showed that casual income earnings had been lower in 1983 than in 1982 ($ 22 million in 1983 as compared with $ 42 million in 1982). The high 1982 figure had largely been due to the budget surplus of over $ 20 million which had arisen in the biennium 1980-1981 and which had been credited to casual income as contributions in arrears for earlier years were being paid in 1982. It was to be hoped that the arrears in contributions for 1982-1983 would again be paid promptly, thus making it possible for the budget surplus for 1982-1983 to be fully reflected in the casual income account in 1984.

The other principal source of casual income was interest earned on deposits made by WHO with banks pending the disbursement of those funds. Such earnings were determined by the rate of interest payable on the deposits and by the prompt payment of assessed contributions. While the former was beyond WHO's control, the latter could be said to be within the control of Member States, but was unpredictable. A further reason why it was too early to make any forecast of the total availability of casual income towards the end of the year was that a substantial fall in the exchange value of the US dollar in relation to the Swiss franc below the budgetary rate of 2.16 Swiss francs per US dollar would give rise to the need to use available casual income in order to finance the ensuing budgetary shortfall. That facility had been approved by the Health Assembly the previous year in resolution WHA36.6. Barring such a development it was quite possible that by the end of the year a substantial sum of casual income would be available to assist in financing the 1986-1987 programme budget to be submitted by the Director-General to the Executive Board in January 1985 and considered by the Thirty-eighth World Health Assembly.

Particular attention was drawn to the substantial appendix on extrabudgetary resources, which contained brief summaries of contributions made by governments and others to the Voluntary Fund for Health Promotion and other funds available to WHO for programme purposes. Contributions to funds such as UNDP and the United Nations Fund for Population Activities (UNFPA) had been excluded, since they were not earmarked for WHO's activities. Details of the Voluntary Fund for Health Promotion, including contributions to individual accounts for project activities, had also been given, as had the expenditures incurred against such contributions. That presentation continued to be required to satisfy the need of a number of donor governments for certified figures of expenditure incurred against contributions made by them to the Voluntary Fund for Health Promotion.

The Committee's attention was also drawn to the summaries of contributions made to and expenses incurred for the Onchocerciasis Control Programme, the Primary Health Care Initiative Fund, the Sasakawa Memorial Health Foundation, the Special Programme for Research and Training in Tropical Diseases, UNDP and UNFPA.

Finally, the Committee's attention was drawn to the report of the External Auditor contained in pages ix to xix of the document. Unfortunately the External Auditor had been unable to attend the meeting but his representative was prepared to answer any questions relating to his report.

Mr DOBSON (representative of the External Auditor) said that the report of the External Auditor (document A37/8, Part II) was based very largely on audit observations addressed to WHO headquarters and the regional offices visited during the biennium. The only paragraphs to which that did not apply were paragraphs 1-5, which related to the audit approach and outturn of the accounts, and paragraph 13, which recorded improvements in computer controls following observations in the report of the External Auditor on the 1981-1982 accounts.

Generally speaking, audit observations served to record the information on which the report was based, following confirmation that they represented a fair summary of the relevant facts. They also included questions directed to obtaining further information or opinions
on proposals for remedial action. After having received replies to the observations, the
External Auditor sent his report in draft form to the Director-General for comments.

The report was divided into two main parts: paragraphs 1-26 dealt with matters relating
to the accounts and the implementation of internal control procedures, including those
relevant to the Regional Office for Africa, and a review of the organization and working
methods of WHO's Internal Audit unit, and paragraphs 27-57 dealt with the continued
examination of the adequacy and implementation of the Organization's procedures for programme
and project monitoring and evaluation. In the report on the 1980-1981 accounts comments had
been made on the position in the Western Pacific Region and at headquarters; in the present
report, comments had been made at length on the position in the Regional Offices for Africa,
South-East Asia and the Eastern Mediterranean, and on recent developments at headquarters.

Mrs THOMAS (representative of the Executive Board) said that the first report of the
Committee of the Executive Board to Consider Certain Financial Matters prior to the Health
Assembly (document A37/28) covered the review by the Committee of the Director-General's
financial report for the period 1 January 1982 - 31 December 1983 and the reports of the
External Auditor. Its presentation was very similar to that of preceding reports.

In the course of its review, the Committee had paid particular attention to the report
of the External Auditor, which covered a number of points concerning both administration and
the WHO programme. Several points related to the regional offices, and regional directors
might therefore wish to provide additional information on them. It could be seen from the
Committee's report that corrective action had been taken by the Director-General in view of a
number of comments made by the External Auditor. In concluding its examination of the
financial report, the Committee had decided to recommend to the Health Assembly the adoption
of the draft resolution contained in paragraph 8 of document A37/28.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that the reported
real increase of less than 2% in obligations incurred under the regular budget seemed to
augur well for the Director-General's objective of maintaining zero growth in the current
biennium, although it was interesting to note that it still represented an increase of almost
11.5% in cash terms. At a time of constraint in most countries, efforts must be made to keep
a close watch on increases and patterns of expenditure to see whether savings could be made
by concentrating expenditure on areas least affected by inflation. Travel and accommodation
expenses provided a good example of an area which deserved particular attention. Full use
should also be made of modern methods of communication so as to save on unnecessary journeys,
postal costs and large and expensive meetings.

He was pleased to note that the policy agreed by the Organization to credit any gains
derived from currency fluctuations to current revenue had been to the benefit of the overall
revenue situation of the Organization and, consequently, of Member States - reducing the
amount of their contributions. It was to be hoped that similar arrangements for crediting gains
from exchange rate fluctuations at the regional office level would facilitate proper
budgeting and accounting by these offices and prevent programmes from expanding merely
because of a windfall brought about by favourable exchange rate fluctuations.

However, it should be borne in mind that, although some savings had been made on
budgeted expenditure, many other reported savings related to delayed rather than cancelled
expenditure. The day of reckoning would inevitably come, possibly at a time when the funds
required might not be available. He would welcome the Secretariat's comments on that point.

He was pleased to note that the task of the External Auditor had been facilitated by the
cooperation and assistance of officials of the Organization and that the External Auditor had
complemented the staff of the Internal Audit unit on their high level of audit competence and
standards of execution, planning and documentation. The External Auditor's report of
apparent weaknesses in the control of expenditure by the Regional Office for Africa was,
however, a source of concern. Funds should be used to the best possible purpose and at the
same time any action should be avoided which might endanger the good name of the
Organization. He noted that the Executive Board had looked into the matter and had
recommended changes in procedures. It would be useful to have the views of the Secretariat
and the comments of the External Auditor as to whether the Executive Board's proposals were
sufficiently far-reaching.

He attached considerable importance to the monitoring process as a means of assessing
effectiveness of services and use of resources. At a time of constraint and limited
resources it was particularly disturbing to note that programme profiles, on which monitoring
was based, were not always up to date. As the Director-General had already pointed out,
monitoring must not be allowed to degenerate into an empty bureaucratic exercise but must be
seen to be of value, particularly to those providing the information, through feedback of
results. There was therefore a need for the Director-General, regional directors and senior
staff of the Organization to feed back information and for all concerned, including the Health Assembly, to learn from the results of monitoring exercises. Moreover, it was only in that way that those in the field could be motivated to ensure accuracy of information and to adopt the right attitude towards their work.

Mr. BOYER (United States of America) said that the quantity and quality of the data contained in the Director-General's financial report, and the frank opinions of the External Auditor, had been greatly appreciated by his delegation. The document before the Committee would be valuable in permitting a better understanding of WHO's operations, and its discussion would provide a useful opportunity for questions and comments by delegations on the financial operations of the Organization, particularly since the Executive Board in its entirety had not had an opportunity to review the matter.

It was gratifying that the External Auditor had found that the WHO Internal Audit unit met the standards for effective internal audit practices and had noted an improvement in WHO's computerized systems, which he had criticized in his report two years previously. That was an area that deserved continuing attention in view of the remarkable and rapid advances in computer technology.

He welcomed the External Auditor's detailed analysis of two problems that had surfaced in the Regional Office for Africa. The first was the use of some US$ 137 000 in savings from health programme activities for the installation of a private elevator for the Regional Director instead of following the traditional method of procuring funds for construction projects through application to the Real Estate Fund. He had not personally been persuaded by the explanations that had been given to the External Auditor regarding the need for the elevator or the unconventional financing method used. According to the report of the Committee of the Executive Board, the Director-General had already taken action on the matter. Information on the details of that action would be appreciated, in particular on the guidelines that had been put into effect to ensure that all construction projects were handled centrally through the Real Estate Fund to prevent any recurrence of the problem and on the guidelines provided by headquarters to the regional directors with regard to the use they could make of any savings made during implementation of the budget. Could such savings be reprogrammed directly by regional directors for other health activities or diverted from health programmes to administrative activities, or must they be returned to headquarters for reprogramming or for return to Member States as credits against future assessments? He supported the United Kingdom delegate's request that the External Auditor should be invited to comment on the adequacy of the corrective measures taken by the Director-General. With regard to the second problem, namely the chartering on three occasions of a private aircraft for the use of the Regional Director at a cost of more than US$ 37 000, that action did not seem to him to have been convincingly justified and he supported the External Auditor's recommendation that guidance should be provided regarding the use of chartered aircraft. Had the necessary guidelines been developed and circulated by the Secretariat?

The External Auditor had taken a very thorough look at monitoring and evaluation systems in WHO and had pinpointed a number of problems, such as programme descriptions that were out of date, not filed, or not being used, which had led to inadequate programme monitoring. The External Auditor had noted that corrections and reforms were already being carried out at the Regional Offices for South-East Asia and the Eastern Mediterranean, and it was hoped that the Regional Office for Africa would be able to follow suit. There were, however, two sides to the evaluation mechanism: not only did WHO regional offices and staff need to be more effective, but national governments also needed to collaborate in the process. The External Auditor's report noted that some national governments did not, or were unable to, supply the necessary information for evaluation, and examples were given of lack of cooperation at national government level which had been the main factor in failure of a WHO project.

Overall, the External Auditor's review raised the question of whether the very impressive resolutions on evaluation and monitoring that had been passed by the World Health Assembly and the Executive Board were in fact trickling down to regional and country levels to receive the attention of both WHO staff and national government officials. If they were not, perhaps new mechanisms needed to be introduced. The Secretariat's views on that point would be appreciated.

With regard to the financial report itself, Mr. Furth had indicated that contributions to a number of voluntary programmes had been reduced. The Health Assembly had been informed in the past that, although staffing under the regular budget was at a standstill because there was no real growth in the regular budget, overall staff numbers in WHO were increasing because of a real growth in programmes financed from voluntary funds, and that in turn had led to a need for more office space and buildings. He asked the Secretariat to comment on the impact the apparent stagnation in contributions to voluntary programmes had had on staffing and space needs.
Overall administrative support costs for the Organization, in other words its overheads, were about 14.05% - a welcome slight reduction from the figure of 14.26% for the previous biennium. However, it would be seen from the relevant table that the actual overheads for the regular budget in 1982-1983 had been 18.8%, which represented an increase as compared with the budgeted figure of 18.3%. Would the 16.7% overheads budgeted for the 1984-1985 biennium also be likely to increase in the same way? Not long ago, the Health Assembly had adopted a policy requiring all voluntary donors to set aside 13% of their grants to cover overheads or administrative support. Was WHO being successful in collecting that charge from donors or had any problems been encountered?

The report on the Casual Income Account failed to make clear how much money was actually in that Account. The impression given was that a further sum was due at the end of December to be added to the amount already there, which would bring it up to a total of about US$ 46.5 million. Information on the exact amount in the Account would be welcome: Mr Futh had mentioned that the sum was a substantial one. The United States delegation's view remained that the full amount in the Casual Income Account at the end of 1984 should be applied to the financing of the regular budget for 1986-1987 by the Thirty-eighth World Health Assembly.

It was striking that most of the savings that had been made in appropriation sections had arisen as a result of staff vacancies or the inability of the Organization to recruit competent staff. That had very serious implications for the effective accomplishment of WHO's business. It would be appreciated if the Secretariat could inform the Committee what the average staff vacancy rate was and how it took expected staff vacancies into account when it prepared the budget for personnel, giving details of the standard budget lapse rate for new positions. What steps was the Secretariat taking to ensure both that vacancies were more rapidly filled and that WHO's planned programme was smoothly implemented? It was quite clear, as other speakers had said, that if WHO did not have the personnel to implement the budget that had been adopted either the programmes would not be implemented or the money would be transferred to other areas and the priorities changed.

He noted from page 13 of the report that the Special Programme for Research and Training in Tropical Diseases appeared to have obligated US$ 3.3 million more than it had had in hand in 1982-1983, which did not seem feasible since it had no working capital or reserve fund; an explanation would be welcome. Furthermore, the report mentioned that contributions for that Programme made to the World Bank were unaudited; the Health Assembly might feel that that was a cause for concern.

The seriousness of the situation regarding payment of assessments deserved comment. No fewer than 68 Members of WHO (42% of the total) had not paid all of their 1982-1983 assessments on time, and 46 had paid nothing at all during 1983; of the latter group, 14 had paid nothing for two years. It would appear that the time was ripe for some serious steps to be taken regarding non-payment of assessments; if the situation remained unchanged, the Health Assembly should, among other things, have the courage to deny the vote to countries more than two years in arrears and countries should be made aware that the Health Assembly would be firm in applying that policy. In addition, more stringent controls on growth were needed for the 1986-1987 budget and its related assessments since, if Member States could not or would not pay their apportioned share of current budgets, they certainly would not be able to afford budgets that were higher. Caution was needed, as the Secretariat was about to begin its preparation of the 1986-1987 budget. There was a need, as the United Kingdom delegate had said, for more efficient operations and greater efforts to cut costs.

Mr TAKAHASHI (Japan) said that the content and presentation of the financial report prepared by the Secretariat and the reports of the External Auditor had been greatly appreciated by his delegation. They provided valuable information on the financing of WHO's activities.

The financial report indicated that, although the rate of collection of assessed contributions at the end of the financial period for the biennium 1982-1983 (96.8%) was higher than that for the 1980-1981 biennium (92.4%), it was somewhat lower than that for the biennium 1978-1979 (97.2%). Furthermore, the number of Members that had not made a full payment of their 1982-1983 assessments had been increasing. There were 68 Members in that position at the end of 1983, including 14 that had made no payment at all, as opposed to 51 at the end of 1981. Late payment of non-payment could impose a heavy charge on or a serious threat to the financial management of WHO's activities. Furthermore, both non-payment and late payment of contributions placed an unfair burden on those Member States that continued to make every effort to meet their obligations promptly and in full despite their financial difficulties. His delegation urged those Members in arrears in the payment of part or all of their contributions to make every effort to honour their commitments as soon as possible, and wished to see the Secretariat make further efforts to collect contributions from those countries.
His delegation had greatly appreciated the External Auditor's reports, which had highlighted a number of major problems relating to various aspects of WHO's activities. Those relating to regional office activities and budget implementation were a major concern of his delegation, which shared the views of the two previous speakers on such problems as inappropriate expenditure on some items, difficulties in programme profiles, including obsolete programme profiles, lack of information on evaluation and the imperfect operation of monitoring and evaluation processes, and ineffective methods of project control - all of which had been pointed out in the reports. In order to ensure the effective and efficient use of WHO's limited budgetary resources, those problems should be resolved as soon as possible. It was hoped that the regional offices and other parties concerned would make every effort to redress the situation.

The External Auditor's reports contained a number of recommendations on the need, for example, for guidelines for the chartering of aircraft by regional directors, for improvement of the information system, including maintenance of programme profiles in accordance with the WHO manual, and for a storage system for project information. Those recommendations should be taken fully into account during implementation of the Seventh General Programme of Work.

With regard to the question of casual income, his delegation wished to reaffirm its basic position on the matter. In view of the obvious financial difficulties faced by many Member States, it believed that the maximum possible amount of available income should be allocated to the regular budget with a view to reducing the assessments of Member States accordingly; it hoped that such a practice would indeed be followed in the future.

Dr GALAHOV (Union of Soviet Socialist Republics) congratulated the Chairman and Vice-Chairmen of the Committee on their election. He noted with satisfaction the precision and high quality of the documents before the Committee, and the manner in which they had been presented.

The item under discussion was one of the most important on the present Health Assembly's agenda. It entailed the consideration and assessment of WHO's activity in financial - and thus the most concrete - terms. The report and the information presented by Mr Furth demonstrated and confirmed that the Organization's financial position remained sound. The Organization was, however, confronted with a number of acute problems, the major one being the large number of Members in arrears in their contributions to the regular budget. The Health Assembly would do well to reflect seriously on the fact that at the end of 1983, no fewer than 68 Member States had not paid their 1982-1983 assessments in full or had made no contribution at all. In monetary terms the amount involved might not be enormous, but in the final analysis that number represented more than one-third of the membership of the Organization.

The increasing number of Member States in arrears with their contributions was a powerful argument in favour of stabilizing the regular budget and making more economical and effective use of available resources. One way of doing so would be to cut down all avoidable and non-essential expenditure on establishment and administration, in accordance with the provisions of resolution WHA29.48. He was glad that information concerning administrative support costs as a whole was contained in the Introduction to document A37/8, but would suggest that in future such information should indicate trends over longer periods. Where 1982-1983 was concerned, the amount involved, US$ 91.9 million, was greater than the expenditure over the same period, from the regular budget, on WHO's most important activities: health system development or disease prevention and control.

In recent years the External Auditor had rightly devoted more attention to the extremely important issue of programme and project monitoring and evaluation, and his present report contained a number of comments and recommendations on that subject in respect of particular regions. Monitoring and evaluation, at WHO headquarters, of interregional and global projects had, however, received less attention, perhaps because those procedures had been described in the report on the 1980-1981 accounts. He nevertheless felt that more details regarding the effectiveness of expenditures on headquarters programmes and projects, as well as some more precise information in the current and anticipated positions with regard to casual income, would be welcomed by the Health Assembly, which had dwelt at length on that matter in 1983.

In conclusion, the monitoring and evaluation of WHO's projects and programmes should be a key preoccupation of the External Auditor and his staff, who could provide the Health Assembly with invaluable assistance in the execution of its constitutional functions.

Mr BROCHARD (France) shared the concern expressed by previous speakers with regard to WHO's financial, management, evaluation and programming problems, which had been admirably evoked in the reports by the External Auditor and the Committee of the Executive Board. The
External Auditor had been particularly outspoken in his comments on management and evaluation methods. The delegation of France endorsed the conclusions reached in those reports, and hoped that the Secretariat would take account of the observations and recommendations they contained in bringing about the necessary improvements.

Mr FURTH (Assistant Director-General) replied to questions put by delegates in respect of budgetary, financial and administrative matters.

The United Kingdom delegate had noted that the arrangements made in previous years for the exchange rate gains stemming from the increase in the value of the United States dollar in relation to the Swiss franc to be returned to Member States in the form of casual income had worked very well, having produced gains of over US$ 12 million in 1982-1983. He had expressed the hope that similar arrangements would be made for the regions, so that no expansion of regional programmes could take place as the result of currency exchange gains. In that connection it should be recalled that since 1 January 1984 similar arrangements had existed for the regions and that, as had been indicated in the Introduction to the proposed programme budget for 1984-1985, certain measures had been taken with regard to savings that could result from fluctuations in the exchange rate between the United States dollar and the major regional office currencies. Any net savings that might result from the rise of the average accounting rate of exchange in excess of 10% over the budgetary rate of exchange of such a major regional office currency during 1984-1985 would not be retained by a regional office for programme purposes. Such savings would be withdrawn from the regional allocations during the implementation of the budget and surrendered as a budget surplus to be fed back into casual income, thus reverting to the Health Assembly.

The United Kingdom delegate had also noted that some of the savings referred to in the section relating to transfers between sections of the Appropriation Resolution in the financial report (pages 9-12) appeared to be due to delays in budget implementation - in the recruitment of staff and start-up of projects, for example - and had asked whether such savings were real or whether the expenditures involved had merely been delayed and would be incurred later. The savings were undoubtedly real because the financial period had ended on 31 December 1983; if savings had arisen during the previous biennium as a result of delays in budget implementation, they had been surrendered in the form of a budgetary surplus.

Several delegations had commented on the number of Member States that had not paid their contributions in full by the end of the biennium. The situation was certainly serious, and the Secretariat was making every effort to collect the contributions concerned. However, a note of optimism should be sounded. In 1984 the rate of collection as of 30 April had been the highest in the Organization's history. It looked as if the trend was changing, and it was hoped that the new trend would be validated by the end of the year.

The delegate of the Soviet Union had stated that in future it would be preferable to present the information relating to the percentage of administrative support costs over a period of years so that comparisons could be made with a view to ascertaining the trend. Account would certainly be taken of that remark, and in the next financial report comparative data covering past financial periods would also be provided. The actual trend regarding administrative support costs was as follows: in 1979, such costs, calculated on exactly the same basis as for 1982-1983, had amounted to 14.93%; in 1980-1981 they had amounted to 14.26%; and in 1982-1983 they had amounted to only 14.05%. There had thus been a definite downward trend over the years. The percentage concerned was in fact the percentage of administrative support costs of the obligations incurred for programme purposes only. If the administrative support costs were taken as a percentage of total obligations, the percentage would be even lower. In 1979 it had been 12.99%, in 1980-1981 it had been 12.48%, and in 1982-1983 it had been 12.32%. The reason for the declining percentage was that the Organization's health programmes, at least in financial terms, were growing at a faster rate than the expenditures for administrative support services.

The delegate of the United States of America had raised a number of important points. First, he had asked what guidelines were in effect to ensure that all construction projects were handled centrally through the Real Estate Fund. In that connection it should be pointed out that resolution WHA23.14, which had established the Real Estate Fund, stated that the Fund might be used - but did not have to be used - to meet the costs of building extensions, purchases of land and other related activities, and authorized the Director-General - but did not require him - to use the Fund to finance those projects subject to certain provisos. The main intention seemed to have been to provide a source of funding for major expenditure on land and buildings rather than to prohibit the use of the regular budget for those purposes.

Nevertheless, in response to the External Auditor's comments, the Director-General had recently instructed all regional directors that, subject to one exception, the Real Estate Fund should be used to finance all projects covered by resolution WHA23.14 - in other words, the maintenance of and repairs and alterations to houses for staff; major repairs and alterations to the Organization's existing buildings; the construction of new buildings or
extensions to existing buildings; and the acquisition of land that might be required. Proposals from the regions for such projects should continue to be submitted to headquarters, where they would be subject to critical review by the technicians in the Building Management unit and the members of the newly established Building Programme Committee. The latter would offer their advice to the regional directors and possibly suggest alternative methods of dealing with the proposed projects. Proposals accepted by the Director-General would be submitted to the Executive Board and Health Assembly for consideration for funding from the Real Estate Fund. The Secretariat would continue to provide the Board and the Health Assembly with annual progress reports on all approved projects, indicating, where appropriate, changes in the cost estimates or costs incurred.

The only exception to that procedure was that projects relating to the maintenance of and repairs and alterations to houses for staff and the Organization's existing office buildings that cost less than US$ 20,000 should normally be financed from the building maintenance provisions in the regular budget and should not be included in the proposals for financing from the Real Estate Fund. That would avoid the submission for approval of relatively small items which did not deserve the time and attention of the Board and the Health Assembly. Headquarters would, nevertheless, be informed of those projects which were being financed from the regular budget allocations of the regions. The guidelines which the Director-General had sent to the regional directors ended by stating that under no circumstances should any funds, including regular budget savings, other than the Real Estate Fund, be utilized without the Director-General's prior personal approval for any real estate activities the cost of which exceeded US$ 20,000.

In addition, in April 1984 the Director-General had established a Building Programme Committee at headquarters to ensure that projects for building, renovation and maintenance were examined for the purpose of ascertaining whether they were indispensable and justifiable under existing policy and in view of current financing and staffing constraints before any funds were obligated or any work was undertaken. The Building Programme Committee was composed of the Director of the Division of Personnel and General Services, who was the Chairman; the Director of the Division of Budget and Finance, the Chief of Conference and Office Services, and the Chief of the Building Management unit, who was the secretary. The Committee would thoroughly review the need and justification for all real estate projects proposed by all offices, including regional offices.

The United States delegate had also asked what guidelines were provided by headquarters to the regional directors regarding the use of "savings" made in the implementation of the budget. While regional directors were allowed a certain degree of flexibility in the use of "savings", the Director-General had nevertheless imposed a number of restrictions on their utilization. In the first place, as previously indicated, measures had been taken with regard to savings which might result from fluctuations in the exchange rates between the United States dollar and the major regional office currencies. Secondly, if a regional office had savings which it wished to transfer to another section of the Appropriation Resolution, such a transfer could be made only with the prior approval of the Director-General, who took his decision on the basis of appropriate justifications submitted with the request for the transfer. That meant that savings in health programmes could not be transferred to finance administrative activities without the express approval of the Director-General. The various transfers between sections of the Appropriation Resolution made in 1982-1983 were listed on pages 4-12 of the financial report. Finally, the regional directors could not use savings in order to create new posts resulting in an increase in the total number of posts in established offices without the express approval of the Director-General.

In response to the External Auditor's recommendation regarding the use of chartered aircraft, the Director-General had recently approved guidelines for their use which the Secretariat was now in the process of issuing as part of WHO's policies and procedures manual. The guidelines would make a distinction between individual travel and group travel. The chartering of aircraft for individual travel should not be resorted to when normal commercial flights offering reasonable arrival and departure schedules were available. However, in emergency situations — for example, when evacuation for urgent medical or security reasons was required — a decision to charter an aircraft might be taken by the regional director concerned and subsequently reported to the Director-General. Any other exceptions to the general rule prohibiting the chartering of aircraft for individual travel could be made only with the approval of the Director-General.

As far as group travel and the shipment of supplies were concerned, the guidelines would provide that the use of chartered aircraft should definitely be investigated as a possibility. For example, such group travel might have to be undertaken in connection with meetings of governing bodies away from headquarters and of regional committees away from the regional offices. Where there was a clear financial advantage over individual travel, chartered aircraft for group travel should of course be used. In that case the customary
provisions concerning the procurement of supplies and equipment should apply: comparative bids should be obtained, if possible on an international basis, and the approval of contracts not exceeding US$ 30 000 should be obtained from the Director of Support Programmes at regional offices or the Director of the Division of Personnel and General Services at headquarters. If the value of the contract exceeded US$ 30 000, a contract review committee should review the bids and its recommendations should be submitted to the regional director of the regional office concerned or the Director of the Division of Personnel and General Services at headquarters.

Replying to a further question raised by the United States delegate, he said that it might be somewhat too early to see the impact on staffing of the recent levelling off of obligations incurred under programmes financed from extrabudgetary sources. The 1980-1981 biennium had seen a very large increase in extrabudgetary funds, with a resulting large increase in staff financed from extrabudgetary resources. As could be seen from page 50 of the financial report, the proportion of all funds (regular budget funds and extrabudgetary funds) spent on salaries and common staff costs had continued to decline, from 49.7% in 1980-1981 to 48.3% in the most recent biennium. However, as compared with the October 1980 staffing figures for headquarters, given to the Executive Board and the Health Assembly in 1981 in connection with the proposal to construct an extension to Building L, there had been a further reduction of 49 staff members financed by the regular budget, offset by an increase of 63 staff members financed from extrabudgetary funds and thus resulting in a net increase of 14 staff members at headquarters in the three-and-a-half year period.

That relatively small increase would not, in itself, have created any undue problem, but there had, in the past three-and-a-half years, been a very significant increase in word-processing equipment, including work stations, printers, central processing units and optical character readers, and a similar increase in computer terminals and microcomputers. Fifty-seven offices were currently being used exclusively for electronic data equipment, compared with 14 offices in 1980. The basic reason for the exclusive use of a large number of offices for electronic data processing equipment was that such equipment was generally shared among several users, and the disturbance caused by visiting users made it impossible for permanent occupants of such offices to work when the equipment was being used by others. That phenomenon should be lessened by the progressive increase of electronic data equipment at headquarters and the consequently reduced need to share such equipment among various users. On the other hand, the noise created by printers and the heat generated by equipment such as the central processing units would always necessitate the use of separate offices for that equipment.

The office accommodation situation at headquarters had become particularly critical because of the need to block off 34 offices until at least the end of 1985 to accommodate occupants of the seventh floor of the main headquarters building, including the Director-General, who would have to move from the seventh floor while the eighth floor was being reinforced. The work in question would begin as soon as the construction of the new restaurant and kitchen had been completed and the existing kitchen and restaurant closed. At least until the end of 1985, therefore, the lack of office accommodation in the headquarters building would be even more acute than hitherto. Programme managers had been instructed that, before recruiting any staff member, they must first ascertain that accommodation would be available within the space currently assigned to the division or programme concerned. Only when accommodation had been specifically set aside could recruitment of the staff member begin. Moreover, office space was no longer being reserved for consultants or other short-term staff, but programme managers had been requested to find accommodation for them in one of the offices already allocated to a division or programme - normally in an office of a staff member absent on duty travel or on leave - before any action was taken on the recruitment of such temporary staff or consultants.

He could therefore offer little hope that the office accommodation picture would become brighter in the foreseeable future.

With respect to the percentages mentioned by the United States delegate in connection with administrative support costs, he explained that the percentage generally used in respect of programme support was the cost of administrative support services incurred under all sources in relation to the total health programmes executed by WHO and financed from all sources of funds. The percentage had been 14.05 in 1982-1983 compared with 14.26 in 1980-1981, and it was true that the figure had tended to decline in recent years. The percentage cited by the United States delegate reflected the ratio of expenditures budgeted under section 8 of the regular budget to the total expenditures under the regular budget. Activities financed from extrabudgetary funds, however, were all managed on an integrated basis: staff financed from regular budget funds might devote a substantial part of their time to the management of activities financed from extrabudgetary funds, and, conversely, staff financed from extrabudgetary funds might devote themselves to activities financed under the regular budget, so that simply to relate section 8 of the 1982-1983
regular budget to the total regular budget expenditures would give a very unrealistic ratio of support costs. He was nevertheless fairly hopeful that the 16.7% mentioned on page 45 of the 1984-1985 budget document would be maintained at the end of the current biennium. The ratio of total administrative support costs from all sources to the total cost of health programme expenditures incurred also from all sources would, however, continue to be reflected in each final financial report, and every effort would be made to maintain the downward trend in the ratio.

In reply to a further question raised by the United States delegate, he said that WHO was successfully collecting the 13% programme support charge from its donors, but some donors and beneficiary countries would like to see the charge either reduced or eliminated. A number of major donors had, on several occasions, asked the Director-General to waive the 13% charge on the ground that the activities to be financed were of particularly humanitarian or social nature, or for other reasons. The donors had often referred to other organizations in the United Nations system which had occasionally reduced or waived the charge. The Director-General felt, however, that he was bound by resolution WHA34.17 to insist in every case on the standard 13% charge on technical cooperation project expenditure incurred under all extrabudgetary sources of funds, in partial reimbursement of the cost of support services provided by the Organization to the projects in question. The donors and beneficiary countries concerned had so far accepted the Organization's position in all such cases.

In relation to the Casual Income Account and the table appearing on page 25 of the financial report the United States delegate had observed that, while the table indicated that there had been US$ 23.3 million in the account on 31 December 1983, the accompanying text gave the impression that a further US$ 23.2 million was about to be deposited in the Account. The balance in the Casual Income Account on 31 December 1983 was indeed US$ 23.3 million. The first paragraph of the text on page 25 merely indicated that on 31 December 1983 a little over US$ 8 million had been due to the Organization, but not yet received in respect of interests on deposits and securities held by banks. When that amount was received in 1984, the part relating to regular budget funds would be credited to casual income and the part relating to other funds, mainly trust funds and other extrabudgetary accounts, would be credited proportionally to those trust funds and extrabudgetary accounts.

The second paragraph of the text referred to arrears of contributions in an amount of US$ 15.1 million, which would be credited to casual income when received. It was unlikely that all the contributions in arrears would be received in 1984; on the basis of past experience, it was probable that no more than US$ 11 million of such contributions would be collected during the year.

Since the beginning of 1984, however, some US$ 11.3 million of casual income had been earned, bringing the balance in the Casual Income Account on 30 April 1984 to approximately US$ 34.6 million. It was impossible to make a prediction as to the total amount of casual income that might be available at the end of the year, since the amount depended on many unpredictable factors, such as the extent to which arrears of assessed contributions would be collected, the pace of collection of the current year's contributions and the interest rates to be paid by banks on deposits. He was hopeful, however, that an amount of casual income approximately equal to what had been available at the end of 1982 might be available by the end of the year 1984 for appropriation by the Health Assembly to help to finance the regular budget for 1986-1987, since interest rates appeared to be remaining high and the collection of contributions so far in 1984 had been good.

The United States delegate's impression that many of the "savings" listed on pages 4-12 of the financial report had been due to staff vacancies was correct. The delays in the recruitment of competent staff, particularly for field project posts, certainly had an unfavourable effect on the successful accomplishment of WHO's mission. There were many factors accounting for recruitment delays, such as the difficulty in finding suitably qualified candidates in some professional fields; the level of WHO remuneration, which was sometimes considered inadequate; difficulties at prospective duty stations, such as difficult living and working conditions, lack of security, inadequate accommodation, lack of employment opportunities for spouses and lack of adequate schooling facilities; unwillingness or inability of selected candidates to join the project quickly; lengthy negotiations with candidates; delay in receipt of interview results; complex and lengthy recruitment procedures, which might have to include release by governments of national civil servants for WHO employment; clearance for assignment to field posts; reference checks; interviews; and medical examinations. It was also necessary to cope with changes in project plans, such as the moving forward of the target date for the commencement of a project, and with preliminary orientation and training of staff. The need to improve geographical distribution of staff and to increase the number of women staff members sometimes required time-consuming research.

The average time from the start of recruitment action to the date of reporting for duty was approximately nine months for vacancies advertised externally and somewhat less for other
vacancies. The average staff vacancy rate (number of vacancies in relation to total number of posts) in March 1984 had been: 13.9% for WHO as a whole, 9.8% for headquarters, 11.8% for regional offices, and 17.6% for field posts.

Replying to the United States delegate's question as to the steps being taken by the Secretariat to arrange for more rapid filling of vacancies, he said that, in view of the difficulties in the recruitment process, there was no simple solution to the problem of delays in recruitment. The Secretariat had been urging the International Civil Service Commission to take steps to improve the conditions of service of staff in the field, with some success. Such measures as increased financial incentives for service in the field, improved medical facilities in field duty stations, more frequent home leave for field staff, and increased education grant travel, had been taken during the past few years, and might have prevented the situation from deteriorating even further. Several recruitment missions had been undertaken in recent months, or were planned for the near future, in order to increase the reservoir of qualified candidates from under-represented countries. Such missions had, for example, been undertaken recently in the USSR and China, and one was shortly to go to Japan. The Personnel office at headquarters had initiated advance recruitment planning for the biennium 1984-1985 and all headquarters posts currently vacant or due to become vacant by December 1984 had been reviewed with the programme managers concerned with a view to expediting recruitment. A recruitment monitoring system was being introduced at headquarters on a trial basis, and improvements were being made in the recruitment roster, which had been computerized. More advertisements were being placed in the press and in specialized publications. Because of the decentralized nature of WHO's operations, a significant number of its recruitment activities were the direct responsibility of the regional offices. Close cooperation between the regional offices and headquarters was, however, a permanent feature of the efforts to obtain qualified candidates. Such cooperation included the notification of vacant posts in all offices of the Organization as well as joint regional office/headquarters participation in recruitment missions.

The United States delegate had asked how the Secretariat took account of expected staff vacancies when it developed the budget for staff costs, and, in particular, what was the standard budget lapse rate for new positions. When the estimates for personnel costs in established offices were developed, average cost factors were established for different categories of staff, and those averages, which were subject to continuous review, were based primarily on the actual cost of staff in the previous five years. The estimated costs for all posts also took account of the period for which they were expected to be required and, as appropriate, anticipated delays in recruitment. Consequently, a standard budget lapse rate for new staff positions was not necessary, since past experience with respect to vacancies was automatically incorporated in the average cost factors, and only the expected period of occupancy of a post was budgeted for.

With respect to the consolidated statement of income and expenditure under all funds, shown on page 13 of the financial report, the United States delegate had asked for an explanation of the negative balances shown at the end of the financial period for the Trust Fund for the Special Programme for Research and Training in Tropical Diseases, as well as for the United Nations Environment Programme (UNEP) and UNFPA, which had appeared to that delegate to indicate that those programmes were spending more than they received, and he had asked whether regular budget resources were being drawn upon to make up the deficits.

He could assure the Committee that regular budget funds were not being drawn upon to make up any shortfall in income for any programme financed from extrabudgetary resources. As indicated in footnote 1 on page 13, the expenditures under the funds in question included the unliquidated obligations as at 31 December 1983, and as could be seen from the table on page 19 the unliquidated obligations of the Trust Fund for the Special Programme for Research and Training in Tropical Diseases, of UNEP, and of UNFPA were represented by cash and deposits which in each case were in an amount larger than the negative balances shown on page 13. Consequently, no cash borrowing had been necessary to cover the overdrawn balances shown.

Moreover, in agreement with the World Bank, UNEP and UNFPA, cash was drawn from those organizations as required to meet disbursements expected to be effected in the following months. Consequently, there appeared to be no risk of any cash shortfall in the funding of the activities in question.

The United States delegate had asked why the statements relating to the World Bank with respect to the Special Programme on Research and Training in Tropical Diseases and the Onchocerciasis Control Programme (pages 133 and 126 of the financial report) had not been audited. Footnote a in each case indicated that the statements were subject to audit. The audited statements would be received from the auditors of the World Bank later in 1984—probably in June.

The meeting rose at 17h35.
SECOND MEETING

Wednesday, 9 May 1984, at 14h30

Chairman: Dr N. ROSDAHL (Denmark)

1. REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION: Item 24 of the Agenda (continued)

Financial report on the accounts of WHO for the financial period 1982-1983, report of the External Auditor, and comments thereon of the Committee of the Executive Board to Consider Certain Financial Matters prior to the Health Assembly: Item 24.1 of the Agenda (Documents EB73/1984/REC/1, resolution EB73.R14, A37/8 and A37/28) (continued)

Dr CHOLLAT-TRAQUET (Managerial Process for WHO Programme Development), replying to questions concerning programme evaluation and related information, said that those subjects should be situated within the general framework of the managerial process for programme development: a process involving the elaboration of general programmes of work, medium-term programming, programme budgeting, implementation, follow-up and evaluation and necessary information support. In short, what happened was that general programmes of work were prepared by the Executive Board, which submitted them for the approval of the Health Assembly and provided general targets and approaches for all programmes; medium-term programmes established quantified goals and determined relatively detailed activities to achieve the objectives of each programme; the programme budgets attributed finances for the activities of those medium-term programmes; and programme implementation and follow-up made it possible to observe development and take corrective action where necessary. Evaluation took place at all stages of the process in the form of evaluation of relevance, effectiveness and efficiency, and analysis of results. An integral part of the management process was to ensure that information to and from all components was easily available, and that was where programme profiles had a role to play. The integration of the components and uniformity of application at all levels were what made the management system so valuable. It required that each level should manage its own activities and that higher levels should in turn be in a position to support and monitor activities. Consequently, information necessary for programme management was kept at the appropriate level and only information selected for monitoring purposes was passed up to a higher level. In a national primary health care programme, for example, the information required at country level would be available at the WHO coordinator's office in the country concerned; selected information of relevance to the countries of the region concerned was available at the regional office – for the regional primary health care programme; general information – relevant to the WHO primary health care programme – was available at the global level. Feedback was consequently very important.

The concern expressed by the External Auditor and delegates to the Health Assembly with regard to programme profiles that had not been updated was certainly justified in some cases. However, programme profiles had never provided the sole basis for programme evaluation because evaluation was carried out on the basis of planning documents – including medium-term programme documents and programme budgets – which existed at all levels for all programmes, as referred to by the External Auditor in paragraphs 33 and 35 of document A37/8. The information in those documents was the same as that which should be stored in programme profiles, therefore the profiles represented only one method of storing information on individual programmes and, as such, constituted a system of reference, with the information generally being stored elsewhere and cross-referenced. Nonetheless, failure to keep accurate and up-to-date profiles could have serious consequences, particularly in relation to feedback. For that reason, a systematic effort had been made since the beginning of the year, in all regions and at headquarters, to promote more regular use of programme profiles, an exercise which would be facilitated through the supply of information at all levels by the management system and by means of increased computerization in updating and storage of information.

Replying to the important questions concerning the relationship between evaluation of general WHO programmes and evaluation of national programmes, and information related to that
subject, she said that the new management structure, designed to make optimum use of WHO resources at country level, specified that WHO activities must bring direct support to country programmes. Therefore, if the focus on the project was broadened, programme evaluation would become at the same time more complex and more relevant. It implied certain changes in the evaluation procedures of WHO programmes at country level. Joint studies by governments and WHO would have to be undertaken to show whether WHO resources at country level had been well utilized and what results they had brought. As the United States delegate had implied, such an undertaking would call for the introduction of new consultative programming and evaluation machinery, involving both the Organization and individual Member States. In that respect, regional offices were experimenting with and developing ways of carrying out such joint evaluation. For example, subcommittees had been set up in some regions and joint missions had taken place in others. About twenty countries had set up permanent high-level WHO government coordinating committees. It was therefore clear that there was no lack of interest in WHO activities on the part of Member States. The guidelines adopted by the Health Assembly and the relevant Assembly and Board resolutions of recent years had been taken very seriously, put into operation and adapted to the most recent policies of the Organization.

The evaluation situation had been fully documented in an internal study undertaken by the Secretariat in 1983 and 1984. It had revealed feedback weaknesses and the need to improve the information base, while at the same time showing that much more evaluation was in fact being carried out than might at first have been expected. It also indicated the importance of internal programme committees at regional and headquarters levels to serve as a basis for the planning of future activities. For example, in 1983, the Headquarters Programme Committee had made an evaluation of all programmes of the Sixth General Programme of Work at the same time as it had developed medium-term programmes of the Seventh General Programme of Work and the 1984-1985 and 1986-1987 programme budgets, demonstrating that the planning of future programmes should be based on an evaluation of past activities. In November 1984, the Executive Board's Programme Committee would begin an evaluation of the main components of primary health care on the same principles and bases.

While much remained to be done, programmes were being carried out on a uniform basis and in the right direction.

Mr DOBSON (representative of the External Auditor), in response to the question whether the External Auditor was satisfied with the procedures introduced in respect of construction projects and the chartering of aircraft, said that the new procedures concerning building projects were quite uncompromising, while those concerning the chartering of aircraft were sufficiently flexible to enable the Organization to take prompt and appropriate measures in the event of an emergency which might endanger health or security. He would, of course, examine how the procedures worked in practice and continue to pay particular attention to the way in which budgetary surpluses were handled and how they were used.

In answer to the Soviet delegate's request for more details regarding the effectiveness of expenditures on headquarters programmes and projects, he drew attention to paragraphs 52-56 of Part II of document A37/8, and confirmed that strenuous efforts were being made to improve those features that had been identified as unsatisfactory in the 1980-1981 biennium. As one of the External Auditor's functions was to ensure that satisfactory management procedures were established and being implemented, he was particularly interested in monitoring and evaluation. But, at the same time, he recognized that it would take time for improvements to be fully effective.

Mr BOYER (United States of America) asked whether the policy on construction projects, to which Mr Furth had referred and according to which regional offices might implement, on their own authority, projects costing up to US$ 20 000 but must submit more expensive projects to headquarters for possible financing from the Real Estate Fund, had already been in effect at the time of implementation of the $ 137 000 project currently the subject of debate or had come into effect subsequently. He also asked whether there was any way in which the Organization might recover the money spent on that project.

He wondered whether the Secretariat's reply on the subject of monitoring and evaluation, which had suggested that there was no fundamental problem or cause for concern over the Organization's evaluation system, implied that - because of the different time scales involved - the External Auditor's focus on programme and project profiles and his expression of concern when they were not available were considered to be somewhat irrelevant to the issue of assessing the long-term impact of WHO activities. Perhaps further clarification and comment could be provided in that connection.

Dr GALAHOV (Union of Soviet Socialist Republics) thanked the Secretariat for its detailed explanation of the methods of evaluation used in the Organization. Concerning the
COMMITTEE B: SECOND MEETING

response of the representative of the External Auditor to his earlier question, he said that although he appreciated the contents of paragraphs 52-56 of the report, was glad that the situation in relation to programme profiles and availability of information was improving, and recognized that it would take time for improvements to have an effect, he would have wished to receive information on a somewhat more broader basis. He would not, however, press the matter further at that stage.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that it was disturbing to note that the External Auditor considered that it would take a long time for new procedures to be implemented satisfactorily. The delivery of health care, particularly at the peripheral level, was of critical importance and depended upon adequate programme implementation. Every effort should consequently be made to implement the new control measures, as a matter of the utmost urgency.

Mr FURTH (Assistant Director-General), in reply to the United States delegate, said that the additional guidelines on the use of the Real Estate Fund had been issued only the previous month in reaction to events and in response to the External Auditor's recommendations. He pointed out that, although the Real Estate Fund was available for such purposes, resolution WHA23.14 which had established the Fund had not imposed any obligation to use it to meet costs of building extensions or purchases of land; it had merely authorized the Director-General to use the Fund for real estate purposes. The use of regular budget funds for the purpose of the construction in question had therefore not been illegal, even though it might have been deemed inappropriate or unwise. There could therefore be no question of recovering the funds used for the project; indeed, as could be seen on page 14 of document A37/8, the value of the Regional Office for Africa had been increased by the addition of the elevator, as shown by the relevant figures in the assets column, and the value of that capital improvement was also referred to in the Explanatory Notes on page 15 of the same document.

Dr CHOLLAT-TRAQUET (Managerial Process for WHO Programme Development), replying to the United States delegate, said that in her statement she had not been concerned with the time-span of programme and project evaluation but rather with the specific function the programme profile was expected to fulfil. The programme profile was neither a management mechanism nor a component of WHO's managerial process, but a reference system and a vital information bank. The fact that programme profiles were missing in certain cases did not mean that there had been no programming or evaluation of the project or programme concerned, but merely that the relevant data had not been stored in the proper place. There was no question of abandoning the programme profile, which was, on the contrary, very important for information communication and feedback at all levels of the Organization - country, regional and global - and efforts were being made to promote its use with WHO programme coordinators, the regional offices and headquarters units.

Mr DOBSON (representative of the External Auditor) said that the External Auditor had identified programme profiles as an important part of the method chosen by WHO to manage its programmes. It was no part of the External Auditor's function to instruct WHO on the management of its programmes; his concern was to see that the management procedures in place were operating properly and to draw attention to the fact if they were not.

The United Kingdom delegate had expressed concern at his earlier remark that it would take time to effect improvements in the management system. However, in his experience it was a fact that a certain length of time was needed in large organizations for established management methods and procedures to filter down to all levels and be fully implemented in all respects - hence the question might well have to be raised again by the External Auditor on future occasions. WHO was, however, making strenuous efforts to improve its management procedures.

The draft resolution contained in paragraph 8 of document A37/28 was approved.  

The CHAIRMAN suggested that the Committee pass at once to consideration of item 27 of the Agenda, in view of its relevance to the matters just discussed.

It was so agreed.

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.4.
2. **FINANCIAL REGULATIONS - ADDITIONAL TERMS OF REFERENCE GOVERNING THE EXTERNAL AUDIT OF THE WORLD HEALTH ORGANIZATION**: Item 27 of the Agenda (Document EB73/1984/REC/1, decision EB73(10) and Annex 10)

Dr MAKUTO (representative of the Executive Board), introducing the item, said that it had been reviewed by the Executive Board on the basis of a note submitted to the Board by the Director-General, the text of which was provided in Annex 10 of document EB73/1984/REC/1.

Article XII of the Financial Regulations of WHO spelt out in broad terms the position of the External Auditor of the Organization, providing for his appointment by the World Health Assembly, for his complete independence and sole responsibility for the conduct of his audit and for the submission of his report on the accounts of the Organization to the Health Assembly through the Executive Board. An appendix to the Financial Regulations of the Organization contained additional terms of reference governing the external audit of WHO, and spelt out in some detail the scope of the audit to be performed, the facilities to be accorded to the External Auditor by the Director-General and the information to be included in the report of the Auditor on the financial statements. The External Auditor of WHO, in agreement with his colleagues in the other United Nations organizations, had proposed certain changes in those additional terms of reference, which formed an integral part of the Financial Regulations. The Board had been given to understand that the executive heads of all United Nations organizations had concurred in the changes proposed by their external auditors and that similar changes were being submitted to their legislative bodies. The Board's conclusion of its review of the matter was to recommend to the Health Assembly that it approve the proposed changes.

**Decision**: The Committee decided to recommend to the Thirty-seventh World Health Assembly that it approve the proposed changes in the Financial Regulations with respect to the additional terms of reference governing the external audit of the World Health Organization, as contained in Annex 10 to document EB73/1984/REC/1.

3. **REVIEW OF THE FINANCIAL POSITION OF THE ORGANIZATION**: Item 24 of the Agenda (continued)

**Status of collection of assessed contributions and status of advances to the Working Capital Fund**: Item 24.2 of the Agenda (Document A37/9)

Mr FURTH (Assistant Director-General), introducing the item, said that document A37/9 contained the Director-General's report on the status of collection of assessed contributions and of advances to the Working Capital Fund. As at 30 April 1984 total collections of 1984 contributions in respect of the effective working budget represented 45.10% of the assessments on the Members concerned. That rate of collection was the highest ever achieved as of 30 April in the history of the Organization. As regarded prior years' arrears of contributions, on 1 January 1984 total arrears of contributions due for years prior to 1984 from Members actively participating in the work of the Organization amounted to US$ 14,975,338. Although payments received up to 30 April 1984 had reduced such arrears to $11,876,459, as many as 50 members contributing to the effective working budget still owed contributions in respect of years prior to 1984. Further, of those 50 Members, 30 had made no payment at all in respect of the 1983 instalment and thus owed the 1983 instalment in full.

During the first nine days of May, up to noon of the day in progress, payments totalling $3,953,951 had been received from 10 Members (Botswana, Democratic People's Republic of Korea, Iceland, Israel, German Democratic Republic, Mexico, Mozambique, Solomon Islands, Uganda, and United Republic of Tanzania) in full or part settlement of their 1984 assessments, thus raising the percentage of current year contributions collected from 45.10% at 30 April 1984 to 46.79% at 9 May 1984. (On the same date the previous year the corresponding percentage had been 43.17%.) Furthermore, since 30 April 1984 payments totalling $324,008 in respect of arrears of contributions had been received from 11 Members - Central African Republic, Costa Rica, Democratic Kampuchea, Democratic People's Republic of Korea, Dominica, Grenada, Guinea, Samoa, Uganda, United Republic of Tanzania, and Zambia.

The Committee's attention was drawn to paragraph 5 of the report, which contained the text of a draft resolution for its consideration.

Dr MAFIAMBA (Cameroon) said the report showed that his country was in arrears with payment of its 1984 assessments. Cameroon was, however, well aware of the importance of prompt budgetary contributions to the smooth running of international organizations; in recent years it had indeed paid its contribution on time. The present delay had been due to

---

1 Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA37(10).
the fact that the 1984 budget assessment had been slightly higher than in previous years; consequently, for technical reasons, authority had had to be sought from the Government to make the full payment. That authority had now been granted and the Organization should receive the sum concerned from the Cameroon Ministry of Finance in the very near future.

The draft resolution contained in paragraph 5 of document A37/9 was approved, with inclusion of the date of 9 May 1984 in operative paragraph 1.

Members in arrears in the payment of their contributions to an extent which may invoke Article 7 of the Constitution; Item 24.3 of the Agenda (Documents EB73/1984/REC/1, resolutions EB73.R1 and EB73.R14 and decision EB73(4), A37/10 and A37/INF.DOC./1)

Mrs THOMAS (representative of the Executive Board) informed the Committee that the Director-General had reported to the Executive Board at its seventy-third session that the Republic of Chad was in arrears in the payment of its assessed contributions for the years 1980 to 1983 inclusive for an amount totalling US$ 88 265. The Director-General had corresponded with the Government of Chad on ways of settling those arrears and the Government had proposed that its contribution for the period 1980-1984, including those arrears, should be settled in 10 instalments to be paid over the years 1985-1994. Such an arrangement would be similar to earlier arrangements agreed to by the Health Assembly in respect of several other countries. The relevant details had been reproduced for the information of the Health Assembly in document A37/INF.DOC./1.

While the Executive Board was convinced that it was the duty of all Member States to pay their assessed contributions in full and on time, it had had to recognize the particularly difficult situation of Chad. Accordingly, the Executive Board had decided, in its resolution EB73.R1, to recommend a draft resolution for adoption by the Health Assembly.

Mr BOYER (United States of America) said that while he was not opposed to the draft resolution recommended to the Health Assembly for adoption, he considered that the Committee should note that in the past the Health Assembly had agreed to extended payment plans on four occasions for four different countries, and that on three of those occasions the Member State concerned had not been able to maintain even the limited payments required. In future, before the Health Assembly entered into arrangements such as those now being proposed for Chad, it should carefully review their utility. Nevertheless, he was sympathetic towards the problem of Chad and agreed with the Executive Board's recommendation in the present instance.

The draft resolution recommended by the Executive Board in resolution EB73.R1 was approved.

Mrs THOMAS (representative of the Executive Board) said that when the Director-General had submitted his report to the Executive Board's Committee to Consider Certain Financial Matters prior to the Thirty-seventh World Health Assembly, there had been eight Members in arrears in the payment of their contributions for two full years or more. In the case of Chad a special arrangement had been recommended. She was happy to report that in the past week the Governments of the Central African Republic, Democratic Kampuchea, Grenada and Guinea had made payments sufficiently large to remove them from the list of Members in danger of losing their vote. That left only three Members - Comoros, Nicaragua and Romania. The Committee of the Executive Board had decided to recommend that the voting rights of those Members should not be suspended for the current World Health Assembly. However, it was clear that all Members must pay their assessed contributions. The Committee had felt that it might be useful if the Health Assembly were to decide that a suspension of voting rights in respect of countries in arrears for two full years or more should be a matter of course. The Health Assembly could, of course, decide on particular cases where exceptional circumstances justified the retention of the right to vote. By comparison with other United Nations organizations, that seemed a reasonable position to adopt. The Committee of the Executive Board had therefore prepared the draft resolution contained in paragraph 5 of document A37/10.

Mr BROCHARD (France) noted that Article 7 of the Constitution indicated that, if a Member failed to meet its financial obligations, the Health Assembly might suspend its voting privileges. That suggested that a formal decision to suspend voting privileges was necessary

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.5.
2 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.6.
and that suspension was not automatic. He therefore wondered whether paragraph 2 of the draft resolution that the Committee of the Executive Board had recommended for adoption was really necessary.

Mr FURTH (Assistant Director-General) replied that the French delegate's interpretation of Article 7 of the Constitution was certainly reasonable. However, as was indicated in paragraph 1 of the annex to document A37/10, the Eighth World Health Assembly had resolved, in resolution WHA8.13, that if a Member was in arrears in the payment of its financial contributions to the Organization in an amount which equalled or exceeded the amount of the contributions due from it for the preceding two full years at the time of the opening of the World Health Assembly in any future year, the Health Assembly should consider, in accordance with Article 7 of the Constitution, whether or not the right of vote of such a Member should be suspended. That seemed to imply that the Health Assembly had to take a decision.

Mr BOYER (United States of America) observed that, in view of the large number of Member States which had been in arrears in the payment of their contributions, it was important that it should be made known that in future years the Health Assembly would adopt a less liberal policy regarding the suspension of voting rights.

Dr CASTELLÓN (Nicaragua) informed the Committee that his Government had just paid its two years' arrears in contributions to the WHO office in Nicaragua.

The draft resolution in paragraph 5 of document A37/10 was approved.1

4. ELECTION OF VICE-CHAIRMEN AND RAPPORTEUR: Item 23 of the Agenda (continued)

Election of Rapporteur

Dr SEBINA (Botswana) nominated Dr Sriati da Costa (Indonesia) for the post of Rapporteur.

Decision: Committee B elected Dr Sriati da Costa (Indonesia) as Rapporteur.2

5. ASSESSMENT OF NEW MEMBERS AND ASSOCIATE MEMBERS: Item 26 of the Agenda (Documents A37/11, A37/12, A37/23 and A37/24)

Mr FURTH (Assistant Director-General), introducing document A37/11 concerning the assessment of Saint Vincent and the Grenadines, which, as a Member of the United Nations, had acceded to membership of the World Health Organization under the provisions of Article 4 of the Constitution by depositing with the Secretary-General of the United Nations a formal instrument of acceptance of the WHO Constitution on 2 September 1983, said that it was necessary for the Health Assembly to establish the assessment of that State in WHO. Its assessment had been fixed at the minimum rate of 0.01% in the United Nations scale of assessments, and the Health Assembly might therefore also wish to fix the WHO assessment rate for 1982-1983 and future financial periods at the minimum, as recommended in document A37/11.

In considering the assessment for the financial period 1982-1983, the Health Assembly would no doubt wish to take into consideration resolution WHA22.6, which provided that new Members should be assessed in accordance with the practice followed by the United Nations in assessing new Members for their year of admission. If that were done, and since Saint Vincent and the Grenadines had become a Member of WHO on 2 September 1983, no assessment would be made on that country for 1982, and the 1983 assessment would be reduced to one-ninth of 0.01%.

If the Committee agreed with the Director-General's proposal for the assessment of Saint Vincent and the Grenadines, it might wish to recommend the adoption of the draft resolution in paragraph 5 of document A37/11.

The draft resolution in paragraph 5 of document A37/11 was approved.3

---

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.7.
2 See decision WHA37(4).
3 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.8.
Mr FURTH (Assistant Director-General), introducing document A37/12 concerning the assessment of Antigua and Barbuda, which, as a Member of the United Nations, had acceded to membership of the World Health Organization under the provisions of Article 4 of the Constitution by depositing with the Secretary-General of the United Nations a formal instrument of acceptance of the WHO Constitution on 12 March 1984, said that it was necessary for the Health Assembly to establish the assessment of that State in WHO. Its assessment had been fixed at the minimum rate of 0.01% in the United Nations scale of assessments, and the Health Assembly might therefore also wish to fix the WHO assessment rate for 1984–1985 and future financial periods at the minimum, as recommended in document A37/12.

The Health Assembly would no doubt wish to take into consideration resolution WHA22.6, which provided that new Members should be assessed in accordance with the practice followed by the United Nations in assessing new Members for their year of admission. If that were done, the 1984 instalment of the assessment of Antigua and Barbuda, which had become a Member of the World Health Organization on 12 March 1984, would be reduced to one-third of 0.01%.

If the Committee agreed with the Director-General's proposal for the assessment of Antigua and Barbuda, it might wish to recommend the adoption of the draft resolution in paragraph 5 of document A37/12.

The draft resolution in paragraph 5 of document A37/12 was approved.

Mr FURTH (Assistant Director-General), introducing document A37/23 concerning the assessment of the Cook Islands, which had been admitted to membership of the World Health Organization in accordance with the provisions of Article 6 of the Constitution on 8 May 1984, subject to its depositing a formal instrument of acceptance of the WHO Constitution with the Secretary-General of the United Nations, said that pending the establishment of the assessment rate for that State by the United Nations General Assembly on the basis of which the definitive assessment could be fixed by the World Health Assembly, the Director-General recommended that the Health Assembly should establish a provisional assessment rate of 0.01% for 1984–1985 and future financial periods, as recommended in document A37/23.

The Health Assembly would no doubt wish to take into consideration resolution WHA22.6, which provided that new Members should be assessed in accordance with the practice followed by the United Nations. If that were done, the 1984 instalment of the 1984–1985 assessment of the Cook Islands, which had become a Member of WHO on 8 May 1984, would be reduced to one-third of 0.01%.

If the Committee agreed with the Director-General's proposal for the assessment of the Cook Islands, it might wish to recommend the adoption of the draft resolution in paragraph 5 of document A37/23.

The draft resolution in paragraph 5 of document A37/23 was approved.

Mr FURTH (Assistant Director-General), introducing document A37/24 concerning the assessment of Kiribati, said that that State had been admitted to membership of the World Health Organization in accordance with the provisions of Article 6 of the Constitution on 8 May 1984, subject to its depositing a formal instrument of acceptance of the WHO Constitution with the Secretary-General of the United Nations.

Pending the establishment by the United Nations General Assembly of the rate of assessment for that State, on the basis of which the definitive assessment could be fixed by the World Health Assembly, the Director-General recommended that the Health Assembly establish a provisional assessment rate of 0.01% for 1984–1985 and future financial periods, as recommended in document A37/24.

In considering the assessment of Kiribati for the financial period 1984–1985, the Health Assembly would no doubt wish to take into consideration resolution WHA22.6, which provided that new Members should be assessed in accordance with the practice followed by the United Nations. If that were done, and since Kiribati had become a Member of WHO on 8 May 1984, the 1984 instalment of its 1984–1985 assessment would be reduced to one-third of 0.01%.

If the Committee agreed with the Director-General's proposal for the assessment of Kiribati, it might wish to recommend the adoption of the draft resolution in paragraph 5 of document A37/24.

The draft resolution in paragraph 5 of document A37/24 was approved.

1 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.9.
2 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.10.
3 Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA37.11.
Mrs THOMAS (representative of the Executive Board) said that the Board had considered the report by the Director-General reproduced in Annex 2 to document EB73/1984/REC/1. That report was in five main parts: Part I, providing information on the status of projects undertaken prior to 31 May 1984; Part II, detailing the estimated requirements of the Real Estate Fund for the period 1 June 1984 to 31 May 1985; Part III, in which the Director-General had reported on developments in the problem of water seepage between the eighth and seventh floors of the main headquarters buildings and on the status of the construction of a building to accommodate the kitchen and restaurant; Part IV, in which the Director-General had informed the Executive Board of the final acceptance of the construction of the extension to building L at headquarters; and Part V, summarizing the estimated requirements of the Fund.

The Executive Board had noted the status of implementation of the approved projects for the period up to 31 May 1984 and the estimated requirements of the Fund for the period 1 June 1984 to 31 May 1985, as listed in the Director-General's report.

It had also noted that preparation of the site of the building to house the new kitchen and restaurant at headquarters had started and that it was estimated that the kitchen and restaurant in the new building would be opened at the end of 1984, following which work to restore the structural safety of the eighth floor of the main headquarters building would begin.

The Executive Board had adopted resolution EB73.R5, in which it recommended that the Thirty-seventh World Health Assembly should authorize the financing of the expenditures, as indicated, from the Real Estate Fund, and approve to that fund the amount of US$ 805 000 from casual income.

Mr BOYER (United States of America) recalled that at the last session of the Executive Board an extensive discussion of the subject under consideration had taken place in which he had raised a number of questions to which Mr Furth had replied: those discussions were summarized on pages 112-119 of the summary records of the Board (document EB73/1984/REC/2). He was still not convinced of the need to spend US$ 750 000 on the construction of 30 additional offices in the Regional Office for Africa. In adopting the 1984-1985 budget, the Health Assembly had determined that there would be zero programme growth, and he failed to understand why 30 additional offices should be required at a time when there should be no increase in staff. The answer he had received was essentially that the Regional Office needed more computer facilities and a dispensary, but no satisfactory justification had been given for the addition of 30 offices. He would be interested to know whether, on reflection, the Secretariat considered that 30 new offices were really necessary at a time of zero programme growth, and whether or not the US$ 750 000 requested could be reduced, particularly in the light of the discussion that had just taken place on the report of the External Auditor.

Dr GALAHOV (Union of Soviet Socialist Republics) said that he, too, had participated in the Board's consideration of the issue. Casual income should be used, first and foremost, to finance the regular budget. Use of that income for any other purposes, including the financing of the Real Estate Fund, should be reduced to a minimum. It was therefore essential to make a careful analysis of all building, repair and maintenance requirements, to seek alternative methods of satisfying them, and to use the Real Estate Fund to finance only such work as was absolutely necessary. The report under consideration showed that not enough was being done in that direction. In a number of projects financed from the Real Estate Fund, considerable overexpenditure had occurred, as compared with the original estimates. The Director-General's report showed that, in certain projects carried out during the period up to 31 May 1983, the funds employed had been less than those provided for in the estimates. Possibilities of making internal economies therefore existed and should be studied and used more widely in the future. Funds saved on particular projects were allocated almost entirely to concealed overexpenditure on others, as a result of which the Health Assembly had had to channel fairly large sums from casual income to the Real Estate Fund, when such funds might be used to finance the regular budget and reduce the assessments of Member States; that was particularly important at a time when economic difficulties had caused more than one-third of the Organization's membership to fail to pay all or part of their contributions. His delegation was therefore unable to support the draft resolution before the Committee, and would abstain if a vote was taken on it.

Mr FURTH (Assistant Director-General), replying to the United States delegate's question as to the justification for the request for 30 additional offices in the Regional Office for
Africa at an estimated cost of $750,000, recalled that, in October 1983, headquarters had received a request from the Regional Office for six projects - repairs to the roofs of staff villas, construction of an additional apartment block building, replacement of the roofs of two blocks of the Regional Office, extension of the Regional Office building (30 offices), extension of the conference hall and replacement of the conference hall ceiling - to be financed from the Real Estate Fund, in a total amount of $2,246,460. The Director of the Division of Personnel and General Services at headquarters, together with his staff in the Building Management unit, had carefully examined those requests and had written to the Regional Director requesting him to reconsider the matter, since headquarters considered that three of the projects did not appear fully justified, or appeared untimely. Headquarters had suggested that only three of the six projects - repairs to the roofs of staff villas, replacement of the roofs of two Regional Office blocks and the extension of the Regional Office buildings - be retained. The Regional Director had replied in November 1983, accepting headquarters' conclusions and requesting that the three retained projects be submitted to the Executive Board. He had also indicated in a separate communication the justification for the request for the 30 new offices, in which he had emphasized that the office extension proposal was not the result of any increase in the staff - no such increase was expected in the foreseeable future - but was put forward because of the need to improve the security aspects of the office and work processing equipment for the staff. He had, in greater detail, established the need for 17 new offices to meet existing overcrowding, based on the accepted formula of one office for each professional staff member and one office for every two general service staff members. Moreover, the request for other offices (in addition to the 17 just referred to) related to the need for greater security and an improved working environment, and the Regional Director had repeated that the offices were not to accommodate a larger number of staff. He had considered that the computer section was far too exposed and lacked proper security, that its relocation was urgent in view of its intensive use, and that such relocation would require eight new offices for the computers and the word processing equipment. Furthermore, with the introduction of the administration and finance information system in the Regional Office for Africa, the Regional Director was forced to make space available for the computer terminals in the budget and finance section and reduce congestion in that section, and at least six new offices would be required for that purpose. The total of 31 offices thus required had been rounded off to a request for 30 new offices. Headquarters had considered the request justified, and it was on that basis that the Director-General had made his proposal to the Executive Board and the Health Assembly.

In response to the comments by the USSR delegate, he said that the Director-General, and he himself, entirely agreed that casual income should be used to the greatest extent possible to help to finance the regular budget. He was unable to agree entirely with the observations concerning overexpending, which was rarely seen in relation to the administration and finance information system. As indicated in the Director-General's report, there were many more cases of underexpending than overspending in individual projects. Underspending might be the result of many factors, one of which might well be that there had been an overestimate of the cost of the project requested. He could not conclude that in every case underspending necessarily meant better management. It was extremely difficult to make a fully accurate estimate of the future costs of any building of any size or of any major maintenance or repair work. The Organization had its own methods of estimating costs in addition to the estimates provided by outside experts; such costs were sometimes overestimated and sometimes underestimated, but those errors were unavoidable.

Mr. BOYER (United States of America) said that he was not wholly satisfied that 30 additional offices were required in the Regional Office for Africa. He was not, however, raising a question about health programmes in Africa, since Africa was probably the most deserving Region in the Organization when it came to health problems and health programmes. It would be preferable by far to put any available money into health programme activity there rather than in the superstructure of a regional office simply to make the staff more comfortable. In the context of the total request for Africa he did not, therefore, question the $136,000 requested to repair the roofs of the villas, nor the $57,000 proposed for the roofs of two of the building blocks, nor did he question the entire sum of $750,000 proposed for providing additional offices. There appeared to be some justification for an extension, according to the statement by the Assistant Director-General, but there did not appear to be sufficient justification for spending the entire $750,000. He therefore suggested that the Committee should approve only one-third of that sum and consequently proposed that the resolution should be amended to deduct $500,000 from the two figures given in operative paragraphs 1 and 2.

Mr. FURTH (Assistant Director-General) said that, while he understood the United States proposal, he felt that to appropriate only one-third of the requirements for that extension,
which would probably not even build 10 offices, would serve no useful purpose. It was not certain that the number of new offices would be decreased in proportion to the decrease in the funds appropriated. Unless the Assembly wished to approve the entire amount, it might be better not to provide any funds for the proposed extension.

Mr BOYER (United States of America) said that his intention had been that part of the facilities programme should be addressed with one-third of the money. However, since he was willing to accept the Assistant Director-General's judgement that it would be useless to spend one-third of the money, he proposed that the entire $ 750 000 should be deleted from the two figures given in operative paragraphs 1 and 2 of the resolution.

Mr FURTH (Assistant Director-General) said that, as he understood the United States proposal, the figures in operative paragraphs 1 and 2 of the draft resolution contained in resolution EB73.R5 would be reduced by $ 750 000, the paragraphs consequently reading as follows:

"(1) AUTHORIZES the financing from the Real Estate Fund of the expenditures summarized in part V of the Director-General's report, at the estimated cost of US$ 848 000.

(2) APPROPRIATES to the Real Estate Fund, from casual income, the sum of US$ 55 000".

If that was what was intended, a further amendment would probably be necessary, for the sake of internal consistency of paragraph 1, by inserting in paragraph 1, after the words "Director-General's report" the words: "with the exception of the proposed extension to the building of the Regional Office for Africa."

Dr DLAMINI (Swaziland) said that, when the Assistant Director-General had earlier presented the justification for the request for new offices, he had based his argument on overcrowding and had mentioned in particular the professional staff. He wondered, therefore, whether the deletion of the entire amount requested implied that the overcrowding was to be allowed to continue in the Regional Office for Africa, thereby treating that office unfairly in relation to others, and whether it also implied that the peace of mind to be granted to the computer department at headquarters through the provision of additional space was to be denied to the Regional Office.

Mr LO (Senegal) endorsed the views of the delegate of Swaziland. The United States proposal was, in fact, contradictory. Good working conditions could not be demanded if at the same time the means for achieving those conditions were reduced. Furthermore, the proposal involved a substantial reduction and thus completely changed the original proposal made by the Secretariat, which appeared to have been based on a very careful study. He also expressed the wish that all proposed amendments should be produced in document form, for circulation at a later date; that would facilitate discussion.

Dr OLIVER (United Kingdom of Great Britain and Northern Ireland) said that the Committee had to rely heavily on the view of headquarters staff who had considered the matter very carefully on the basis of much more information than was available to the Committee. Everyone was concerned about unnecessary expenditure and the requirement that, where possible, monies should be spent where needed rather than on the administration of the need. However, it was difficult to know what conclusion to draw in the absence of all the facts, and perhaps more time should be allowed for reflection and for more details to be provided before any irrevocable conclusions were reached.

Dr SEBINA (Botswana) asked whether the proposed reduction of $ 750 000 would affect repairs to the roofs of villas, the extension of the conference hall and the relocation of the computers, which the United States delegate had already approved.

Mr BOYER (United States of America) explained that the total amount proposed by the Executive Board for appropriation for the Regional Office for Africa was $ 943 000. His figure of $ 750 000 applied only to the extension of the office complex. The other two projects would be funded from the monies that would be made available. He was not attempting to restrict space but was not satisfied with the request for the entire $ 750 000 to be spent on 30 new offices. He did not necessarily think that the only conclusion was all or nothing as the Assistant Director-General had stated. Rather, the Committee should try and develop some intermediate position whereby some of the problems of the African Region could be solved without the entire amount having to be provided. Such a position might be reached if the agenda item could be concluded at a later stage.
Dr BARKER (New Zealand) asked whether the provision of one office for each professional staff member and one office for two other staff members was the result of a negotiated agreement with the staff or whether it was simply the practice in the Organization. If it were the former, the Organization might be under an obligation to honour the agreement, but if it were the latter, the Organization might have a choice.

Mr FURTH (Assistant Director-General) replied that the mentioned office allocation formula had not been the subject of a negotiated agreement with the staff, but was considered to be good practice. Moreover, it did not seem to be unreasonable to headquarters, where on the average one office per professional staff member and one office for every two general service staff was also the accepted practice.

Dr BARKER (New Zealand) said that in that case he did not understand why there was any objection to accepting a very reasonable proposal.

The CHAIRMAN proposed that, in the light of the views expressed, the Committee should postpone its debate on the matter until the following day.

It was so agreed. (For continuation, see summary record of the third meeting, section 2.)

The meeting rose at 17h20.
THIRD MEETING

Thursday, 10 May 1984, at 14h30

Chairman: Dr N. ROSDAHL (Denmark)

1. TRANSFER OF THE REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN: Item 30 of the Agenda (Document WHA36/1983/REC/1, resolution WHA36.18 and Annex 4)

Mr VIGNES (Legal Counsel), introducing the item, said that during the past year the Director-General had, as requested in resolution WHA36.18, continued to implement resolution WHA35.13. A significant development in that respect had been the holding, from 17 to 20 October 1983, of the first regional meeting for four years. The Regional Director had reported to the Executive Board on that meeting, which had been widely attended by Member States of the Region and had reviewed the progress made in strengthening cooperation among them and promoting the exchanges that had been jeopardized as a result of the prevailing situation. The Director-General had, in addition, continued his efforts to ensure the smooth operation of the Region's technical, administrative and managerial programmes. The Special Programme for the Eastern Mediterranean and its extension had been a significant factor in enabling the Regional Office to continue its work. The Director-General considered that those temporary measures, together with the October meeting, marked a considerable advance towards a return to normal in the Region. The Director-General was fully conscious of his responsibilities in the matter and wished to assure the Committee that he would, in close cooperation with the Regional Director, continue to make every effort to ensure that health activities in the Region were carried out as effectively as possible for the benefit of its peoples.

The CHAIRMAN called attention to the draft resolution submitted by the delegations of Bahrain, Iraq, Jordan, Kuwait, Lebanon, Saudi Arabia, Syrian Arab Republic and United Arab Emirates, which read as follows:

The Thirty-seventh World Health Assembly,
Having considered resolutions WHA35.13 and WHA36.18, other resolutions on this subject and the report of the Director-General;

1. THANKS the Director-General for his report;
2. REQUESTS the Director-General to continue the implementation of resolution WHA35.13.

The draft resolution was approved.¹

2. REAL ESTATE FUND AND HEADQUARTERS ACCOMMODATION: Item 28 of the Agenda (Document EB73/1984/REC/1, resolution EB73.R5 and Annex 2) (continued from the second meeting, section 6)

The CHAIRMAN recalled that discussion of the item had been adjourned at the previous meeting of the Committee to allow time for consultations. Those had now been completed and the floor was again open for further discussion of the matter.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that the request for additional offices had undoubtedly been examined very carefully by the Director-General. His delegation was well aware of the difficulties of controlling temperature and humidity in

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA37.20.
accommodation containing sophisticated electronic equipment such as computers even in a relatively temperate climate such as that of the United Kingdom. Such problems would be even more acute in a hot climate and the cost of the proposed extension seemed reasonable. The resolution proposed by the Executive Board should therefore be approved as it stood.

Mr BOYER (United States of America) agreed with the previous speaker on the need to protect the computer facilities at the Regional Office for Africa. However, since the expenditure of US$ 750 000 proposed was intended to cover the construction of office space in excess of that required to rehouse the data processing facilities, he continued to consider the full amount unjustified. He wished to be reasonable, however, and proposed that the resolution should be amended to permit the Regional Office for Africa to extend its offices, to provide primarily for computer facilities and the relocation of data-processing staff, up to an expenditure ceiling of US$ 400 000.

Mr LO (Senegal) said that, although the problem under discussion was being treated as one of computer facilities, what was in fact being questioned was the value of projects originated by the Regional Office. Although the Senegalese delegation did not always share the views of the United States delegation, it had always appreciated the clarity, objectivity, boldness and relevance with which they were presented. However, on the present occasion he found the United States position difficult to understand. Plans of action had laid down new policies that required a minimum of expenditure to provide the Regional Office with appropriate structures, bearing in mind the special difficulties it had to contend with in its work - not the least of which was the problem of intercountry communications - and in its efforts to achieve efficient and effective monitoring. The proposal that had been made amounted to the cancellation of programmes that had already been drawn up and were regarded by the Secretariat and the Executive Board as useful, since, as Mr Furth had pointed out at the previous meeting, it would be difficult to implement only certain parts of them. The African Region was not the only region with building projects, but it appeared to be the only one to come under fire, presumably because of the errors of management made in the past. He was opposed to any reduction in the scope of the project, based as it was on properly conducted studies of the relevant facts.

Dr DLAMINI (Swaziland) said that, while the question of the need for space for computer accommodation appeared to have been settled, that of extra office space for staff was still in dispute. He felt, as he had said the previous day, that the issue was one that involved staff morale. If professional category staff elsewhere in the Organization were expected to have individual offices, then asking them to share offices in the Regional Office for Africa appeared to imply that a double standard was in operation. He shared the view of the United Kingdom delegate that the project should be allowed to go forward and proposed that the resolution should be accompanied by a request to the Director-General to keep a close eye on the project.

Dr SEBINA (Botswana) said that, as he understood it, the only point remaining in dispute in the building project for the Regional Office for Africa was the construction of the 17 offices needed to solve the problem of staff overcrowding. Under the circumstances, he felt that it was unreasonable to impose a ceiling of US$ 400 000 on construction costs. He shared the view of those speakers who considered that standards of office space should be uniform throughout the Organization, and supported acceptance of the full project as proposed.

Dr NSUE MILANG (Equatorial Guinea) shared the views expressed by the delegates of Swaziland and Botswana and supported approval of the resolution as it stood.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) suggested that the United States delegation might like to reconsider its proposal in the light of the suggestion by the delegate of Swaziland that the project should be allowed to go forward but that the Director-General should be asked to monitor it very closely and satisfy himself that adequate standards and proper financial control were being applied.

Dr CHETTY (Seychelles) expressed his support, for the reasons given by previous speakers, for approval of the resolution as it stood.

Mr BOYER (United States of America) agreed fully with the delegate of Senegal that there was a need to strengthen the managerial aspects of health programmes and activities in Africa. The United States delegation's particular concern was that money was perhaps being spent in the wrong place. For example, the sum indicated in the External Auditor's report as
being expended on a private elevator and on chartering aircraft amounted to more than 40% of the annual country allocation for the Congo, the country in which the Regional Office was located. Would the money not have been better spent on health projects in the Congo? In the present instance it was difficult to see why additional offices were needed at the Regional Office at a time of planned zero programme growth. The way funds had been applied had already been discussed in the Committee; it would seem that the apparent mismanagement and spending of the past was not to be remedied by the allocation of close to US$ 1 million for real estate activity. Some of that activity might be necessary — he did not dispute the fact that if roofs were in disrepair they should be mended — but he did question the priority of all the proposed expenditure. The cut of US$ 350 000 in office extension expenditure that his delegation proposed (less than half of the proposed total) would still leave the Regional Office for Africa in receipt of the largest amount of money provided under the proposed appropriations from the Real Estate Fund. That did not seem to indicate that a double standard was in operation. He could not accept the total appropriation proposed. In view of the statements made by other speakers he would not press its amendment but would instead call for a vote on the resolution with the intention of voting against it.

Dr QUENUM (Regional Director for Africa) said that for almost 20 years he had been responsible for one of the Organization's largest regional offices, where problems were particularly acute. In 1965 the facilities available to it had been almost nil, and he and his staff had devotedly built it up into what it was at the present time. Mistakes had, of course, been made in such a complex managerial task, but WHO staff could not do as they liked and had to abide by the rules. The Regional Director had to accept his responsibilities. He should not be a mere puppet impassively watching over the decline of his Office at a time when remedial action was called for.

Mention had been made of a private lift, whereas the reference should have been to a supplementary lift for the Regional Office. The chartering of aircraft was a long-standing practice where certain missions had to be undertaken in well-defined circumstances. With the progressive deterioration in communications, resort to it had become more frequent. The auditors had now drawn attention to the situation. Those two matters might be termed "mismanagement", but only those who did nothing made no mistakes.

The United States delegate might be unwilling to pardon the Regional Director for his mistakes, but there was no reason to punish the rest of the Regional Office staff, who were working and living in the conditions described. Detailed questions had been asked, and full information had been given by Mr Furtth. Moreover, after making a thorough study of the situation the Executive Board had seen fit to submit to the Health Assembly a draft resolution incorporating a precise and well-considered figure. The costs incurred in respect of the new lift and the chartering of aircraft had nothing to do with any health programmes that might have been carried out in the Congo with the funds concerned, since that country had its own budgetary allocations. He hoped that, after such a personal affront, there would be no more confusion and that the sacrifices which he had made in his work for WHO, including that of his own health, would not be overlooked.

Mr LO (Senegal) said that the United States delegate had adduced no purely objective arguments to challenge the architectural and technical validity of the studies which had been made by the Secretariat and confirmed by the Executive Board. Moreover, it was difficult to see how the kind of proposals made in respect of the Regional Office for Africa differed in essence from those made for the Regional Office for Europe and the Regional Office for the Western Pacific. He therefore hoped that the United States delegate would show a greater understanding of the problem and accept the solution suggested by the United Kingdom delegate.

Dr OULD HACEN (Mauritania) said that the consideration of management problems and of the External Auditor's report should be kept separate from that of the objective requirements of the regional offices, which should be judged on their own merits. His country, which had received consistent support from the Regional Office for Africa, would consider it highly regrettable if that Office did not have the full range of facilities that it needed in order to continue and strengthen its activities to promote the health of the peoples of the Region. Measures to rectify any mistakes detected should be taken independently. In any case it was quite understandable that the Regional Office responsible for the largest number of least developed countries in health and other fields should receive more, or at least the same, support as regional offices representing the most advanced countries enjoying the best health conditions in the world.
Dr TAPA (Tonga) attached the highest priority to the welfare of WHO staff, wherever they might be. Since the expenditure being discussed was intended primarily to promote the welfare of WHO staff at the Regional Office for Africa, he supported the draft resolution recommended. In doing so, however, he had the greatest respect for the United States delegate's concern regarding the justification for the expenditure.

The draft resolution in resolution EB73.R5 was approved by 77 votes to one, with 12 abstentions.¹

3. FIRST REPORT OF COMMITTEE B

Mr FURTH (Assistant Director-General), referring to the situation with regard to Members in arrears in the payment of their contributions, informed the Committee that on 9 May 1984, after the consideration of agenda item 24.3 had been concluded, the Secretariat had received a telex message from the Federal Reserve Bank of New York advising it that the Government of Comoros had paid the sum of US$ 20 694 into the WHO account. Consequently, that country still owed part of its contribution for 1981 as well as the full contributions for 1982 and 1983; it thus remained one of the Members in arrears in the payment of their contributions to an extent which might invoke Article 7 of the Constitution.

In addition, the Director-General had been informed by the PAHO/WHO Representative in Nicaragua that a cheque for US$ 44 900 had been delivered to him on 8 May 1984 by the Ministry of Health of that country in respect of contributions due to WHO. Thus Nicaragua was no longer one of the Members in arrears in the payment of its contributions to an extent which might invoke Article 7 of the Constitution.

The CHAIRMAN suggested that, in view of the information just given by Mr Furth, the references to Nicaragua should be deleted from the draft resolution on page 5 of the Committee's draft first report.

It was so agreed.

Dr DA COSTA (Indonesia), Rapporteur, read out the draft first report of Committee B.

The report was adopted subject to deletion of the reference to Nicaragua from the draft resolution (see document WHA37/1984/REC/2).

4. RESTRUCTURING THE TECHNICAL DISCUSSIONS: Item 32 of the Agenda (Document EB73/1984/REC/1, resolution EB73.R7 and Annex 3)

Dr MAKUTO (representative of the Executive Board), introducing the item, said that, in response to a request by the Executive Board in January 1983, the Director-General had submitted to the Board at its seventy-third session an analysis of the role of the Technical Discussions at the Health Assembly, with additional reference to participation, periodicity and duration, and organization, scheduling and method of work. The text of the Director-General's report was reproduced in Annex 3 to document EB73/1984/REC/1.

Having concluded that the Technical Discussions at the Health Assembly served a useful purpose and should be continued, the Board had discussed at some length the question of their periodicity. Although some members had felt that the Technical Discussions should be held biennially - in even-numbered years, when there was no proposed programme budget to consider - a majority had been in favour of holding them annually, as in the past. The Board had therefore agreed to recommended that the Technical Discussions should be continued and held annually. It had also been the consensus of the Board that future Technical Discussions should be devoted to subjects crucial to the attainment of health for all by the year 2000. Finally, the Board had agreed that the duration of the Technical Discussions should continue to be one-and-a-half days and that the Secretariat should, in future years, experiment with alternative arrangements for the organization, scheduling and methods of work of the Discussions on the lines suggested in the Director-General's report.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA37.19.
The Board's recommendations to the Health Assembly were before the Committee in resolution EB73.R7.

Dr REID (United Kingdom of Great Britain and Northern Ireland) recalled that the issue under discussion had first arisen in January 1982, when the Executive Board had established its Working Group on the Method of Work at the Health Assembly, with particular regard to the programme budget review and restructuring of the general discussions in the plenary. The Working Group had reported to the Board in January 1983, when various recommendations had been approved. Those recommendations had included the limitation of the duration of the Health Assembly to two weeks in even-numbered (non-budget-review) years. In odd-numbered (budget-review) years, the Health Assembly was to be limited to "as near to two weeks as is consistent with the efficient and effective conduct of business". The Working Group had also reached a consensus that Technical Discussions should be held only in even-numbered years, when there was not a programme budget to consider, thereby enabling the Health Assembly to complete its work in two weeks in budget-review years as well as in non-budget-review years. The Board had not transmitted that recommendation to the Health Assembly, but had requested the Director-General to prepare a comprehensive report on restructuring of the Technical Discussions. That report had been considered by the Board at its seventy-third session and its findings and recommendations were before the Committee in resolution EB73.R7.

He supported the Board's recommendations that the Technical Discussions should be continued, that their duration should continue to be one-and-a-half days and that they should be relevant to the Organization's overall theme of health for all by the year 2000. He also agreed with the proposed request to the Director-General to experiment with various alternative methods of conducting the Technical Discussions, since evolution was an essential component of any living organism or organization. All delegations would undoubtedly look forward to evaluating the experimental modifications in future Technical Discussions.

With respect to periodicity, his delegation was anxious to secure three objectives: firstly, that the Technical Discussions should be well prepared and should have sufficient time devoted to them; secondly, that there should be no conflict between the Technical Discussions and the devotion of adequate attention, particularly in budget-review years, to the many matters before the Health Assembly, of which the Technical Discussions were not an integral part; and, thirdly, that costs and benefits should be carefully balanced to ensure that the best possible use was made of what would always be a limited budget. He would therefore welcome further information on the financial implications of maintaining the Technical Discussions in budget-review years, when it was essential for adequate time to be devoted to a full debate on, and analysis of, the programme budget. Retention of the Technical Discussions in those years appeared liable to extend the Health Assembly to a third week. The Committee should consider the financial implications carefully before coming to any conclusion on periodicity. It would be helpful if the information could be provided at the current stage in the Committee's discussion rather than at its conclusion, since the financial facts would help to illuminate the debate on periodicity. The representative of the Executive Board had referred to the fact that the Board had debated the matter at some length, and there had clearly been two differing points of view on the issue.

Mr FURTH (Assistant Director-General) explained that the cost of the Technical Discussions formed an integral part of the cost of the Health Assembly, since the Conference Hall and offices required for the Technical Discussions were rented from the United Nations in any case, in connection with the Health Assembly. Additional costs for interpreters, the General Chairman and possibly one or two consultants amounted only to some US$ 9000 to $ 10 000 a year. There was occasionally an additional cost for the representation of a regional office, but that was not large. However, if the cost of the Technical Discussions was related to the length of the Health Assembly, the picture might be somewhat different. If it was considered that a decision not to hold Technical Discussions would shorten the Health Assembly by a day or a day-and-a-half, there might be a saving of some $ 50 000 to $ 80 000.

Mrs GARCÍA LORENZO (Cuba) welcomed the Director-General's report on restructuring the Technical Discussions. There was no need to dwell on their value and importance; in the past they had provided an opportunity for a detailed analysis of health matters of considerable international importance, and they were of greater significance at the present time in view of their possible contribution to the strategies for health for all. Given that background, it was highly desirable that the Technical Discussions should be held annually and for a duration of one-and-a-half days. The Director-General's report had stressed the supportive role of the Technical Discussions in tackling problems essential to the success or failure of the implementation of the strategies of health for all. Member States should therefore appoint delegates who were particularly well qualified to participate in them.
Other innovative elements might also be taken into account with a view to improving the quality of the debates and enhancing their positive effects. In that connection, the Secretariat should be allowed to try out methods of work which would permit subsequent evaluation, preferably in 1987, of the implementation and effectiveness of those ideas.

The Cuban delegation consequently supported the draft resolution recommended by the Executive Board for adoption by the Health Assembly and would propose that a sentence be added at the end of operative paragraph 2 to the effect that a report on the matter should be submitted to the Health Assembly in 1987.

Dr Reid (United Kingdom of Great Britain and Northern Ireland), in response to the statement by the Assistant Director-General, said that while he acknowledged the value of the Technical Discussions, he believed that there would be considerable merit in limiting their periodicity to non-budget-review years, in view of the substantial savings of time and money which would be made in budget-review years and the extra time which delegates would have to digest and apply the results of the Discussions themselves. If other delegates concurred with that belief, the question of whether or not the draft resolution required modification could be considered in due course.

Dr Quamina (Trinidad and Tobago) said that the Executive Board had been aware of the problem faced by small delegations from countries whose funds to send delegates long distances were limited. To include in such delegations an additional person with particular expertise in the subject matter of the Technical Discussions was extremely difficult. Her own country, for example, was obliged to send generalists who could cope with all items on the agenda of the Health Assembly. Furthermore, when Technical Discussions were held each year, the relevant documents were received one month or less prior to the Health Assembly, which allowed little opportunity to discuss the subject matter at the national level and prepare a national viewpoint taking into account all the available expertise. As many other delegations were undoubtedly in the same position, the Committee might wish to consider that problem further. For her part, she considered that the position of the small countries would be eased if the Technical Discussions were held every other year; she therefore supported the idea of holding biennial Technical Discussions, an idea which would have the additional merit of limiting the expenditure incurred by World Health Assemblies.

Dr Cabral (Mozambique) said that having read the Director-General's report and carefully analysed the draft resolution submitted by the Executive Board, he felt that the Technical Discussions should continue to be held annually. He could not in fact conceive of Health Assemblies without some form of discussion on technical issues. As a specialized agency of the United Nations, WHO had a mandate which included the coordination and stimulation of technical matters within the field of health. However, the agendas of the Health Assemblies of recent years appeared to show a reduction in the number of discussions on technical issues. If that trend were to continue, and if Technical Discussions were held only every other year, Health Assemblies would be limited to the examination of administrative and budgetary questions: a state of affairs which had been one of the reasons why the Technical Discussions had been introduced in the early 1950s. The usefulness and relevance of the issues discussed were undoubtedly open to criticism, and greater care could certainly be taken in the choice of subjects in order to attract greater interest than had been shown in recent years. He therefore fully agreed with the Director-General's suggestions contained in paragraphs 13-16 and 39-42 of his report, and supported the draft resolution recommended by the Executive Board for adoption by the Health Assembly.

Dr Mafiamba (Cameroon) agreed that Technical Discussions should be held biennially, in even-numbered (non-budget-review) years. The Technical Discussions and the resulting technical publications were an important source of information and instruction for national health administrations. However, experience had shown that some Discussions were rushed, and that the smaller and lesser-known delegations had little chance of making a fair contribution to the debates. Furthermore, the working documents were received too late to enable satisfactory intersectoral information to be collected as a useful contribution, and countries with budgetary constraints or experiencing difficult economic situations could not afford to send an extra delegate to Geneva each year just for the Technical Discussions.

Dr Galahov (Union of Soviet Socialist Republics) said that Technical Discussions were of undisputed importance; he quoted approvingly the statement to that effect in the second preambular paragraph of the draft resolution submitted by the Executive Board. The contribution of health programmes to socioeconomic development; national policies and practices in regard to medicinal products, and related international problems; and technical cooperation in the field of health among developing countries were among the subjects
discussed in the past which had had a direct bearing on corrective measures with regard to WHO's action or on the concretization or clarification of the Organization's objectives. Technical Discussions, through the examination of important issues, could contribute substantially to the attainment of health for all by the year 2000.

He consequently shared Dr Cabral's concern that the number of technical items on the agenda of the Health Assembly was tending to decrease, and pointed out, in response to Dr Reid's remarks, that experience at the Thirty-sixth World Health Assembly had shown that the holding of Technical Discussions in no way jeopardized the timely completion of the Health Assembly's work, even in a budget-review year, or conflicted with the provisions of resolution WHA36.16; nor could it be claimed that they entailed substantial additional expenditure, since the Secretariat had made it clear that they involved only an additional US$ 10 000 and that it remained to be proved that significant savings could indeed be effected by doing away with them. He would further submit that the argument of inadequate preparation was unsubstantiated, as there had been no criticism in that sense on the part of the Organization or of individual countries since the initiation of Technical Discussions in 1951.

On the question of participation by technical experts, he suggested that while such participation might be desirable, it was by no means mandatory; those present at the Health Assembly surely had sufficient breadth of knowledge to permit them to contribute positively to discussions on all items of the agenda; to involve them in an additional Technical Discussion would not, he believed, impose an undue burden on their capacities.

In conclusion, he fully supported the draft resolution submitted by the Executive Board.

Mr VOIGTLANDER (Federal Republic of Germany) said that, for the reasons advanced by the United Kingdom delegate, he favoured the holding of biennial Technical Discussions. A parallel development could already be observed between general debate, with its focus on the health-for-all strategy, and discussions on the same topic in Committee A. Biennial Technical Discussions dealing with specific aspects of the strategy for health for all would make it easier to establish a certain distance from the Health Assembly agenda items and avoid the risk of duplication.

Dr MORKAS (Iraq) said that Technical Discussions in the past had included many topics vital to the implementation of the strategy for health for all and the reports which were distributed to interested parties in Member States had certainly facilitated the implementation of related recommendations. He consequently hoped that Technical Discussions would continue in the same way as before. The expenditure which they entailed was of small account in comparison with the benefits derived from them by the participants in their efforts to promote better standards of health in their countries.

Mr CHAUHAN (India) said that, while it was clear that there was general support for the Technical Discussions, the fact that periodicity and financial implications appeared to be the main subjects of the present discussion implied a tendency to consider them in isolation from the proceedings of the Health Assembly as a whole. As the Executive Board had already emphasized, it was important that Technical Discussions should be directly relevant to the work of the Organization and to country programmes; their significance in that connection should never be lost from sight. For example, Technical Discussions on the role of universities in the strategies for health for all, including national development and their contribution to primary health care, which would take place during the current session, would obviously be most relevant at a time when so much was being said and written about primary health care. The role of universities was indeed considerable; in many developing countries, medical schools were still following the old form of cure-oriented, hospital-based medical education, and attitudes must be changed if the primary health care approach was to be implemented. Relevancy of that sort was an indication that Technical Discussions should be held during the Health Assembly.

Concerning the problems of countries with small delegations, which did not have enough technical experts available, his own opinion was that, as Technical Discussions were directly related to the work of the Health Assembly, the participation of a more representative cross-section of technical experts, health administrators and other health workers could well lead to a positive exchange of views on important issues and the identification of solutions to the problems. Such a cross-section could, he submitted, be found in the delegation attending the Health Assembly.

Taking an overall view of the matter, he fully supported the draft resolution recommended by the Executive Board.

Dr SEBINA (Botswana) acknowledged the considerable importance and usefulness of Technical Discussions. But discussion of the budget was equally important, and he believed
that the holding of Technical Discussions concurrently with discussions on the budget would inevitably involve a compromise on the amount of time and energy spent on the latter. The suggestion that Technical Discussions be held biennially, in non-budget-review years, naturally stemmed from that consideration. Such a two-yearly arrangement need not, moreover, detract from their significance. Attendance at the Technical Discussions was, of course, important but should not lead to decreased participation in plenary and Committee meetings of the Health Assembly, especially on the part of small delegations.

In the light of those remarks, he would support the draft resolution submitted by the Executive Board, with the exception of the recommendation that the Technical Discussions be held annually; his own preference was for a biennial arrangement, with Discussions in non-budget-review years.

Mr LO (Senegal) said that, as the year 2000 drew closer, no opportunity should be lost to gain more knowledge and experience for the attainment of the objectives of health for all. It had been shown in recent years that improved organization could make it possible to complete the work of the Health Assembly more expeditiously, and thereby reduce its duration. It was not evident that substantial savings could be made by holding Technical Discussions less frequently, especially when account was taken of the benefits - in terms of knowledge - to be derived from them. He consequently believed that although further efforts might be made to improve working methods, the Discussions should be continued on an annual basis, and he supported the draft resolution recommended by the Executive Board.

Dr GURMUHK SINGH (Malaysia) said that, after considering the arguments concerning the periodicity and duration of Technical Discussions and the savings which might be effected in that connection, he was not convinced that such savings would weigh substantially against the overall cost of attending the Health Assembly. He supported the view that Technical Discussions should not adversely affect the debate on the budget - which was the main task of the Health Assembly in budget-review years - but did not believe that considerations of shortening the period of the Health Assembly in budget-review years should become a major issue. Endorsing the recommendation that Technical Discussions should focus on issues that were crucial to the problems of health for all by the year 2000, he suggested that the themes chosen should sensitize public opinion in areas that were or might become difficult and require detailed technical discussion. He further supported the recommendation, clearly expressed by the Executive Board after extensive deliberation, that Technical Discussions should be held annually, and the recommendation that the Director-General should in future years try out experimentally alternative arrangements for the organization, scheduling and methods of work of the Technical Discussions.

Mr BOBAREVIĆ (Yugoslavia) said that his delegation, which favoured the continuation of annual Technical Discussions on subjects crucial to the attainment of health for all by the year 2000, fully supported the draft resolution recommended by the Executive Board.

The meeting rose at 17h20.
FOURTH MEETING
Monday, 14 May 1984, at 9h00

Chairman: Dr B. P. KEAN (Australia)
Later: Dr N. ROSDAHL (Denmark)

1. RESTRUCTURING OF THE TECHNICAL DISCUSSIONS: Item 32 of the Agenda (Document EB73/1984/REC/1, resolution EB73.R7 and Annex 3) (continued)

Mrs WOLF (German Democratic Republic) noted that most speakers agreed on the important role the Technical Discussions played in extending knowledge and technical information. Her delegation considered that they should be held annually, should last one-and-a-half days, and should be devoted to subjects crucial to the attainment of health for all by the year 2000. It seemed reasonable that the Director-General, in his invitation to Member States to attend the Health Assembly, should draw attention to the types of participant who should attend the Technical Discussions, and that Member States should give careful consideration to the designation of individuals particularly fitted to participate in them.

Mr DE BURGER (Canada) informed the Committee that PAHO had carried out a review similar to that in which the Committee was now engaged, and that the Directing Council of PAHO at its XXIX meeting (thirty-fifth session of the Regional Committee for the Americas, 1983) had adopted a resolution discontinuing Technical Discussions in programme budget years. His delegation was convinced that the situation now being discussed by the Committee paralleled that in the Americas, and it thus supported the view that Technical Discussions should take place in non-programme-budget years only.

If the Health Assembly decided that Technical Discussions should continue to be held annually, it was advisable that the subjects should be communicated to Member States two years in advance and that all relevant material should be sent to Member States at least one year in advance to ensure that sufficient time was available for the necessary preparations at the national level.

Dr CABRAL (Mozambique) said that time spent on Technical Discussions did not seriously impede consideration of the programme budget where the main problem was not so much the time spent as the relevance of the debates to the budget itself. If Technical Discussions were held biennially, interest in the Health Assembly might be diminished; it might also indirectly lead to the holding of biennial Health Assemblies, and reduce the Health Assembly's role in supervising the Organization's affairs.

Dr REID (United Kingdom of Great Britain and Northern Ireland) recalled that at the previous meeting he had supported the draft resolution recommended by the Executive Board, while reserving his position on the question of periodicity. Since then, Technical Discussions had been held, leaving certain fresh impressions.

He did not wish to press the question of costs too far, since it was clear that the Technical Discussions were widely appreciated among all delegations and that the costs involved, as quoted by the Secretariat, were not too high, even allowing for the additional costs that might be incurred if in a budget year they extended the duration of the Health Assembly; however, he suggested that the total cost of the Technical Discussions was of the order of US$ 100,000. Nevertheless, if an event was of great value, cost should not be the sole determining factor.

Several speakers had seemed to imply that, if there were no Technical Discussions, the Health Assembly would not discuss technical matters at all. That was not so, particularly in budget years, when the major part of the debate was centred on technical health matters.
The preparations for the Technical Discussions were, of course, extremely time-consuming for both the Secretariat and Member States. In his country, for instance, the amount of work involved in preparing concurrently for a Health Assembly and for the accompanying Technical Discussions was very considerable.

In any case Technical Discussions should not be looked upon as an end in themselves. The important issue arising from the Technical Discussions that had just been held was the action which Member States would take at the national level to follow up the matters dealt with. For many countries, including his own, a substantial effort would be needed in that respect. To make that effort and, at the same time, to start preparing for the following year’s Technical Discussions was a demanding process, particularly since preparations also had to be made for the regional Technical Discussions. Consequently, in budget years the Health Assembly should concentrate its attention on the many technical items in the programme budget. In his country the preparations for the debate on the programme budget imposed an extremely heavy burden on the administrative machinery.

Thus, while he would certainly not favour biennial Health Assemblies, he would like to see the Technical Discussions held in years when the programme budget was not discussed. He therefore proposed that operative paragraph 1(1) of the draft resolution recommended in resolution EB73.R7 should be amended to read:

"(1) that the Technical Discussions shall be continued and that they shall be held in even (non-budget) years;".

Dr QUAMINA (Trinidad and Tobago) supported that amendment.

Dr GALAHOV (Union of Soviet Socialist Republics) said that it was clear from Annex 3 of document EB73/1984/REC/1 that there was unanimous agreement on the significance and value of Technical Discussions and that disagreement arose over their periodicity. The arguments of those delegations speaking against the holding of annual Technical Discussions had failed to convince him. Mr Furth, Assistant Director-General, had stated at the Committee’s third meeting that the additional cost of services would be only some US$ 10 000.

The figures for technical subjects discussed at even- and odd-numbered sessions of the Health Assembly were as follows: there had been 13 such items in Committee A at the Thirty-second World Health Assembly and only six at the Thirty-sixth; 14 at the Thirty-third World Health Assembly and only five at the Thirty-seventh.

In relation to the difficulties experienced by countries in preparing for the Technical Discussions, it should be noted that, generally speaking, Technical Discussions had been successful in the past and given impulse and direction in the areas discussed, thereby suggesting that it was worthwhile for countries to make the effort of preparation.

The argument raised by the delegate of the United Kingdom that Technical Discussions gave rise to a great deal of work within countries should not be a source of concern; on the contrary, the fact that the Technical Discussions had been so successful that they called for changes to be brought about in countries confirmed their value.

His delegation supported the proposal of the Executive Board to continue to hold Technical Discussions annually.

Dr SEBINA (Botswana), recalling that the Executive Board vote on the issue had been very close - which doubtless indicated that the arguments for annual and biennial Technical Discussions were fairly evenly balanced - said that his delegation supported the amendment proposed by the delegate of the United Kingdom, and moved closure of the debate.

Mr CHRISTENSEN (Secretary) read out Rule 63 of the Rules of Procedure.

In the absence of any objection, the motion for closure of the debate was carried.

The CHAIRMAN invited the Committee to take a decision first on the amendment proposed by the delegate of the United Kingdom and then on the draft resolution as a whole.

The amendment was rejected by 31 votes to 30, with 11 abstentions.

In reply to a request for clarification from Dr GALAHOV (Union of Soviet Socialist Republics), Mr VIGNES (Legal Counsel) confirmed that, in the absence of any objection, the draft resolution might be approved without a vote.

The draft resolution recommended by the Executive Board in resolution EB73.R7 was approved.1

1 Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA37.21.
Dr LAW (Canada) reiterated her delegation's suggestion that the Director-General and Executive Board should consider the communicating of subjects of Technical Discussions two years in advance and the circulating of documents one year in advance.

Dr Rosdahl took the Chair.

2. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM: Item 33 of the Agenda

General matters: Item 33.1 of the Agenda (Document A37/14)

The CHAIRMAN recalled that at the beginning of the session the Health Assembly had considered a request from a delegation to add to the provisional agenda an item entitled: "Health aspects of chemical weapons and medical protection", but had not agreed to have it included in the agenda. The Secretariat had subsequently received a draft resolution on the subject, sponsored by the delegation of the Islamic Republic of Iran, to be taken up under that agenda item.

After very careful consideration and consultation he had reached the conclusion that the draft resolution, which referred to chemical weapons and the effects of their use, should be circulated in the usual way in accordance with the Rules of Procedure, since it was being submitted in relation to agenda item 33.1, under which was included a report by the Director-General which in one paragraph referred to certain actions of the United Nations with respect to the use of chemical weapons (document A37/14, paragraph 4.26). While being quite aware that there were differing views among delegations as to the receivability of such a draft resolution, considering the Health Assembly's earlier action on the proposed supplementary agenda item and, naturally, respecting the opinions of others, he had nevertheless come to the conclusion that, as Chairman of Committee B, he should not decide unilaterally that the draft resolution could not be circulated to delegations in accordance with the Rules of Procedure. It seemed to him not only procedurally correct but also - thinking of future Health Assemblies - advisable for the Committee as a whole to be given the opportunity to decide for itself how it wished to deal with the draft resolution in question. Such an approach was also in line with the democratic way of conducting business which had always prevailed at the Health Assembly.

In conclusion, he stressed that when the Health Assembly discussed the documents submitted, including the text of the proposed draft resolution, it would be very important that all speakers should bear in mind the need for their remarks to be relevant to the subject under discussion - that of collaboration within the United Nations system. As delegates would no doubt agree, Committee B must not be seen to have engaged, in a substantive sense, in a discussion on a subject which the Health Assembly had decided not to include in its agenda of the current session.

Mr LAWTON (Director, Division of Coordination), introducing document A37/14, said that the report by the Director-General on collaboration within the United Nations system focused on resolutions adopted in 1983 by the United Nations General Assembly and the Economic and Social Council which were relevant to WHO or might call for action by the Organization.

Section 2 of the report dealt with issues which had been considered by the Executive Board at its seventy-third session; he invited the Committee's attention to paragraphs 2.6 to 2.9 concerning WHO's continuing efforts in the fields of economic and technical cooperation among developing countries.

Section 3 described briefly resolutions and decisions adopted by the Economic and Social Council relating to such questions as aging; youth; the implementation of the Declaration on the Granting of Independence to Colonial Countries and Peoples by the specialized agencies and international institutions associated with the United Nations; support to the oppressed people of South Africa and their national liberation movement; assistance for the Palestinian people; strengthening the capacity of the United Nations system to respond to natural and other disasters; and progress and prospects in the implementation of the Mar del Plata Plan of Action and the International Drinking Water Supply and Sanitation Decade.

In section 4, the Director-General had drawn attention to a number of resolutions adopted by the General Assembly, including resolutions on cooperation between the United Nations and the Organization of the Islamic Conference, the Organization of African Unity and the League of Arab States, with all of which WHO enjoyed working relations. In its resolutions on the question of apartheid, racism and racial discrimination, the General Assembly had called inter alia for WHO's assistance and support. The General Assembly had also adopted a number of resolutions on the question of Palestine and assistance to the Palestinian people as well as on such issues as youth, aging, the World Programme of Action
concerning Disabled Persons, food problems, and international cooperation in the field of the environment.

The General Assembly continued to be concerned by the international struggle against the illegal production of drugs, illicit drug traffic and drug abuse as well as the international campaign against traffic in drugs. The question of protection against products harmful to health and the environment, on which the Director-General had reported to the Thirty-sixth World Health Assembly, had again been raised by the General Assembly, which had urged the competent United Nations organizations to continue to provide information for the consolidated list and to provide technical support to the developing countries in establishing or strengthening national systems for better use of the information on banned hazardous chemicals and unsafe products. WHO continued to cooperate in the implementation of that resolution.

In a series of resolutions, the General Assembly had requested the organizations of the United Nations system to take special measures for the social and economic development of Africa. In the 1980s, in favour of the least developed countries and of a number of other countries listed in paragraph 4.24 of the report.

The General Assembly had also adopted several resolutions on issues related to certain implications of warfare, including disarmament; those resolutions were listed in paragraphs 4.25-4.27. It would be noted from Annex I of the report that the General Assembly, in its resolution 38/188J, had taken note of and commended the WHO report on effects of nuclear war on health and health services. 1

With reference to World Health Assembly resolution WHA36.28 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 Director-General wished to invite attention to the establishment of the WHO management group on the follow-up on resolution WHA36.28 and to the future work of the group as set out in paragraph 4.28.

The report also mentioned the preparations for the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women, to take place in Nairobi in July 1985; the International Conference on Assistance to Refugees in Africa (ICARA II) to be held in Geneva in July 1984; the United Nations Conference for the Promotion of International Cooperation in the Peaceful Uses of Nuclear Energy to be held in 1986; and the International Year of Shelter for the Homeless in 1987.

In section 6, reference was made to the International Conference on Population, which would convene in Mexico City from 6 to 13 August 1986 and for which preparations were well in hand. The Conference was a follow-up to the World Conference on Population organized in Bucharest in 1974. Ten years after the Bucharest Conference, the close relationship between population, health and socioeconomic development was generally recognized, and national development plans usually took account of the population issue. A good climate prevailed concerning population policies and family planning as important aspects of health and development. The main objectives of the Conference were: to strengthen and sustain the momentum already generated in population activities; to identify emerging problems for concerted action; and to initiate programmes in areas where no significant impact had yet been achieved. The answer to providing appropriate family planning care to all couples who wished to avail themselves of it lay in the implementation of the Global Strategy for Health for All.

The health and quality-of-life aspects of population activities required to be emphasized in the recommendations of the Conference, as had already been the case in, for example, the Arusha Declaration of the African countries. It was therefore important that national delegations to the Conference should include experienced persons from the health administrations of each Member State. WHO had taken part in the preparatory work for the Conference, and would, of course, play its full role in the Conference itself.

In section 5, the Director-General had drawn attention to the question of operational activities for development and to General Assembly resolution 38/171 on the comprehensive policy review of operational activities for development. Members would recollect that a similar General Assembly resolution (37/226) had been brought to the attention of the Committee during the Thirty-sixth World Health Assembly. General Assembly resolution 38/171 was the fruit of considerable debate in the Economic and Social Council and in the Second Committee of the General Assembly. It had been adopted by consensus and constituted a comprehensive overview of aspects of operational activities of concern to all Member States. The Committee might therefore wish to consider the draft resolution proposed in section 8 of document A37/14 acknowledging the resolution and reaffirming the commitment of WHO's Member

---

States to the health-for-all strategies. If the resolution was adopted, it would be brought to the attention of the United Nations General Assembly when it next considered the question of operational activities.

In paragraph 4.18, the Director-General had drawn attention to the General Assembly resolution on the International Development Strategy for the Third United Nations Development Decade which contained provisions concerning health. The first overall review and appraisal of the implementation of the International Development Strategy was being carried out currently. WHO was participating in the process of review and appraisal and had submitted, as its contribution, the report on monitoring progress in implementing strategies for health for all prepared by the Executive Board and contained in document A37/4.1

In section 7, the Director-General had referred to the critical economic and social situation prevailing in Africa and to the Secretary-General's appeal for urgent and coordinated action to stave off disaster. In that connection, the Director-General, in close collaboration with the Regional Director for Africa, was taking the necessary measures in support of the countries to tackle the critical health conditions currently prevailing in the African continent.

Dr OULD HACEN (Mauritania) said that in paragraph 2.4 of the report, reference had been made to the people in the occupied Arab territories. He wished to emphasize that the correct reference should have been to the Palestinian people. His comment was one of form but the issue was important because if the term "Palestinian people" was not used, it might imply that the Palestinian people did not exist.

Mrs WOLF (German Democratic Republic) said that the areas of collaboration dealt with in the Director-General's report were highly relevant to the health sector. The issues involved were significant in terms not only of cooperation among States within one agency but in the United Nations system at large. WHO's contribution towards resolving those issues had been considerable and included, in particular, the work accomplished in laying bare the dangers implicit in a nuclear catastrophe from a health policy angle. The General Assembly, in its resolution 38/186J, had cited the report of the International Committee of Experts as an example of appropriate efforts undertaken by specialized agencies. The current international situation lent increasing urgency to the need for mobilizing intensified efforts by the world public to avert the threat of a nuclear catastrophe, for the findings of the International Committee of Experts had borne out with still greater clarity the devastating consequences which would attend any use of nuclear weapons. Her delegation considered that thought should be given to the publication of an abridged, popularized version of the report with a view to making it accessible to a wider public.

Her delegation welcomed the establishment by the Director-General of a WHO management group on the follow-up on resolution WHA36.28 which was clearly in keeping with the will of the World Health Assembly that the work undertaken should be continuously brought up to date. The planned work of the group includes studies on such fields as atmospheric chemistry and climatic changes during and after nuclear war in relation to the health of populations. In that connection it would be useful for WHO to cooperate with the World Meteorological Organization which had discussed the preparation of a similar study during its May 1983 Congress.

Dr QUAMINA (Trinidad and Tobago) thanked the Director-General for the informative report (document A37/14). She referred to paragraph 4.16 which dealt with the international campaign against traffic in drugs and to resolution EB73.R11 of the Executive Board which reiterated the acceptance by WHO of its legal responsibilities with respect to international conventions on narcotic and psychotropic substances. WHO had endorsed strategies to promote health and prevent illness; the abuse of drugs and alcohol was therefore of major concern. WHO responsibilities should be shown in active education programmes and thorough epidemiological research to identify factors contributing to the increased use of drugs and psychotropic substances, especially cocaine.

She said that Trinidad and Tobago wished to co-sponsor the draft resolution on the abuse of narcotic drugs. She emphasized the importance of activities concerned with the dissemination of information on and control of hazardous chemicals and unsafe pharmaceutical products, especially as regards making information and draft legislation available to developing countries. Lastly, she supported the draft resolution contained in section 8 of the report in document A37/14.

1 See document WHA37/1984/REC/1, Annex 3.
Mr BOYER (United States of America) referred to the draft resolution contained in section 8 of the report. The United Nations General Assembly had adopted resolution 38/171 by consensus and there were not likely to be any objections to it in the World Health Assembly, but he felt that care should be taken not to set a precedent for the Health Assembly systematically to endorse General Assembly resolutions. He warned of the danger of merely transmitting resolutions back and forth between the two bodies. He had no objection to this particular draft resolution but he saw no need for the Health Assembly to endorse all the many resolutions referred to in General Assembly resolution 38/171.

Mr ZAHIRNIA (Islamic Republic of Iran) referred to paragraph 4.26 of the report, which dealt with General Assembly resolution 38/187 on chemical and bacteriological (biological) weapons. He recalled the longstanding interest of WHO in this question, especially mentioning Health Assembly resolutions WHA20.54, WHA22.58 and WHA23.53, as well as the Executive Board resolution on the same subject. He noted efforts being made towards the elimination of chemical weapons and the advanced stage of discussion at the Disarmament Conference where a draft convention had been drawn up on the prohibition of chemical weapons, even though this convention would allow 10 years for the elimination of stockpiles and facilities from the date of its coming into force. He noted a 1970 WHO report on the health aspects of chemical weapons, although this report had not dealt with the medical aspects of the question.

He commended the Director-General's report, and noted the reference therein to the relevant resolutions of the General Assembly of the United Nations seeking to prohibit the use of such weapons.

The draft resolution in section 8 of document A37/14 was approved.¹

The meeting rose at 10h45.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA37.22.
FIFTH MEETING
Monday, 14 May 1984, at 14h30
Chairman: Dr N. ROSDAHL (Denmark)

COLLABORATION WITHIN THE UNITED NATIONS SYSTEM: Item 33 of the Agenda (continued)

General matters: Item 33.1 of the Agenda (Document A37/14) (continued)

The CHAIRMAN drew attention to a draft resolution entitled "Abuse of narcotic drugs", presented by the delegation of Colombia and co-sponsored by the delegations of Argentina, Bolivia, Chile, Costa Rica, Ecuador, Mexico, Panama, Peru, Spain and the United States of America, which read as follows:

The Thirty-seventh World Health Assembly,
Recalling resolution WHA33.27 on the abuse of narcotics adopted by the Thirty-third World Health Assembly in May 1980;
Recognizing the dramatic global increase in abuse of drugs, and particularly cocaine, all the more alarming in that the young are the chief victims of narcotics dependence;
Considering that the efforts made by the various countries to combat and prevent drug dependence have been insufficient and that WHO is the agency which, by virtue of its responsibility for the health of the population, has an important role to play in stimulating more effective national efforts;
Noting with satisfaction the development of the WHO global programme on drug dependence;

1. INVITES Member States to implement in its entirety resolution WHA33.27 of May 1980 and to combine their efforts in exploring new methods for prevention and treatment of drug dependence and improving information on this problem;

2. REQUESTS the Director-General:
(1) to seek extrabudgetary resources to permit WHO to strengthen epidemiological surveillance systems in this field;
(2) to continue his action in the spirit of resolution WHA33.27 and report to the Health Assembly on the progress achieved in this sector.

Professor OSPINA (Colombia) introduced the draft resolution on behalf of the co-sponsors, and pointed out that the delegation of Bolivia, a country which was gravely affected by the problem, had participated actively in the preparation of the text.
All those present at the Health Assembly were aware that narcotics dependence and drug addiction were increasing dramatically; as the Colombian Minister of Health had said in the plenary, the Colombian Government was doing its best to combat the traffic in drugs, which was organized on an international scale, and the Minister of Justice had recently been assassinated as a consequence of the measures taken to deal with the corrupt and degrading situation.
WHO's help was sought in stimulating efforts by Member States to explore new methods for the prevention and treatment of drug addiction and narcotics dependence. Colombia and Bolivia hoped that the text would be adopted by consensus.

Mrs LORENZ (Bolivia) said that increased production of cocaine, a dramatic increase in drug addiction, particularly among the young, with all the adverse consequences for health, and a pronounced expansion of the illicit trade in drugs were among the most important problems faced by the Bolivian Government. The cultivation of coca, its transformation into cocaine and the subsequent, highly profitable commercialization of the drug on an
international scale had produced an extremely complex social, political and health situation, especially in Bolivia but also in the other countries of the Andean Region. In the first place, an increasing number of farmers were turning to the cultivation of the coca leaf and its transformation; by neglecting the production of essential foodstuffs they were undermining the nutritional status of the entire population. Secondly, an increasing number of transporters and suppliers of foodstuffs and of middlemen in general were being caught up in the vast network of drug trafficking. All those activities, which were marginal when they were not illegal, had resulted in the creation of a parallel economy which challenged and distorted the official economy, disrupting the currency market, over-paying certain services, corrupting and subverting State officials, penetrating banking and other circles and drawing peasants, the unemployed and other deprived social groups into its orbit. The political and administrative mechanisms of the State itself had also been caught in the net, particularly during the dictatorial regime of General Luis Garcia Mesa in 1981-1982, but even earlier as well, under General Vances Suárez; it was by no means certain that the old associations had ceased to exist.

It was obvious that the situation required urgent measures, including the creation of a profitable agricultural alternative to the cultivation of coca and the dissemination of information on the dangers of cocaine consumption. The efforts of individual governments would clearly be inadequate; the problem was not confined to Bolivia, to the coca-producing countries or even to Latin America. It was worldwide in its effects, and the efforts of the international community were needed if it were to be handled properly.

Although the subject was perhaps not directly related to the business of Committee B it was nevertheless very closely connected with health in general, and that was why the Bolivian delegation supported the draft resolution presented by Colombia. In view of the urgency of the issue, she would suggest that the text be expanded by a third sub-paragraph to operative paragraph 2, to read as follows:

(3) to include this item in the agenda for the Thirty-ninth World Health Assembly in 1986.

Professor OSPINA (Colombia) agreed with the proposed amendment.

Mr BOYER (United States of America) accepted the proposed amendment on behalf of his delegation, which was a co-sponsor of the draft resolution, and proposed two further amendments. Firstly, since no mention had been made in the preambular paragraphs of the action taken by the Executive Board in January 1984 on a related topic, a reference should be included at the end of the first preambular paragraph, to read "as well as resolution EB73.R11 on the same subject;". Secondly, since both the Health Assembly and the Executive Board had taken action in the past on drug abuse, the title of the draft resolution should be amended to read "Abuse of narcotic and psychotropic substances", the words "and psychotropic substances" being added after "narcotics" in the first preambular paragraph.

Professor OSPINA (Colombia) agreed with the proposed amendments.

The draft resolution, as amended, was approved.¹

The CHAIRMAN drew attention to a draft resolution on chemical weapons submitted by the delegation of the Islamic Republic of Iran.

Dr SUFI (Somalia), rising to a point of order, said that the draft resolution concerned a subject which the Health Assembly had decided not to include in the agenda of its present session. He submitted that it was consequently not receivable, and called for an immediate vote on the matter.

Mr ZAHRNIA (Islamic Republic of Iran), rising to a point of order, said that the point of order raised by the delegate of Somalia failed to conform to Rule 58 of the Rules of Procedure of the World Health Assembly, which provided that a point of order could be raised during - not prior to - the discussion of any matter. His delegation's proposal was based on a series of Health Assembly and Executive Board resolutions (WHA20.54, WHA22.58, WHA23.53, EB39.R36 and EB45.R17) on the same subject. No delegate, therefore, could question the Organization's competence to deal with it.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA37.23.
His delegation had submitted a compromise, providing for a technical study on the medical aspects, and had sought to avoid any confrontation. It was prepared to enter into any discussion or negotiation with any other delegation concerned, and to delete any part of the draft resolution that might cause offence or that might be considered beyond the Organization's mandate. Delegations must uphold the Organization's Constitution. If they concurred with the proposal by the delegate of Somalia, they would be setting a dangerous precedent for WHO, which was required to work for the health of the international community. He hoped the draft resolution would be considered as a technical question. The wording of resolution WHA20.54 was stronger than his delegation's text. All concerned must consider the future of the international community and consult their conscience on the issue.

Mr VIGNES (Legal Counsel), outlining the legal situation, noted that the delegate of Somalia had expressed the view that the draft resolution before the Committee was not receivable. Since the Chairman had had the text circulated and submitted to the Committee, it appeared to have been the Chairman's ruling that the draft resolution was receivable. The delegate of the Islamic Republic of Iran had challenged the decision to put the Somali delegate's point of order to the vote. The Committee should decide, by a vote, whether to support the Chairman's ruling that the draft resolution should be circulated and thus considered receivable, or whether to consider the draft resolution not receivable, as recommended by the delegate of Somalia.

The CHAIRMAN invited the Committee to vote on his ruling that the draft resolution before it was receivable.

By 22 votes to 17, with 54 abstentions, the Committee decided not to uphold the ruling. The draft resolution was therefore declared not receivable.

Health assistance to refugees and displaced persons in Cyprus: Item 33.2 of the Agenda (Resolution WHA36.22; Document A37/15)

Dr GEZAIRY (Regional Director for the Eastern Mediterranean), introducing the item, said that, in pursuance of resolution WHA36.22, the Director-General had provided various forms of health assistance to refugees and displaced persons in Cyprus. During the last quarter of 1983, a joint Government/WHO review mission had taken place to discuss issues of health development in Cyprus, with particular reference to the achievement of the goals of the strategy for health for all. A WHO consultant had visited Cyprus to advise on intersectoral collaboration for the proper use of health services. A further consultant had visited the country in December 1983 to explore the possibility of establishing a central health sciences library. WHO had awarded 21 fellowships for training in maintenance and repair of medical equipment, intensive care paediatric nursing, theatre nursing, endoscopy, radiography, scoliosis surgery, toxicology, orthopaedics, sanitation in urban areas, health education, physiotherapy, psychiatric rehabilitation and thalassaemia prevention and treatment.

Supplies and equipment had been provided to strengthen health facilities, particularly those of the three main hospitals - in Limassol, Larnaca and Nicosia. WHO had contributed nearly US$ 0.5 million from the regular budget during the biennium 1982-1983. Further resources available for the WHO collaborative programmes in Cyprus included UNHCR support for the construction and equipment of the Larnaca General Hospital and funds from the World Bank, the Kuwait Fund for International Development and the European Investment Bank.

The CHAIRMAN drew attention to a draft resolution sponsored by the delegations of Algeria, Australia, Cuba, Czechoslovakia, France, German Democratic Republic, Ghana, Greece, Guyana, India, Mali, Malta, Mexico, Sri Lanka, Syrian Arab Republic, Tonga, United Republic of Tanzania, Yugoslavia and Zambia, which read as follows:

The Thirty-seventh World Health Assembly,
Mindful of the principle that the health of all peoples is fundamental to the attainment of peace and security;
Recalling resolutions WHA28.47, WHA29.44, WHA30.26, WHA31.25, WHA32.18, WHA33.22, WHA34.20, WHA35.18 and WHA36.22;
Noting all relevant United Nations General Assembly and Security Council resolutions on Cyprus;
Considering 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-eighth World Health Assembly on such assistance.

Mr FARRUGIA (Malta), introducing the draft resolution, said that his delegation had carefully studied the Director-General's report (document A37/15) concerning the continuation of the health assistance provided to Cyprus by the Office of the United Nations High Commissioner for Refugees and WHO, and had noted with satisfaction the measures taken by the Organization during the past year in its efforts to meet the health needs of the population of Cyprus in the current situation. It fully appreciated WHO's technical collaboration with UNHCR in providing equipment and supplies to strengthen health laboratories, to support disease control measures, to achieve the various health projects in Cyprus and to implement other important projects, as shown in the Director-General's report.

The sponsors were confident that the draft resolution would meet with the Committee's approval and would be approved unanimously.

Dr CASTELLÓN (Nicaragua) and Mrs LORENZ (Bolivia) supported the draft resolution.

Mr ZAHRNIA (Islamic Republic of Iran), rising to a point of order, said that his delegation, after the rejection by the General Committee of its proposal for a further item to be added to the Health Assembly's agenda, had subsequently tabled a draft resolution for discussion under existing agenda item 33.1. He submitted that those were two separate and unconnected proceedings. The Committee's earlier action in voting that discussion of the draft resolution submitted under agenda item 33.1 was not receivable had therefore, he contended, set a precedent which obliged the Committee to take a vote on the receivability of every draft resolution henceforth laid before it before proceeding with its discussion. If it did not wish to follow that procedure, the Committee would have to reverse its earlier decision.

The CHAIRMAN ruled as out of order the objection by the delegate of the Islamic Republic of Iran. The Committee's decision had been taken as a result of special circumstances relating to the decision taken earlier by the plenary not to include an additional item on the agenda.

Mr ZAHRNIA (Islamic Republic of Iran) appealed against that ruling.

By 81 votes to none, with two abstentions, the Committee decided to uphold the Chairman's ruling.

Mr APAKAN (Turkey) said that the policy of the Turkish Government on the Cyprus question was well known; he would, however, draw attention to certain points of relevance to the draft resolution before the Committee. The first was that the health assistance provided by WHO to Cyprus should be extended to both communities on the island, namely the Turkish Cypriot community and the Greek Cypriot community, on an equal footing. The second was that there were no refugees in Cyprus, only displaced persons from both communities. On that understanding, his delegation would join the consensus on the draft resolution on humanitarian grounds.

The draft resolution was approved.

Mr NICOLAIDES (Cyprus) thanked the Committee for its unanimous approval of the draft resolution. The refugees and displaced persons in Cyprus were still in need of help in various fields, and especially in the health field; the Director-General was consequently to be thanked and commended for his detailed report on the assistance provided jointly by UNHCR and WHO to those in need. That report, at the same time as it described the wider scope of the assistance provided, reflected the great interest shown by, and the intensive activity of, the Government of the Republic of Cyprus towards meeting the needs of refugees and

---

1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA37.24.
displaced persons on the island; the Government and people of Cyprus were grateful for the genuine and unfailing interest the Health Assembly continued to show in the tragic situation which, unfortunately, still persisted despite all the obvious and well-intentioned efforts being made.

The delegate of Malta was to be warmly thanked for once again introducing the resolution, as were the other co-sponsors, who had repeatedly shown their interest in and full support for the cause of the refugees and displaced persons in Cyprus. Thanks were also due to the Director-General, the Regional Director for the Eastern Mediterranean and their staffs for their excellent work. It was fervently hoped that they would spare no effort to continue and, indeed, to intensify health assistance to refugees and displaced persons in Cyprus in accordance with the resolution just approved. His delegation, which maintained that there were both refugees and displaced persons in Cyprus, assured the Committee that all the aid provided by WHO was being distributed by the Cyprus Government to all of those in need.

Health and medical assistance to Lebanon: Item 33.3 of the Agenda (Resolution WHA36.22; Document A37/15)

Dr. GEZAIRY (Regional Director for the Eastern Mediterranean), introducing the item, said that a health working group led by the WHO representative in Beirut had been established, within the Coordinating Committee composed of representatives of international organizations, to coordinate relief operations with governmental and nongovernmental organizations, providing assistance to more than 500,000 displaced persons in Lebanon. WHO had provided 20 emergency health kits, each kit providing pharmaceutical relief to 10,000 people for three months. Other supplies and equipment provided in response to specific urgent requests included intravenous fluids, tetanus immune globulins and toxoids, plasma expanders, disinfectants, baby milk, and medicaments to meet emergency needs. Eight fellowships had been awarded from March 1983 to April 1984 for training in mycology and parasitology, primary health care, public health information, water and food chemistry, microbiology, and supply and material management.

The CHAIRMAN drew attention to a draft resolution submitted by the delegations of Algeria, Bahrain, Iraq, Jordan, Kuwait, Lebanon, Saudi Arabia, Syrian Arab Republic and United Arab Emirates, which read as follows:

The Thirty-seventh World Health Assembly,
Recalling resolutions WHA29.40, WHA30.27, WHA31.26, WHA32.19, WHA33.23, WHA34.21, WHA35.19 and WHA36.32 on health and medical assistance to Lebanon;
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 1982-1983 and the first quarter of 1984;
Aware that the tragic situation that has arisen from the latest events requires urgent assistance and relief to the persons displaced from their homes and regions;
Noting the health and medical assistance provided by the Organization to Lebanon during 1983-1984;

1. EXPRESSES its appreciation to the Director-General for his continuous efforts to mobilize health and medical assistance for Lebanon;
2. EXPRESSES also its appreciation to all the international agencies, organs and bodies of the United Nations and to all governmental and nongovernmental organizations for their cooperation with WHO in this regard;
3. CONSIDERS that the growing health and medical problems in Lebanon, which have recently reached a critical level, constitute a source of great concern and necessitate thereby a continuation and a substantial expansion of programmes of health and medical assistance to Lebanon;
4. REQUESTS the Director-General to continue and to expand substantially the Organization's programmes of health, medical and relief assistance to Lebanon and to
allocate for this purpose, as far as possible, funds from the regular budget and other financial resources;

5. CALLS upon the specialized agencies, organs and bodies of the United Nations, and on all governmental and nongovernmental organizations, to intensify their cooperation with WHO in this field, and in particular to put into operation the recommendations of the report on the reconstruction of the health services of Lebanon;

6. CALLS also upon Member States to increase their technical and financial support for relief operations and the reconstruction of the health services of Lebanon in consultation with the Ministry of Health and Social Affairs in Lebanon;

7. REQUESTS the Director-General to report to the Thirty-eighth World Health Assembly on the implementation of this resolution.

Mr TAWFIQ (Kuwait) said that his delegation, one of those co-sponsoring the draft resolution, was acutely conscious of the tragic circumstances in which the Lebanese people at present found themselves. The ferocity of the events they were still enduring was common knowledge. His delegation therefore appealed to the Committee to approve unanimously the draft resolution and to make every effort to assist Lebanon to alleviate the suffering and the health problems it was experiencing and to supply the Lebanese people with the health supplies they needed.

Dr BASSIOUNI (Egypt) said that his delegation wished to be a co-sponsor of the draft resolution, which it fully supported.

Mr BOYER (United States of America), noting that his Government had been pleased to make contributions to Lebanon during its difficult moments over the past two years - much of that contribution being in the form of assistance in health care and medicine and in aid to refugees - said that the United States delegation would be pleased to be a co-sponsor of the draft resolution.

The CHAIRMAN said that the delegate of Yugoslavia, who had been unable to attend the present meeting, had asked him to convey to the Committee the Yugoslav delegation's wish to be a co-sponsor of the draft resolution.

The draft resolution was approved.¹

Assistance to the front-line States, to Namibia and national liberation movements in South Africa, and to refugees in Africa: Item 33.4 of the Agenda (Resolutions WHA36.24, WHA36.25 and WHA36.26; Document A37/17)

Dr QUENUM (Regional Director for Africa), introducing the item, said that the report before the Committee, submitted in pursuance of resolutions WHA36.24, WHA36.25 and WHA36.26, contained a description of measures taken during the biennium 1982-1983 to meet the health requirements of the front-line States and the national liberation movements recognized by the Organization of African Unity. It was well known that the situation prevailing in that part of Africa was liable to destabilize the Governments of the front-line countries and Lesotho and Swaziland, thereby jeopardizing the economic, social and health development of their populations. In the same geographical area, the Namibian people were continuing their long struggle for liberation. WHO's contribution to the efforts of that people to safeguard human dignity and establish social justice was exercised in three ways: first, international collaboration; secondly, direct assistance to the Member States concerned - Angola, Botswana, Lesotho, Mozambique, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe; and thirdly, cooperation with the national liberation movements recognized by OAU. The political instability and the socioeconomic insecurity that prevailed in the sub-region created a dramatic situation for refugees, and the second International Conference on Assistance to Refugees in Africa would be held in Geneva in July 1984. WHO, in collaboration with the United Nations Development Programme and other agencies of the United Nations system and the Member States, had contributed considerable technical support in the formulation of 24 projects for the benefit of Angola, Burundi, Ethiopia, Kenya, Lesotho, Rwanda, Uganda, United Republic of Tanzania, Zaire and Zambia. A regional emergency assistance plan for

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA37.25.
refugees of the WHO Regional Office for Africa over the five-year period 1984-1988 was being prepared for submission to that Conference. WHO was thus pursuing its efforts to improve the health situation of peoples who continued to suffer from the absence of peace and security.

The CHAIRMAN drew attention to a draft resolution entitled "Liberation struggle in southern Africa: Assistance to the front-line States, Lesotho and Swaziland", sponsored by the delegations of Angola, Botswana, Congo, Cuba, Ethiopia, Ghana, Mozambique, Sao Tome and Principe, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe, which read as follows:

The Thirty-seventh World Health Assembly,

Considering that the front-line States and Lesotho continue to suffer from the consequences of armed banditry, political and economic destabilization by the South African racist regime which hamper their economic and social development;

Considering that the front-line States and Lesotho have to accept enormous sacrifices to rehabilitate and develop their health infrastructure which has suffered as a result of military destabilization planned, directed and carried out by the South African racist regime;

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

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

Further considering the support that has been reaffirmed for the front-line States, Lesotho and Swaziland in many resolutions of the United Nations, the movement of non-aligned countries, the Organization of African Unity, and other international organizations and institutions;

1. THANKS the Director-General for his report;

2. RESOLVES that WHO shall:

(1) continue to take appropriate and timely measures to help the front-line States, Lesotho and Swaziland solve the acute health problems of the Namibian and South African refugees;

(2) continue to provide countries which are or have been targets of destabilization by South Africa with health assistance, health personnel, pharmaceutical products and financial assistance for their national health programmes and for such special health programmes as are necessary, as a consequence of the destabilization activities, for the rehabilitation of their damaged health infrastructures;

3. CALLS upon the Member States, according to their possibilities, to continue to provide adequate health assistance to the front-line States (Angola, Botswana, Mozambique, United Republic of Tanzania, Zambia, and Zimbabwe) and Lesotho and Swaziland;

4. REQUESTS the Director-General:

(1) to make use, when necessary, of funds from the Director-General's Development Programme to help the countries concerned to overcome the problems arising both from the presence of the Namibian and South African refugees and from destabilization activities, as well as for the rehabilitation of their damaged health infrastructures;

(2) to report to the Thirty-eighth World Health Assembly on the progress made in the implementation of this resolution.

Mr SOKOLOV (Union of Soviet Socialist Republics) reaffirmed the position adopted by his delegation on the issue under discussion at previous World Health Assemblies. It supported WHO's activities with regard to medical assistance to the front-line States, to the national liberation movements in southern Africa recognized by the Organization of African Unity and to refugees from Namibia and South Africa. It considered that such assistance could be provided from the WHO budget, from resources contributed by other international organizations and on a bilateral basis. The main causes of the aggravation of the refugee problem in southern Africa were the aggressive activities of the racist Pretoria regime which was pursuing its policy of apartheid and genocide.

The Soviet Union did not shirk its responsibility in providing assistance to refugees and gave substantial bilateral material and other aid in various sectors to African
countries, including those with refugee problems. In consequence, his delegation fully supported the draft resolution before the Committee.

Dr SEBINA (Botswana) thanked the Director-General and the Regional Director for Africa for their reports on cooperation with and assistance to the countries of southern Africa which were in the forefront of the struggle against apartheid and the minority regime in South Africa. Over the past two or three years, the situation in the region had been aggravated by natural disasters which in some countries took the form of the severest drought in living memory and, in others, paradoxically, of torrential rain and devastating floods.

WHO was to be commended for its humanitarian mission to the national liberation movements recognized by the Organization of African Unity. While his delegation considered international collaboration and assistance to those movements to be laudable, it remained convinced that the permanent and final solution of the problem was for those countries to decide their destiny through self-determination and majority rule. Then and only then could they hope to begin to achieve health for all.

Miss TOUATI (Algeria) welcomed the steps taken in pursuance of resolutions of the Thirty-sixth World Health Assembly on cooperation with the front-line States and the peoples of Namibia and South Africa. The gravity of the health problems which were so acute in the region, and which were related to the aggressive policy of the racist South African regime that disregarded the most elementary human rights of African peoples and States, demonstrated the need for the Organization to intensify its efforts to implement the plan of action adopted by the International Conference on Apartheid and Health. Despite its condemnation by the international community, the racist regime in South Africa was pursuing its policy of terror and repression with a view to strengthening the apartheid system. That institutionalized policy had been raised to the level of an ideology by a regime which, far from trying to conceal it, proclaimed it and had developed the whole system of repression to apply it, so that it constituted a crime against the whole of humanity. Those racist policies were being pursued in Namibia, where the Pretoria regime was trying to perpetuate its occupation by systematically and stubbornly using methods of obstruction in order to impose solutions excluding the South-West Africa People's Organization (SWAPO), the only legitimate representative of the Namibian people.

That policy was at the root of the health problems of southern Africa. Indeed, the health and well-being of the populations of South Africa and Namibia could not be ensured until those peoples had gained their freedom and independence. Accordingly, WHO should reassert its condemnation of the racist Pretoria regime, should reaffirm its support for the national liberation movements and should endorse the position adopted by the non-aligned countries which called for a settlement of the Namibian question on the basis of United Nations Security Council resolution 435. Algeria was sure that WHO would continue to work for the improvement of the health of the peoples of southern Africa; it also unreservedly supported the front-line States and deplored the many forms of assistance which were still being given to the Pretoria regime and which did not, as some claimed, encourage it to relax its policy, but merely served to provide it with additional facilities for deploying its military action in the region.

In conclusion, she thanked the Director-General for the measures he had taken in preparation for the Second International Conference on Assistance to Refugees in Africa. It was to be hoped that the Conference would intensify general awareness of the dimensions of the refugee problem and of the burden that it placed on the countries of asylum. Algeria was sure that the international community would respond positively to the requests that would be submitted during the Conference and would make it possible to attain the objectives assigned to it. Finally, she pointed out that Algeria had been omitted from the list of sponsors of the draft resolution.

Mrs LUETTGEN DE LECHUGA (Cuba) said that her country recognized that the constant struggle in southern Africa had seriously affected the health situation of the peoples of that area. That struggle was principally due to the racist policy of apartheid pursued by the South African regime. Cuba continued to support the struggle of the African peoples to eliminate apartheid and to achieve independence for the people of Namibia.

The newly-independent States and the national liberation movements of southern Africa needed the assistance and solidarity of the international community. Cuba condemned the constant acts of aggression perpetrated by the fascist regime of South Africa against the peoples of the region. In order to achieve the goal of health for all by the year 2000, WHO should continue to keep the health of the populations of the region under review. With greater assistance from the Organization itself, as well as bilateral assistance, it was to be hoped that the health situation in that area would improve.
Mr KWON Sung Yon (Democratic People's Republic of Korea) said that some success had been achieved in the field of health in the front-line States, Lesotho and Swaziland, since the Thirty-sixth World Health Assembly; in that connection he commended the Director-General on the steps taken during the past year. The countries attacked by South Africa faced serious difficulties from the point of view of their socioeconomic development as well as in the field of health. Under such conditions, WHO should urgently extend its support and solidarity to those countries and increase its assistance. His delegation strongly supported the draft resolution before the Committee.

Dr XU Shouren (China) endorsed the Director-General's report and welcomed the effective work carried out by WHO in cooperation with other international organizations. Racism and apartheid were the root causes of the refugee problem and related problems in Africa; support for the national liberation movements was one of the fundamental ways of solving those problems, particularly in the field of health. Technical cooperation with African States should therefore be strengthened with a view to reorganizing the repatriation of refugees in Africa. The Chinese delegation supported the draft resolution before the Committee.

Mrs WOLF (German Democratic Republic) said that by its efforts to improve the health situation of the peoples of the front-line States and the national liberation movements, through the preparation and implementation of health projects, control of diseases and training of health personnel, WHO was making useful and specific contributions to the worldwide struggle against the criminal regime of apartheid in South Africa. That regime flagrantly violated the rules of democratic international law and negated the purposes and principles of the United Nations Charter and the Constitution of WHO. In spite of innumerable international protests there had been no change in its inhuman and aggressive nature. The racist regime persisted in its policy of apartheid and the statement made at the 1981 International Conference on Apartheid and Health in Brazzaville, that the goal of health for all by the year 2000 could not be achieved under the conditions of apartheid, was still valid. Her country shared the view of the majority of States that political, moral and material assistance would be needed by the peoples struggling for national and social liberation until the policy of apartheid was completely eradicated. In 1983, the Solidarity Committee of the German Democratic Republic had provided over 200 million marks as solidarity assistance to friendly States and liberation organizations. It had also supplied urgently needed medicaments, clothing, tents, foodstuffs and other goods to the front-line States, the African National Congress, and SWAPO. Namibian and South African women and children in refugee camps had also benefited.

Active anti-imperialist solidarity with the peoples in southern Africa struggling for their liberation was an integral part of her country's foreign policy which, by expanding cooperation and relations in a broad range of areas, was aimed at assisting those States and peoples in their struggle to overcome their colonial inheritance and strengthen their political and economic independence. Her delegation therefore supported the draft resolution before the Committee.

Mr DE BURGER (Canada) said that his delegation was aware of the many significant health issues facing the front-line States, Lesotho and Swaziland, and supported the essential WHO activity in that area. It likewise supported the draft resolution before the Committee. However, the unfortunate choice of such words as "armed banditry" detracted from what was otherwise a good resolution.

Dr CASTELLÓN (Nicaragua) said that the system of terrorism and murder prevailing in southern Africa was a consequence of the system of apartheid, whose victims were the peoples of the region and particularly of Namibia. The South African Government was trying to exert its influence on neighbouring countries and to assume power over the front-line States. The struggle of liberation movements like the African National Congress and SWAPO was a legitimate one. Under the apartheid system, a modern system of slavery, proper health conditions could not possibly be developed. The Nicaraguan delegation endorsed the request to the Director-General and the international community for the continuation of health assistance to those people and particularly to the people of Namibia and the refugees from the front-line States who were the victims of the barbarous policy of apartheid. For all those reasons the Nicaraguan delegation approved the Director-General's report and supported the draft resolution before the Committee.

Mrs RUMJANEK CHAVES (Brazil) said that the Government of her country had consistently spoken in the United Nations and other international forums, in favour of the liberation of the peoples of southern Africa and against apartheid; it once again associated itself with
COMMITTEE B: FIFTH MEETING

those calling for action to put an end to racial discrimination and to the illegal occupation of Namibia. Brazil was also in favour of any programme designed to establish or strengthen cooperation with the newly-independent States in southern Africa. Everything in its power had been done to intensify the cooperation programmes which it had established with the said countries, and particularly with the Portuguese-speaking countries, in the field of health. The guidelines for those programmes had been drawn up to meet the specific needs of each country and to provide for the transfer of technology and the training of personnel. They provided long-term and short-term technical assistance, particularly in the fields of psychiatry, surgery, paediatrics, and orthopaedics, and fellowships in public health, nutrition, rehabilitation and nursing.

Dr CABRAL (Mozambique) joined previous speakers in thanking the Director-General and the Regional Director for their reports. Mozambique, together with all the front-line States, Lesotho and Swaziland, was grateful for the moral and material support given to those countries. Due to an error during preparation, for which he apologized, the name of Lesotho did not appear on the list of co-sponsors of the draft resolution.

The CHAIRMAN informed the Committee that Yugoslavia also wished to be a co-sponsor of the draft resolution.

Mr BOYER (United States of America) asked whether the Chairman would be willing to postpone a decision on the draft resolution, since its distribution only two days previously had not allowed adequate time for consideration. It appeared to contain judgements which were not entirely within the mandate of WHO, and some of its language was politically oriented. The United States strongly supported health assistance to the front-line States, Lesotho and Swaziland and believed that efforts should be made to reach a consensus on the text, as had been done at the United Nations in many similar circumstances. There had also been considerable success at the present Health Assembly in avoiding divisiveness on resolutions. He therefore wondered whether the co-sponsors would be willing to discuss the wording of the text with a view to developing a resolution that could be supported by consensus and provide a clear statement that health assistance to the front-line States was supported by all.

Mr BLAUROCK (Federal Republic of Germany) was also in favour of health assistance to the front-line States, but was disturbed by the political language in the first paragraph of the draft resolution. He therefore fully supported the idea of discussions with the co-sponsors with a view to achieving a consensus, and was consequently in favour of postponing a decision on the draft resolution for the time being.

Dr SEBINA (Botswana), speaking on behalf of the co-sponsors of the draft resolution, said that they were - as always - prepared to hold discussions with any delegation, with a view to achieving a consensus, provided that they were not pushed to compromise on matters of principle.

The CHAIRMAN suggested that the discussion be suspended, and resumed at a subsequent meeting, by which time an acceptable text should be available.

It was so agreed. (For continuation, see summary record of the eighth meeting, section 2.)

Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa: Item 33.5 of the Agenda (Resolution WHA36.29; Document A37/18)

Dr QUENUM (Regional Director for Africa), introducing document A37/18, said that it described the health situation created in Africa as a result of famine and drought, while identifying the priority needs which the African countries had expressed. The document did not claim to be an exhaustive list of the countries affected. Consequently the list contained in paragraph 2 of document A37/18 was not all-inclusive. He drew attention to the unhappy coincidence that drought was affecting nearly all the least-developed countries. Studies carried out had highlighted the main health problems as: malnutrition, famine, psychosomatic disorders, depressive syndromes, neuroses and a weakening of national cultural values. More than 150 million human beings were presently unsure of their survival; thousands of head of livestock were destined to perish because of the lack of water and pasture. The general world economic crisis, he explained, caused global insecurity which
would have a predictable effect on the health of mankind. WHO, with its limited resources, was cooperating with the international community and individual countries to devise national primary health care programmes. Since 1965, WHO had had a regional programme for nutrition supported through intercountry activities. To streamline such cooperation with Member States, the Organization had been involved in the field of food and nutrition with FAO and OAU as far back as 1972; there had been similar collaboration since 1982 with UNICEF, UNDP, the World Food Programme, the Sahel Institute and IFAD. Moreover, the WHO cooperation programme with Member States in the sphere of maternal and child health care had been restructured to take account of the drought situation. That programme had been designed and implemented in close cooperation with the United Nations Fund for Population Activities. On the occasion of the setting-up of the International Drinking Water Supply and Sanitation Decade, WHO had worked out cooperative programmes with various international agencies to give more active support to those activities dealing with drought. The programme was being sponsored by the World Bank, UNDP, the German agency for technical cooperation (GTZ) and the Swedish International Development Authority. WHO's direct cooperation with the African countries took the form of an intercountry project divided into seven branches and 39 national projects, 16 of which had the benefit of the services of WHO staff. Yet the results obtained to date, although encouraging, could be improved upon. Some 12 countries had finalized and approved a national plan of action for the International Drinking Water Supply and Sanitation Decade; some 30 countries had submitted more than 220 project outlines for assessment by financial backers - the external financing for which would require some US$ 800 million. WHO's efforts to assist drought-affected African countries followed three broad trends: food and nutrition; maternal and child health; and drinking-water supply and sanitation. The Director-General had requested Member States to identify their requirements and submit them to him. At the time of drafting of the present report, 14 replies had been received; they figured in the document. In due course others would be received and would be incorporated. He concluded by stressing the severity of the health situation in African countries and the great need for international support. Of course, each African state must ensure its own survival and identify its needs. Community participation, in individual countries, had until recently been underestimated. The African countries had to determine clearly what exact assistance was required from the international community to boost national efforts. WHO would continue to cooperate with Member States in the implementation of national, subregional and regional programmes for food, nutrition, and maternal and child health, as well as for drinking-water and sanitation projects. Only if it were coordinated could support from the specialized agencies of the United Nations for drought-affected African countries effectively respond to the aspirations of the people and communities involved. It was to be hoped that the international community would not fail in its mission to defend justice, peace and security in the world.

Professor GIANNICO (Italy) commended the Director-General on his clearly presented report on the emergency assistance provided to countries affected by drought and famine. His country was very concerned about the situation in Africa and was monitoring it very closely. Italy had in 1981 set up an assistance programme for countries affected by famine and drought, special priority being given to emergency medical assistance; it was currently trying to overcome some logistic problems in order to provide immediate and effective assistance, and was committed to cooperating either directly or through international emergency relief institutions. His country hoped that WHO could develop and expand its special assistance programmes, thereby demonstrating the solidarity of the international community with countries affected by natural disasters.

Dr CABRAL (Mozambique) said that his country had been afflicted for the past four years by the worst drought in 70 years, which had affected more than 4.7 million people. The action of armed bandits had also been the cause of famine and a rise in the mortality rate. A survey conducted in 1981 in two provinces showed that the percentage of children whose body weight was below 80% of the normal weight was 12% in one province and 20% in the other. The general mortality rate was 69.5 per thousand in one province and 139.4 per thousand in the other for the 12 months preceding the survey. Under normal conditions the national rate would have been 19 per thousand. The most common causes were diarrhoea (27%) and malnutrition (35%). More recently, in a province in the centre of the country a survey showed that there were rates of malnutrition among children (determined as less than 80% of the normal weight/height ratio) of 36%. The general mortality rate had been 160 per thousand in the year preceding the survey. His delegation wished to express the gratitude of Mozambique for the assistance provided by the international community - assistance which enabled it to avoid even greater mortality rates. Emergency relief was excellent but normal conditions of life had to be restored and therefore the international community was being
Mr LO (Senegal) highlighted the crucial importance of providing health and medical support to African countries affected by drought. The OAU group had for that reason examined the matter in great detail. His delegation hoped to have a draft resolution ready for consideration the following day.

Dr LISBOA RAMOS (Cape Verde) said that the public at large was not aware that his country had been severely affected by drought, and that there had been grave consequences for public health. Local efforts, together with external assistance, had certainly facilitated the task of dealing with that disaster in the past, but drought had struck his country again in 1983. He appealed to the members of the Committee, to the Organization and to all Member States to continue their support.

Mr TAWFIQ (Kuwait) thanked the Director-General for his report and for his continued interest in the dreadful health situation caused by drought. Thousands were facing death daily in a number of drought-affected African countries — a situation which was getting worse. Since the chief aim of WHO was to create the best possible level of health for all peoples, it had a great responsibility in supporting health services. Appealing to the Director-General to highlight even more the health situation of people in drought- and famine-affected countries, he also requested all Member States to give close consideration to the plight of peoples in the countries concerned; they were in need of all forms of international assistance.

The CHAIRMAN suggested that the discussion be suspended until the promised draft resolution was available, and invited the Regional Director for Africa to respond to questions raised.

Dr QUENUM (Regional Director for Africa) replied to the request for clarification by the Mozambique delegation. When the list contained in paragraph 2 of document A37/18 was submitted in January/February 1984 by UNDRO the same of Mozambique had not appeared. The list was not intended to be exhaustive. Referring to paragraphs 13 and 14 in the same document, he explained that in 1982 Mozambique had not been involved in the joint UNICEF/WHO programme of nutritional support. Perhaps, however, paragraph 14 was still too vaguely worded. The extremely complex programme referred to was not operational in its entirety as some of it was at the planning stage. In regard to section VI, "Direct cooperation with countries — expressed needs", he explained that, here again, the actual content depended on when the document had been released. Headquarters had access to only a limited amount of information which had to be submitted by a given deadline. Other countries had submitted estimates of their needs only on 28 April: they were Angola, Chad, Gambia, Lesotho, Mozambique, Zambia and Zimbabwe. The updated programme provided a more complete list. The item under discussion had not been examined at the thirty-third session of the Regional Committee. On the other hand, the regional implications of resolutions adopted by the Thirty-sixth World Health Assembly had been discussed, and resolution AFR/RC33/R8 on cooperation in the field of health with the countries of the Sahel and other countries affected by drought had been submitted to the Director-General; the Executive Board's attention had been drawn to that resolution. If Dr Cabral desired more detailed information, they could discuss the matter further in private.

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

The meeting rose at 17h40.
HEALTH CONDITIONS OF THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 31 of the Agenda (Resolution WHA36.27; Documents A37/13 and A37/INF.DOC./2, 3 and 4)

The CHAIRMAN drew attention to the documents before the Committee which included - besides the report of the Special Committee of Experts Appointed to Study the Health Conditions of the Inhabitants of the Occupied Territories (document A37/13), and the report of the Minister of Health of Israel (A37/INF.DOC./2), the abridged report of the Director of Health of UNRWA (A37/INF.DOC/3) and the PLO report (A37/INF.DOC./4) - the following draft resolution sponsored by the delegations of Afghanistan, Algeria, Angola, Bahrain, Bangladesh, Bolivia, China, Congo, Cuba, Democratic People's Republic of Korea, Democratic Yemen, Ethiopia, German Democratic Republic, India, Indonesia, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Malta, Mauritania, Morocco, Mozambique, Nicaragua, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Upper Volta, Viet Nam, Yemen and Yugoslavia:

The Thirty-seventh World Health Assembly,
Mindful of the basic principle established in the WHO Constitution, which affirms that the health of all peoples is fundamental to the attainment of peace and security;
Aware of its responsibility for ensuring proper health conditions for all peoples who suffer from exceptional situations, including foreign occupation and especially settler colonialism;
Affirming the principle that the acquisition of territories by force is inadmissible and that any occupation of territories by force gravely affects the health, social, psychological, mental and physical conditions of the people under occupation, and that this can be rectified only by the complete and immediate termination of the occupation;
Considering that the States parties to the Geneva Convention of 12 August 1949 pledged themselves, under Article One thereof, not only to respect the Convention but also to ensure that it was respected in all circumstances;
Recalling United Nations General Assembly resolutions 38/58 of 13 December 1983 and 38/79 of 15 December 1983 and all other United Nations resolutions relative to the questions of Palestine and the Middle East;
Mindful of the struggle that the Palestinian people, led by the Palestine Liberation Organization, their sole legitimate representative, have waged for their rights to self-determination, to return to their homeland and to establish their independent State in Palestine;
Reiterating the support to this struggle expressed in many resolutions of the United Nations and other international institutions and organizations that call for the immediate and unconditional withdrawal of Israel from the occupied Arab territories, including Palestine;
Taking note of the report of the Special Committee of Experts;
Considering the right of the peoples to organize for themselves the provision of their own health and social services;

1. ENDORSES resolution WHA36.27 and previous relevant resolutions of the Health Assembly;
2. CONDEMNS Israel for its continuing occupation of the Arab territories, including Palestine, and its continuing arbitrary practices against the Arab population;
3. CONDEMNS Israel for the continued establishment of Israeli settlements in the occupied Arab territories, including Palestine and the Golan, and the illegal exploitation of the natural wealth and resources of the Arab inhabitants in those territories, especially the appropriation of water resources and their diversion for the purpose of occupation and settlement, and demands that the establishment of new settlements be stopped immediately and that those already established be dismantled;

4. DEMANDS an immediate end to occupation, violence and oppression to enable the Palestinian people to exercise its inalienable national rights, which is a prerequisite to the establishment of a health and social system that would include all necessary institutions to meet its needs;

5. CONDEMNS Israel for its policy aiming, as part of its overall plan of annexation of the occupied territories, at making the Arab population dependent on the Israeli health system by paralysing the services in the Arab health and social institutions;

6. CONDEMNS Israel for continuously raising obstacles to the implementation of resolution WHA36.27, sub-paragraph 8(2), which requests the establishment of three health centres in the occupied Arab territories, including Palestine, under the direct supervision of WHO;

7. THANKS the Director-General for his efforts to implement sub-paragraph 8(2) of resolution WHA36.27 and requests that he pursue these efforts until the full implementation of this resolution and submit a report to the Thirty-eighth World Health Assembly;

8. REAFFIRMS the right of the Palestinian people to have its own institutions which provide medical and social services, and requests the Director-General:
   (1) to collaborate and coordinate further with the Arab States concerned and with the Palestine Liberation Organization regarding the provision of the necessary assistance to the Palestinian people;
   (2) to take suitable steps to ensure WHO participation in the implementation of the programme of action adopted by the International Conference on the Question of Palestine convened in Geneva on 29 August 1983;
   (3) to monitor the health conditions of the Arab population in the occupied Arab territories, including Palestine, and report regularly to the Health Assembly;

9. THANKS the Special Committee of Experts for its report and requests it 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, both physically and psychologically, and to report to the Thirty-eighth World Health Assembly, in coordination with the Arab States concerned and the Palestine Liberation Organization.

Dr IONESCU (Chairman, Special Committee of Experts Appointed to Study the Health Conditions of the Inhabitants of the Occupied Territories in the Middle East) introduced the Special Committee's report (document A37/13). The presentation of an annual report since 1980 had made the Special Committee's task particularly difficult in view not only of the circumstances in which it operated but also of the technical problem of making frequent evaluations in such a field, since of course no precise elements of evaluation of health status had so far been found owing to the multiple factors involved and because the situation did not so much change from one year to another as evolve over a long period. The Committee had therefore found it necessary to include in its current report a series of facts contained in previous reports so as to establish the necessary perspective for a complete evaluation of the situation. To do so, it had established an overall picture of the situation, basing its examination of programmes on the indicators for monitoring progress towards health for all by the year 2000 and on the Seventh General Programme of Work covering the period 1984-1989. For the sake of clarity, it had taken as the basis for its report the guidelines of the Seventh General Programme of Work and included sections on the situation and trends in the health field and in related socioeconomic sectors, health protection and promotion, and diagnostic, therapeutic and rehabilitative technology.

Under the heading "General considerations", the Committee had reported that the "technical" agencies were being increasingly criticized for interfering in political fields which were the responsibility of other authorities. In that respect it must be borne in mind that WHO had had to choose between two concepts of health - the biomedical concept and a more
global concept. The biomedical concept saw health as a state of equilibrium in the complex biological processes taking place within the organism. It explained why, at the individual level, man was at the same time ill - in that certain biological processes were affected - and healthy - in that he could nonetheless satisfactorily carry out his daily tasks. When applied to the collectivity, it meant that for as long as the collectivity met its social needs and obligations and, above all, continued production, it was healthy. WHO had opted for the second, more global concept, which was in many respects oriented similarly to the human and social sciences and involved not only physical but also mental and social health. The difference between the two concepts not only changed the factors involved but also explained why health was no longer limited to the strictly medical context but was an interdisciplinary matter. While health services certainly contributed towards curing or, at least, improving the health of the sick, it was difficult to measure precisely to what extent they influenced the general health status of the population. Research had shown that living conditions had a much greater influence in that respect than did health services. Because it had chosen the second concept, WHO could not take the view that analysis of economic and social aspects of the living conditions of the population signified that the matter had been taken out of the health field and transferred to the political arena. The remarks of the Director-General on the spiritual dimension of health for all at the seventy-third session of the Executive Board\(^1\) were particularly relevant. When taking note of the improvement of some health services and programmes, to which international organizations, private bodies in the Arab countries and individuals had also contributed, the Committee considered that, in the current situation, only efforts in the direction described above could restrict the undesirable effects of the state of occupation on the health of the population. At the same time, it was convinced that until the fundamental problem in the occupied territories was solved, it would not be possible to apply in that area WHO principles and strategies for health for all by the year 2000.

In conclusion, he expressed the Special Committee's thanks to all those who had made information available to it and its gratitude to the Director-General and other members of the Secretariat for their high degree of professionalism and objectivity and their technical, legal and administrative assistance.

Dr HIDDLESTONE (Director of Health, United Nations Relief and Works Agency for Palestinian Refugees in the Near East) expressed the gratitude of the Commissioner-General 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 to the Agency.

UNRWA, during its 34 years of service to the Palestine refugees, had relied almost entirely on voluntary contributions to meet the cost of its different activities. The high levels of inflation which prevailed in the world, especially in UNRWA's area of operations, had outstripped contributions, making it increasingly difficult for the Agency to cover its budget needs. When those needs were magnified by extraordinary additional responsibility, the problems were compounded.

The year 1983 had been a period of trial and challenge to UNRWA in general, and to the Department of Health in particular. The Israeli invasion of Lebanon in the summer of 1982 had caused loss of life, homes and property to many refugees. To that had been added the continued sectarian fighting in Lebanon and the inter-Palestinian confrontation at the end of 1983 in and around Tripoli. By decision of the Commissioner-General, UNRWA's help had been extended to all distressed Palestinians in Lebanon, whether or not they were registered with the Agency. Emergency care had reinforced established health and relief services; the Agency acknowledged particular additional aid donations and the outstanding work of nongovernmental organizations and other international agencies. The Agency's resources had been severely strained and certain difficulties had hampered the delivery of emergency help; not only had there been the obvious factor of the fighting but also for some weeks uncertainty on the part of those in authority or control as to the form, manner and location of assistance to the Palestinians. However, despite the most complex political and security problems, the extent to which there had been cooperation on all sides to ensure that UNRWA aid would reach the refugees had been remarkable.

\(^1\) Document EB73/1984/REC/1, Annex 1.
It was extraordinary and deeply moving to note how very quickly the refugees had recovered from the initial shocks of war and displacement and had, once again, set to reassembling the shattered fragments of their lives. A typical example was the large camp of Ein el-Hilweh in south Lebanon, which had been almost completely flattened, and where a new township had risen from the rubble, constructed very largely by women, children and old men—the numbers of able-bodied men and youths still being much depleted because they had been killed or seriously wounded, had fled, or were being held in detention.

The destitute had been given additional assistance with the repair of their homes. Similarly, UNRWA had concentrated more recently on the needs of the most vulnerable, for example, in the programme offering a midday meal to all children up to the age of 15 years, or that attempting to compensate in part for the loss in south Lebanon of the important medical facilities of the Palestinian Red Crescent Society.

Despite financial uncertainty, UNRWA had continued in 1983 to maintain its health care services in full and to operate them with reasonable smoothness. It had been concluded several years ago that it would be unacceptable to make any savings by curtailing the health services, as they already met only the most basic health needs. Over the past 34 years, the services provided had evolved into a comprehensive community health programme which however needed improved physical facilities as well as essential maintenance and replacement of supplies and equipment. The past years' difficulties had increased those requirements.

He had been asked by the Commissioner-General to appeal to delegations to draw the attention of their respective governments to the prevailing state of affairs and to ask them to sympathetically consider UNRWA's need for increased donations.

An abridged version of the annual report of the Director of Health of UNRWA for 1983 (document A37/INF.DOC./3) included a summary account of the health conditions of the refugees registered with UNRWA as well as a brief record of the different health services provided by the Agency. He drew the attention of delegates to the earlier part of the report, which showed how the record of UNRWA through the years illustrated the true meaning of primary health care as enshrined in the Alma-Ata Declaration.

In conclusion, he referred to 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 Palestine refugees, putting at their disposal some of their hospital and clinical services as well as public health laboratory facilities. He thanked the many other governmental and nongovernmental organizations which had assisted the Agency's Health Department in the delivery of its services and in providing personnel, equipment, medical supplies and food commodities or by meeting in cash the operational cost of some of its health units. The Commissioner-General of UNRWA expressed his gratitude to all those organizations for their valuable assistance and to the ministries of health in the fields of operation for their close cooperation with the Agency, which had made possible the execution of its task.

The DIRECTOR-GENERAL said that, in compliance with resolution WHA36.27 and relevant United Nations General Assembly resolutions, the Organization was constantly endeavouring to improve the health conditions in the occupied territories. As the Director of Health of UNRWA had already mentioned, the two organizations were working very closely together.

In relation to direct assistance, the Executive Board had been informed in January 1984 of the most recent activities of the Organization, particular mention having been made of WHO participation in the International Conference on the Question of Palestine, held in Geneva in August 1983. The role of the Organization was to determine, through on-the-spot investigations, and improve, the health situation of the populations. Efforts were being directed towards improving the delivery of primary health care and strengthening health centre services for mothers and children. In addition to the Special Committee visit, the Organization had supported a study on diarrhoeal diseases and had been facilitating evaluation of immunization coverage for target diseases within the framework of the Expanded Programme on Immunization. Assistance was also provided to medical specialists, health technicians and administrators of the Palestinian Red Crescent Society.

In the field of emergency health assistance, WHO had mobilized funds following the events in Lebanon during the previous year to provide the Palestinian people in the areas concerned with medicaments, laboratory equipment and dispensary supplies, which had been channelled through UNRWA by special agreement. Emergency health kits to meet the needs of the Palestinian population in the Tripoli area had also been provided.

With reference to operative paragraph 8(2) of resolution WHA36.27, concerning the establishment of three medical centres, it was pleasing to note that there had been considerable progress. Constructive and helpful collaboration had been received at all stages of negotiations from the United Nations Development Programme with whose Programme of Assistance to the Palestinian People WHO was working very closely. In June 1983 he had appointed a personal representative who had made two visits to the areas concerned, met with
key health professionals there, negotiated with all authorities concerned and identified three centres to be designated WHO collaborating centres for primary health care research. The first, in Ramallah, had already been designated. It was intended that the three centres would undertake health systems research programmes aimed at ensuring total primary health care coverage for the local population by means of the most appropriate technology. More specifically, it was anticipated that, under a series of protocols to be developed in close association with local health professionals and UNDP, the first centre in Ramallah would shortly embark upon a series of studies on evaluation of the referral process in operation between health centres (clinics) and hospitals; means of reducing excessive case loads in the primary medical clinics and in one or more hospitals; the benefits of hospital versus non-hospital delivery and the reasons for patient choice and decision; the training and supervision of traditional birth attendants (dvas); growth and development in infants; neonatal tetanus prevalence and prevention; and continuing work relating to the publication of a study on lead poisoning, with strong social implications, which had already been carried out by local health professionals. Funds had been mobilized to launch those activities and WHO input would consist of support for training and for research design, supply of equipment and materials necessary for the carrying out of research, and essential consultancy services. As the programmes expanded, substantial additional funding would no doubt soon be required and it would become necessary to seek additional extrabudgetary resources.

Negotiations regarding the other two centres were proceeding. It was expected that the second would be in Gaza, possibly with special emphasis on epidemiological studies related to primary health care; and the third would be in the West Bank operating in close association with the Ibn Sina Nursing School currently located in Ramallah, which would probably expand its training role to include other categories of health personnel. The third centre would focus on research related to training of health manpower in the context of primary health care.

The adoption of such a research and development approach for the study and subsequent improvement of health services was very much in line with the Organization's current policies and strategies, as was the strong emphasis on primary health care. He was convinced that the health systems research approach was the most likely to achieve continued progress in upgrading the quality and the coverage of health services in the area and the consequent continuing improvement of the health status of the Palestinian population concerned. Both direct involvement of Palestinian health professionals and close technical supervision by WHO could be achieved under the mechanisms described.

In conclusion, he thanked all concerned for their acceptance of the approach in order to do everything possible for the health of the Palestinian people in the areas concerned, and he paid tribute to the health professionals in those areas who, in spite of the difficulties inherent in a state of occupation, were demonstrating so much commitment and dedication to the health of the Palestinian people under their care.

Dr OZAIRY (Regional Director for the Eastern Mediterranean) said that in section 2.3 of its report (document A37/13) the Special Committee of Experts had mentioned that a request for a consultant submitted six months earlier had met with no response. There had been other inferences that such things happened in the Regional Office. He wished that it might have been possible for the Special Committee of Experts to ask the Regional Office what had happened. The fact was that an invitation had been received very early in 1982 for a consultant to be made available by the Regional Office. The person concerned had subsequently moved away from the Region and no written or verbal request of any form had since been received.

Another request concerned a study of the causes of diarrhoeal diseases. The Regional Office had arranged for a visit to the area and considerable correspondence had been received regarding the study. The Regional Office had been asked to formulate a report but had been unable to do so because the figures received had been completely different from those received from UNRWA at the same time based on the same research. A consultant sent to try to find a common denominator between the two reports had been unable to do so.

In connection with the request on mental health, following written and telex correspondence, the Regional Office had been informed by the Israeli authorities that the visit was completely unnecessary.

Mr DOWEK (Israel) said that, as in previous years since 1978, item 31 of the agenda had been singled out for lengthy discussion. Each year ever harsher resolutions against Israel had been introduced and voted upon by a show of hands. The implicit goal of the exercise continued to be to compel the World Health Assembly to embark on a political discussion well beyond its clear-cut mandate in the field of health, and to endorse - by an automatic majority of votes - political stands and opinions which best served the military, diplomatic and propaganda warfare which had been relentlessly waged against Israel since the day of its inception.
To those delegations, the fact that WHO was a specialized agency dedicated exclusively—by virtue of its Constitution—to health and to the promotion of health throughout the world was of no relevance. The knowledge that political issues were well beyond the competence of the Organization and might also pervert its most fundamental principles was also of no relevance to those delegations. Their only aim was to fan hatred and conflict by any and every means.

To those delegations, the health situation of the Palestinian Arabs was not relevant. The Palestinian Arabs themselves were not relevant. The only relevant factor was hatred of Israel and how to keep tension and strife alive in the Middle East and how to close the door to any possible negotiations, to any compromise, to any solution that might allow Arabs and Jews to live together in peace and harmony.

To those delegations, the report of the Special Committee was of no relevance, to the extent that it did not substantiate their contention that life in Judea, Samaria and Gaza was hell on earth, and if so far as it did not vindicate their allegations that the Government of Israel was not only failing its basic duties towards the Arab population in the field of health and social care, but was also perpetrating full-scale genocide against it.

The Special Committee had not reported what those delegations would have liked it to report on the basis of their nightmarish imagination and unfounded allegations, but had reported only what it had seen with its own eyes, underlining the satisfactory health situation of the Arab population. Consequently the report was of no use for the purpose of the unholy jihad against the small and peace-loving country of Israel.

His delegation did not propose to discard the report of the Special Committee, nor to overlook its content. Nevertheless, it had no intention to comment on it nor to rely on its findings in order to substantiate the true health situation of the Palestinian Arab population. Israel had always been and would continue to be completely open to the world, as truly democratic societies were. Israel had nothing to hide and would never draw an iron curtain behind which it would have a free hand to perpetrate gloomy and bloody designs as some countries did. Diplomatic representatives had free access everywhere, while international correspondents travelled up and down the country and met freely with whomever they wished. Each year more than one million tourists, including 300,000 Arab tourists, visited the area. Hundreds of physicians, health workers, WHO delegates and personnel travelled into the remotest regions. All of them were witnesses, on a daily basis, of the living conditions of the Arab population, and of the very high standards they had attained with the active help of the Israeli authorities in every field of life, including health and medical care in all its aspects, making them one of the most advanced ethnic groups in the Middle East. Even the sponsors of the draft resolution condemning Israel must know that the health situation of all inhabitants, including the Palestinian Arab population, was far better than in any neighbouring country; that it was constantly improving; and that in many fields it had almost reached the standards of developed countries. Long before the target year 2000, they would certainly attain, and even overtake, the goals set by WHO. The technical details were available in the voluminous report submitted by his delegation in document A37/INF.DOC./2.

As usual, a political resolution had been introduced regardless of facts, justice or constitutional aspects. The draft resolution would certainly be passed in the Committee, and later in the Assembly, because mathematics were stronger than logic, and because diplomatic expediency and complacency carried more weight than facts and fairness. His delegation wished to emphasize in the strongest terms that the draft resolution had nothing to do with health or health-related topics; it was a purely political resolution, in its content, in its spirit and in its aims. The list of sponsors spoke for itself: most were countries actively engaged in the diplomatic and military onslaught against his country; almost all had the worst possible health situation as well as the most dreadful record of ruthless violations of elementary human rights against their own citizens. Thousands of people died in those countries every day from epidemic diseases, lack of elementary medical services, starvation, mismanagement of resources, wars or internal strife. Some of those countries were or had recently been engaged in terrible wars of repression against their defenceless minorities, wars which levied a very heavy toll in human lives and suffering. Iraq was engaged in a protracted war with Iran under the complacent eyes of the world community, which remained silent despite the proven use of chemical weapons, the slaughter of thousands of young children and the open flouting of each and every relevant international instrument.

The CHAIRMAN requested the delegate of Israel to speak within the subject under consideration in order to avoid the raising of points of order.
Mr. DOWEK (Israel) said that someone must have the courage to speak the truth. He was speaking within the framework of the agenda item under consideration and had the right to continue to do so freely.

The situation of the Palestinian Arabs in Judea, Samaria and Gaza, including their health conditions, was many times better than the situation of the citizens and minorities in many of the countries sponsoring the draft resolution. Those countries had no concern whatsoever for the alleged plight of the Palestinians. All they wanted to do was to use them - or rather to misuse them - for their own selfish and narrow interests. One of the sponsors, namely the Syrian Arab Republic, had never hesitated to use naked and ruthless force against the Palestinians, massacring thousands of them in Tel Zaatar, Tripoli and elsewhere, each and every time it seemed that the Palestinians were considering some kind of modus vivendi with Jordan or were contesting total control of their future by the Syrian Arab Republic; that country now pretended shamelessly and brazenly to express concern for the health of the Palestinian Arabs.

The draft resolution contained condemnations of Israel based on unfounded allegations or disconnected from the general context of conflict in the Middle East, including the establishment of settlements, exploitation of national wealth, appropriation of water resources, annexation of territories and paralysis of social institutions. It also contained a number of statements of principle, namely: that the acquisition of territories by force was inadmissible; that the Palestine Liberation Organization (PLO) was the sole legal representative of the Palestinians; that the Palestinians had the right to self-determination; that they had the right to return to their homeland and to establish their independent state; and that WHO reiterated its support for the immediate and unconditional withdrawal of Israel. In other words Israel should, with the blessing of WHO, be wiped off the map and PLO allowed to continue blind terror and indiscriminate bloodshed.

Those matters were clearly political issues of great magnitude that were beyond the competence and authority of the Committee and of WHO. Debating those topics and the related political issues in the World Health Assembly was not only futile, counter-productive and harmful to WHO and to the parties concerned, but it was also flagrantly unconstitutional. Article 2 of the Constitution of WHO stated the functions and purposes of the Organization quite clearly. Political and conflict situations were not included in the terms of reference of WHO. That did not mean that the world community had overlooked those problems, but rather that it had not entrusted WHO with them but had preferred to tackle those problems in institutions which dealt exclusively with political problems. WHO had been established with the sole, but extremely important objective of combating health problems and promoting the improvement of health conditions throughout the world.

His delegation formally requested that the opinion of the WHO Legal Adviser be sought regarding the constitutionality of the draft resolution, especially with respect to its many paragraphs of a political nature, before allowing it to be put to a vote. In the view of his delegation, the draft resolution was unconstitutional and therefore could not be put to a vote. In the preamble to its resolution WHA6.47, the World Health Assembly had taken a clearcut position on the issue, considering "that a technical organization such as WHO should not be called upon to judge or to determine questions of a political character ..." and "that there exist other political or judicial bodies having such competence and which are better qualified to deal with such differences;".

The sponsors were endeavouring to compel the Committee and WHO to endorse as a matter of course the programme of action adopted by the so-called "International Conference on Palestine" in which many countries had refused to participate. They were also attempting to compel Member States to endorse, in 1984, resolutions which they had voted against in previous years. Moreover, in the very few paragraphs of the draft resolution that allegedly pertained to the subject matter, namely health, the sponsors had relied on unfounded allegations and even on slanderous lies. For example, paragraph 5 condemned Israel for raising obstacles to the implementation of a resolution seeking to establish health centres at the very time that an agreed mechanism for the creation of such centres had been decided upon between the Director-General and the Government of Israel in an official exchange of letters.

The Committee, if allowed to vote on the draft resolution, would pass it by an automatic show of hands. As a matter of conscience, his delegation appealed to all countries that abided by international morality and legality, and that strove to keep politics out of WHO, to prevent the Organization from being deflected from its most important humanitarian mission; not to condone resolutions of a political nature; and to vote against the draft resolution, not for the sake of Israel, but for the sake of WHO and the millions of human beings who depended on it for relief from their suffering, poverty, starvation and disease.
The findings of the Special Committee of Experts had confirmed, year after year, the satisfactory health conditions prevailing among the Palestinian Arabs. Its report had been misused in order to promote political campaigns and resolutions against Israel as part of the diplomatic warfare waged against his country, and his delegation therefore considered that it was high time to ponder whether such a costly and useless ritual should continue. In any case, his Government would certainly give the matter due consideration.

His Government would continue, as in the past, to provide, in the most efficacious way, for the health needs of the Arab population and would continue to help them to plan and maintain an infrastructure of preventive and curative health care, as well as to improve their health personnel. The Palestinian Arabs did not need to be protected from Israel but rather from those who pretended to help them and constantly incited them, in return for propaganda resolutions, to refuse the hand outstretched for peace and cooperation. The Palestinians did not need resolutions but rather courageous initiatives that would, at long last, put them on the track of a peaceful solution to the problems of the area, in close collaboration with their natural neighbours with whom they were bound to co-exist by virtue of history and geography. The interest of the Palestinian Arabs was in peace and peaceful coexistence. That was also the interest of Israel and indeed the interest of all States and peoples in the Middle East.

Mr BROCHARD (France), speaking on behalf of the 10 members of the European Economic Community, said that although the members of the Community were extremely sensitive to the psychological sufferings caused by the situation obtaining in the occupied territories, they also considered that the World Health Assembly was a technical forum at which attempts to find solutions to political problems were inappropriate. The members of the Community highly esteemed the work done by the Special Committee of Experts, which, as in previous years, had made a thorough examination of the situation in difficult circumstances.

Note had been taken of the criticisms which the Special Committee of Experts had formulated with regard to the health system established in the occupied Arab territories, as well as of the progress which it had ascertained in certain fields. The antiquated nature of the equipment found in some units might be a source of concern, as might the limited number of quality services that hospitals could provide. It would have been desirable to give more precise figures regarding the credits allocated by the Israeli Government to the health infrastructure in the occupied territories. It was also regrettable that the persons affected were not more closely associated with the management of programmes and health budgets in the Gaza area. It was, however, gratifying to know that there had apparently been some progress in the promotion of maternal and child health and that efforts had been made by the Israeli authorities to improve the environment. The 10 members of the European Economic Community hoped that, as long as the Special Committee of Experts was required to perform its functions, the Israeli authorities would continue to provide it with the necessary facilities.

Mrs LUETTGEN DE LECHUGA (Cuba) said that the conclusion of the Special Committee of Experts on the health conditions of the inhabitants of the occupied territories, including Palestine, that it was not possible to have genuine health promotion without peace, freedom and justice, fully justified the condemnation of Israel as proposed in the draft resolution. Israel was condemned for its occupation of Arab territories, for its use of force against the inhabitants of the area and for the damage caused. The strategy of health for all by the year 2000 could not be applied in a situation such as prevailed in the occupied Arab territories. The Palestinians were a people who had struggled for years for their rights and independence and were justified in calling on the international community, including WHO, for help. She was confident that the Committee would approve the draft resolution.

Mr CHAUHAN (India) said that his country had always supported the just cause of the Arab population of the occupied territories. He expressed his appreciation of the work done by the Special Committee of Experts and referred to paragraph 2.2.1 of their report which pointed out that Arab doctors serving in the occupied territories felt that the infrastructure of the health system would have developed differently under independence and that while the West Bank hospitals had been among the leading establishments 30 years ago, they had subsequently fallen behind those of neighbouring countries. There was a close relationship between the health and independence of peoples, and the health conditions of the Arab population in the occupied territories could not improve meaningfully unless there was full involvement of the people in the formulation and implementation of their health plans. As the report correctly concluded, "there can be no genuine health promotion without peace, freedom and justice" for the Arab population in the occupied Arab territories. He said that the refusal of Israel to vacate the occupied Arab territories and allow the Palestinians to return to their homelands constituted a great threat to the health and well-being of the
peoples of those territories. Under such circumstances, it was natural for the United Nations agencies, including WHO, to provide assistance to the Arab population living in occupied territories, with a view to meeting their health needs. He said that assistance should be provided on a continuing basis. For this reason, India had co-sponsored the draft resolution and he was confident that it would be adopted by the Committee, because of the widespread support it enjoyed.

Mr LO (Senegal) requested that his country be included among the sponsors of the draft resolution on the health conditions of the Arab population in the occupied Arab territories, including Palestine.

Dr ARAFAT (Palestine Liberation Organization), speaking at the invitation of the Chairman, said that, according to WHO, health was a state of complete social, physical and mental well-being, not merely the absence of disease or disability. As the report of the Special Committee of Experts indicated, the health conditions of the Arab population in the occupied Arab territories should be monitored with those criteria in view, placing health problems within their social and economic context. The Special Committee of Experts had concluded that existing political, social and economic conditions in the occupied territories were unfavourable to the health status of the Palestinians and the overall development of social welfare services.

The objective of the Israeli military occupation authorities was to destroy the infrastructure of national Palestinian institutions by oppression. He noted the detrimental effect of Israeli practices on the economy, agriculture, industry, education, housing, tourism and all the elements that go to make up the fabric of society. Israeli policies had, in addition, undermined the productive capacity of the population. Since 1967 the occupying authorities had confiscated 41.7% of the total territory of the West Bank and appropriated over 80% of its water resources. A total of 150 settlements had been established and more were planned; that was but a preliminary to the annexation of the West Bank and Gaza, following the similar annexation of Jerusalem and the Golan Heights, in violation of all international covenants. The violations of human rights in the occupied territories were unimaginable. The occupying authorities had issued no less than 900 military orders to govern the daily lives of the population of the occupied territories. In addition to a policy of severe punishment, exorbitant taxation, destruction of homes, detention, exile and imprisonment, there were repeated attacks on the sacred monuments, assassination attempts against religious men and the destruction of Palestinian camps to make those displaced persons even more displaced, if that were possible. This showed that Israeli policies were clearly contrary to international law. They were simply designed to destabilize the demographic structure of the occupied territories.

Over the years, reports of expert committees had included analyses which showed no improvement in the situation of the Arab population; indeed, certain factors had been noted as hindering the economic development of the occupied territories, affecting the social life of the Palestinian people and consequently their health conditions. Health services provided to the Arab population in the occupied territories had increasingly deteriorated. This was true of all other services. He referred to paragraph 2.1.1 of the report of the Special Committee of Experts, which indicated that it was difficult to apply the principles of the health-for-all strategy in the occupied territories. He said that the report of the Israeli Minister of Health on health and health services in the occupied territories was not concerned with health policy but was a document that WHO had recommended each country prepare. The policy and strategy of the Israeli occupying authorities in the health field was based on maintaining health institutions and services as they were prior to the 1967 occupation, with no attempt to plan for their development. In fact, the contrary obtained. Many institutions had been closed down; amongst them were six hospitals in the West Bank and Gaza Strip. The number of hospital beds in the West Bank had declined from 1235 in 1967 to 984 in 1982. In Gaza the number of beds had declined from 955 in 1967 to 779 in 1982. The Israeli occupying authorities had continued their persistent efforts to close down the "Hospice" hospital in Jerusalem. The number of beds had decreased from 106 to 40. This hospital was the only government Arab hospital in the city of Jerusalem. It provided care at nominal cost to the Palestinian people who could not afford the excessively expensive Israeli state or private hospitals. This was one way in which the occupying authorities put permanent pressure on the Palestinians. He regretted that the Israeli occupying authorities had not enabled the Special Committee of Experts to examine the situation at this hospital, in order to make recommendations concerning it.
Referring to paragraph 2.2.1 of the report of the Special Committee of Experts, which stated that there had been no development of the health infrastructure in the occupied territories, he said that there was no unit within the pyramidal system to provide the Arab population with services of a suitable level and quality. The report also highlighted unresolved health manpower problems. There were no school health services for the surveillance of the children. No code of occupational medicine had been issued. Environmental conditions were unsatisfactory. Regarding mental health, the effects of the occupation exerted a detrimental effect on Palestinian society, with serious psychological and mental health consequences. This deterioration in health conditions was not surprising in the light of the decreased budget allocation due to the tight control of the Israeli occupying authorities.

The report clearly showed that the Arab population was not allowed to participate or express its views regarding health planning, and that there had been no attempt to develop health services. In the face of the refusal of the occupying powers to provide health services to Arabs in the occupied territories, voluntary agencies were attempting to provide assistance to the Arab population, but the policy of the Israeli occupying authorities was based on preventing any development or establishment of private or charitable health institutions. This had been noted in earlier reports of the Special Committee of Experts. As in other fields, the Israeli occupying authorities were attempting to destroy the infrastructure of Palestinian health institutions and subsequently fuse them with Israeli institutions. He asked the Committee to take account of his comments, together with the report of the Special Committee of Experts and the report of the Director of Heath of UNRWA, to support the draft resolution, and to condemn the Israeli occupying authorities for their attempts to prevent the promotion of the health of the Arab population in the occupied Arab territories, in compliance with the objectives of health for all by the year 2000.

Miss TOUATI (Algeria) expressed her delegation's great appreciation of the difficult work done by the Special Committee of Experts, whose report correctly stated that there could be no real promotion of health without peace, freedom and justice. To be healthy, peoples needed to be masters of their own destiny.

In paragraph 2.1.1 of the report on management of health programmes, it was stated that "the Arab directors of health have only partial responsibility for certain aspects of public health in these territories" and that "it is difficult to achieve genuine health promotion unless the populations concerned themselves have responsibility for drawing up socioeconomic plans in accordance with their interests." Thus there was a clear link between the health conditions of the Arab population and the denial of the Palestinian people's right to self-determination. To consider health conditions in the occupied Arab territories in isolation from the Palestine problem as a whole was to grasp only one aspect of the situation. The serious health conditions, which might be made worse by the systematic expropriation of water resources and their diversion for the benefit of the new occupiers, were a challenge to the conscience of mankind and their perpetuation was an insult to WHO.

The Zionist authorities were continuing to disregard the resolutions adopted by the United Nations and by WHO. The Committee had a duty to attach maximum importance to the draft resolution before it, in the context of its efforts to attain the goal of health for all by the year 2000 and to implement United Nations General Assembly resolution 38/145, which requested organizations of the United Nations system, in cooperation with the Palestine Liberation Organization, to intensify their efforts to provide assistance to the Palestinian people.

The health conditions of the Arab population in the occupied territories could not improve without Israel's withdrawal from all the occupied Arab territories, including Jerusalem, or without the restoration of the national rights of the Palestinian people, including its right to establish a state in its homeland, or without the participation of PLO as the sole legitimate representative of the Palestinian people in any negotiations to settle the Middle East conflict. Pending such a solution WHO should use all its moral influence to help to relieve the distress of the population in the occupied Arab territories. Her delegation was proud to be a sponsor of the draft resolution before the Committee, which dealt with a health problem that could not be dissociated from its overall political context.

Professor JAZBI (Pakistan) said that the situation in the Middle East remained a subject of the highest international concern, as was amply brought out in the excellent report of the Special Committee of Experts. The central issue was the continued denial of the inalienable right of the people of Palestine to self-determination and to the establishment of its own
independent State. That, coupled with the history of recurrent Zionist expansion and aggression, had created a very serious situation with grave implications for international peace and security.

The tribulations of the people of Palestine had always evoked anguish and concern among the people of Pakistan. His country's commitment to support the Palestinian and Arab peoples transcended considerations of narrow self-interest, expediency or even close historical, cultural and religious affinity. It was based on the principles of the United Nations Charter and of universally recognized international law.

Israel's brutal occupation of Arab lands and its flagrant disregard for the rules of international conduct had already caused incalculable damage in the occupied areas. The deteriorating health conditions of the Arabs and Palestinians in those areas were only one of the numerous unfortunate consequences of the reprehensible policies under which Israel continued to expropriate Arab land, to persecute the Palestinian and Arab populations of the occupied territories, and to proceed with its insidious endeavours to change the physical and demographic composition of the Arab territories and thus obliterate the identity of the Palestinian nation. His delegation fully endorsed the idea that WHO should monitor the health conditions of the Arab population in the occupied Arab territories, including Palestine, and supervise them directly with a view to securing a proper health environment.

Dr MULLER (German Democratic Republic) said that the health conditions of the Arab population in the occupied territories had aroused great concern on more than one occasion. Apparently no significant change could be expected while the territories were occupied by Israel. His delegation was of the view that health conditions would change only when a political solution had been found to the Middle East conflict. However, in the interest of the Arab population living in the occupied territories, it was necessary to make a further effort to implement the relevant Health Assembly resolutions and to continue WHO's health assistance to the Arab population in close cooperation with PLO.

The German Democratic Republic unreservedly supported the Arab peoples in their just struggle to secure a fair and lasting settlement of the Middle East conflict on the basis of the complete withdrawal of Israeli forces from all Arab territories occupied since 1967; of the recognition of the legitimate rights of the Arab population of Palestine, including its right to create its own independent State; of the rights of all States in the region to independent existence and development; of an end to the state of war and the establishment of peace between the Arab States and Israel, and of the elaboration and adoption of international guarantees for its preservation. For that purpose an international conference on the Middle East should be convened, with the participation of all countries concerned and PLO.

Mr KWON Sung Yon (Democratic People's Republic of Korea) recalled that the Thirty-sixth World Health Assembly had adopted a just resolution calling for such positive measures as the monitoring of the health conditions of the Arab population and the establishment of medical centres in the occupied Arab territories, in line with the requirements of WHO's strategy for health for all. Unfortunately that resolution had not been fully implemented, and the Israeli aggressors were still occupying the territories concerned. In such circumstances WHO should take more positive action to implement the Health Assembly resolutions designed to stop Israeli threats to the life and health of the Arab population. His delegation fully supported the draft resolution before the Committee.

Dr OULD HACEN (Mauritania) noted that in its report the Special Committee of Experts had drawn attention to a large number of inadequacies in the health conditions of the Arab population in the occupied Arab territories and had concluded by asking how it was possible, in a context where relationships were governed by mistrust, to set up an effective health system to achieve the objective of health advocated by WHO. Although some members had referred to the " politicization" of the Committee's debate, it was clear that health problems in the occupied Arab territories were indissolubly linked with the survival of the Palestinian people on its own territory. It was hardly possible to protect the health of a population when over 40% of its land and over 80% of water resources had been seized.

Reference had been made to an "automatic" majority, but the majority alluded to was really nothing else than the general conscience of mankind, which refused to accept the plundering and physical disappearance of the entire Palestinian people, whose effective presence in a homeland of its own was an essential prerequisite for its progress in all fields, including health.
The Israeli delegate had affirmed that the health conditions of the Arab populations in the occupied territories were remarkable, implying that the Zionist occupation had been a blessing for them. However, the horrifying reality was to be found in the words of the Israeli general in charge of the invasion of Lebanon, who had asserted that the essential interest of settlers was to reduce the Arab population to the state of bottled cockroaches. The Committee might wish to arrive at its own conclusions regarding the health status of a population so treated. The denial of the right to have a health system of its own was only one of the many barbarous crimes perpetrated by the Israeli expansionists against the homeless Palestinian people. That was why his delegation unreservedly supported the draft resolution condemning Israel and supporting the right of the Palestinian people to health and to the development of autonomous health institutions. Quite apart from any political considerations, the international community had a duty to help to put an end to a process of spoliation in all fields, including health, which had been taking place for several decades.

The meeting rose at 11h00.
HEALTH CONDITIONS OF THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 31 of the Agenda (Resolution WHA36.27; Documents A37/13 and A37/INF.DOC./2, 3 and 4) (continued)

The CHAIRMAN asked if there were any more delegates who wished to be included on his list of speakers. He then declared the list of speakers closed.

Mr AL FARAGUI (Egypt) welcomed the report of the Special Committee of Experts (document A37/13). His delegation, which had taken part year after year in the discussion on the dangerous effects of the Israeli occupation on the health conditions of the population in the territories concerned, considered that WHO had fulfilled its historic responsibilities by repeatedly affirming the need to put an end to Israeli occupation and to all acts of violence and suppression, so that the Palestinian people could enjoy their inalienable rights, including the right to self-determination and to their own humanitarian institutions providing the necessary health and social services.

The preamble to the Constitution of the World Health Organization proclaimed that health was a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It would be a sad distortion of that definition to consider that the health conditions of any people went no further than statistics on the number of hospital beds or the amount of hospital equipment. The health conditions of the population in the occupied Arab territories, including Palestine, should thus be considered from a conceptual standpoint, taking account of all the political, social, economic and cultural factors and of the right of the peoples concerned to administer their own national health and social service institutions and to make their own quantitative and qualitative assessment of such services. It would be fallacious and ironical to suggest that health conditions could prosper under occupation, oppression and denial of the inalienable right to self-determination of the people concerned. It was rightly stated in section 3.2.5 of the Special Committee's report that the economic situation, emigration, changing life-styles and above all the latent tension within the community, claimed by the Palestinians to be a consequence of the occupation, were all exerting unfavourable effects on Palestinian society, which took the form of the deterioration of mental well-being, not only in the individual but also within the community. The report concluded by expressing the Special Committee's awareness that there could be no genuine health promotion without peace, freedom and justice.

The Special Committee had affirmed clearly that occupation was a violation of human rights and fundamental freedoms. His own country had repeatedly declared that the Israeli presence in the West Bank, Arab Jerusalem, the Golan Heights and the Gaza Strip was unlawful. An occupation based on military power, the imposition of Israeli policies, the obliteration of indigenous features and the suppression of free speech and of other freedoms violated the principles of international law, the Charter of the United Nations and the Geneva Convention of 1949.

The continued construction of Israeli settlements in the occupied Arab territories, the confiscation of Arab properties, seizure of Arab land, expulsion of the indigenous population and settlement of new populations constituted a flagrant defiance of United Nations resolutions and of the Geneva Convention, 1949, particularly Article 49, which prohibited the arbitrary transfer of individuals or peoples from an occupied territory to any other territory. Israel's claim that the Fourth Geneva Convention of 1949 was inapplicable to the occupied Arab territories, including the Arab city of Jerusalem, was totally inadmissible to any body whose rules and regulations were based on a belief in international law and the Charter of the United Nations, and which was fully aware of the extent of Israel's dangerous practices, going as they did beyond all humanitarian bounds.

His delegation had studied the Special Committee's report with the closest attention and had noted that the Syrian Golan Heights had been placed under Israeli law, jurisdiction and
administration. It firmly believed that Israel's decision to annex the Syrian Golan Heights and the Arab city of Jerusalem constituted a flagrant violation of Security Council resolutions, of the Hague Convention of 1907 and of the Geneva Convention of 1949. Occupation was, by its nature, a temporary state in which sovereignty could not be transferred.

The Special Committee's report had revealed some shortcomings in the provision of the necessary health services and health care to the Arab population in the occupied territories. It could be seen from section 2, for example, that Arabs enjoyed little participation in the management of health programmes and no participation at all in the management of the health budget. Daily hospital fees in the occupied Arab territories had increased considerably in comparison with fees in Israel. Difficulties in the health system in the occupied territories encouraged attendance at Israeli hospitals, and the occupied territories were left with planning and manpower problems which had an adverse effect on the implementation of the Organization's strategy for health for all — a strategy that should cover all areas of the world, including the occupied Arab territories.

There could be no improvement in the health conditions of the Arab population in the occupied territories in the absence of the necessary political, economic and social conditions. His delegation looked forward to the time when a complete, durable and lasting peace could prevail in that part of the world, and when all the factors militating against its establishment were eliminated. Such a situation could be brought about only by the immediate cessation of the Israeli occupation of the occupied Arab territories and the restoration of the legitimate rights of the Palestinian people, including their right to self-determination, so that all the peoples of the area could enjoy a life of peace, security and freedom.

Mr TAWFIQ (Kuwait) observed that every year, during the Committee's discussion of the health conditions of the Arab population in the occupied Arab territories, including Palestine, it was emphasized that the Arab nation was suffering injustice, oppression, dispersal, the occupation of its land by force, the destruction of its homes, and other inhuman acts committed by the Israeli occupational authorities. The Palestine Liberation Organization had submitted a comprehensive report on such practices, committed in violation of the most elementary human rights. The Health Assembly annually condemned those acts and called upon the Israeli authorities to restore to the Palestinian people their usurped land and their human rights and human dignity, but to no avail. Those authorities, which were determined to defy human society and the international community, had shown their disregard for resolutions of the United Nations and WHO. At its previous meeting, the Committee had heard the views of the Special Committee of Experts appointed to study the health conditions of the inhabitants of the occupied territories, whose efforts his delegation greatly appreciated. The Chairman of the Special Committee had expressed the conviction that health for all by the year 2000 could not be achieved without a solution to the problem of occupation. It was rightly stated in the conclusion to the Special Committee's report (document A37/13) that there could be no genuine health promotion without peace, freedom and justice.

The Director-General had drawn attention to the efforts to establish three health centres as called for by the Health Assembly. The delegation of Kuwait hoped those efforts would be continued, since the services they would provide were greatly needed. It was important for the Palestinian people to participate in the preparation and establishment of such centres.

It was inadmissible that the guilty party should play the role of innocent and mock the peaceful efforts being made. That party could hardly expect that the atrocious crimes it had committed against innocent victims had been forgotten: its siege of southern Lebanon with the cutting-off of water and electricity supplies; and the oppression, injustice and bloodshed to which it had subjected its victims. The delegate of Israel had professed to regret and lament the absence of peace, and had made accusations against the world community, and particularly against the sponsors of the draft resolution before the Committee which was designed to provide assistance to a nation suffering from oppression and occupation. He was confident that the Committee, which represented humanity and human society and was striving to uphold human dignity and the right to a dignified life, would not have been misled by those accusations.

In alluding to the Sabra and Shatila massacres, the Israeli delegate appeared to have forgotten that Israel had been the prime mover in the collusion against the Palestinian people in the camps concerned. Had not the Israeli Minister of War, known to be a party to the events, been demoted as a consequence? The Israeli delegate's position could aptly be described by an Arab proverb, to the effect that a murderer would readily attend the funeral of his victim.
That delegate had also apparently forgotten that all members of the Committee had probably seen television broadcasts of the cutting-off by the Israeli army of water and electricity supplies in southern Lebanon and the destruction of buildings by Israeli tanks. Israel, which knew no shame, now lamented peace.

The Israeli delegate had claimed that the health conditions in the occupied Arab territories were far superior to those in any of the countries sponsoring the draft resolution. He, the delegate of Kuwait, would like to invite members of the Committee to visit his own country and see for themselves how far its health services had been developed and how sophisticated they had become. As for the claim that the draft resolution was not in accordance with the provisions of the WHO Constitution, the subject to which it related had been included in the Health Assembly's agenda for the past ten years. Any constitution that failed to guarantee the provision of health services to all nations, and particularly to nations suffering occupation and repression, would be unworthy of the name. Members had reason, however, to be proud of the Constitution of their Organization, which defined health in its full sense, as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The preamble to the Constitution further stated that the health of all peoples was fundamental to the attainment of peace and security and was dependent upon the fullest cooperation of individuals and States. He had been astonished to hear the Israeli delegate quoting from Article 2 of the Constitution as further so-called proof of the illegality or unconstitutionality of the draft resolution before the Committee. Article 1 of the Constitution stated that "the objective of the World Health Organization shall be the attainment by all peoples of the highest possible level of health . . .", while Article 2 listed the functions of the Organization for the achievement of that objective - functions that included: ". . .(c) to assist Governments, upon request, in strengthening health services; (d) to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments; (e) to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories; (f) to establish and maintain such technical services as may be required, including epidemiological and statistical services; . . ." and "(v) generally to take all necessary action to attain the objective of the Organization".

The draft resolution, which was designed to enlist the Organization's support for and promotion of the health conditions of the Palestinian people, conformed to Article 2 of the Constitution, which the delegation of Israel claimed had been violated by its submission. He urged the Committee to support the draft resolution; that was the least it could do for the Palestinian people, which had suffered and continued to suffer from oppression and occupation, and which needed the Committee's support.

Dr MORKAS (Iraq) said that his delegation had co-sponsored the draft resolution because it believed that a basic principle of the WHO Constitution was involved and because it fully endorsed the Palestinian people's heroic struggle to achieve self-determination, to return to their homeland and to establish their own State in their national territory of Palestine. That heroic people were expecting the membership of WHO to show its commitment to them by endorsing the draft resolution as an element of compensation to the many mothers and children who had suffered from brutal oppression.

At every Health Assembly, newly independent States were admitted to membership of the Organization, yet the ancient land and nation of Palestine remained a mere observer of WHO's deliberations. The efforts the Director-General and the Special Committee had made with regard to the Arab population in the occupied Arab territories were greatly appreciated by his delegation, as were the relevant resolutions of the United Nations and other international agencies. He hoped that the Palestinian people would eventually enjoy prosperity, health and security in their own homeland. In common, no doubt, with many other delegates, he was sceptical of the claim that Israel's intentions were entirely peaceful; his own country had, in the past, been the target of unprovoked attack by Israeli aircraft.

Mr SOKOLOV (Union of Soviet Socialist Republics) observed that yet again the health conditions of the Arab population in the occupied Arab territories were being discussed at the Health Assembly, in the absence of any ray of light from past resolutions. The continuing urgency of the issue and the need for a prompt and definitive solution were confirmed by the present discussion, by the extensive documentation before the Committee and by the draft resolution with its large number of sponsors. Israeli occupation and continued aggression against the Arab population obviously remained a major impediment, and that was why many speakers had pointed out that a solution to the troubles, including the health problems, of the population in the occupied Arab territories lay through a comprehensive settlement of the Middle Eastern conflict.
Soviet representatives had on many occasions and in various international forums spelled out the Soviet Union's position on the issue, which was based on a number of well-known resolutions of the United Nations Security Council and General Assembly and reflected five main principles. Firstly, all the Arab territories occupied by Israel should be restored in strict observance of the inadmissibility of seizing the territory of others, and the borders between Israel and the neighbouring Arab countries should be declared inviolable. Secondly, there should be an effective guarantee of the inalienable right of the Arab people of Palestine to self-determination and to the establishment of their own independent State in the Palestinian lands, which must be freed from occupation; Palestinian refugees should be given the possibility of returning to their homes. Thirdly, the eastern part of Jerusalem should be returned to the Arabs and become an inalienable part of the Palestinian State. Fourthly, hostilities should be halted and peace established between the Arab States and Israel. All parties to the conflict, including Israel and the Palestinian State, should jointly undertake to respect each other's sovereignty, independence and territorial integrity and to settle any disputes by peaceful means through negotiation, each State enjoying the right to exist and develop in safety. Finally, international guarantees for settlement in the Middle East should be formulated and adopted. Any comprehensive, genuinely just and lasting Middle Eastern settlement must depend on collective international efforts, with the participation of all interested parties, including the Palestine Liberation Organization, which was the sole legal representative of the Palestinian people.

Those aims were reflected in the Soviet Union's proposal for an international conference on the Middle East. In its turn, United Nations General Assembly resolution 38/58, also calling for such a conference, reflected growing international awareness of the validity of the views of those States that had from the first spoken out in favour of a comprehensive, just and realistic Middle Eastern settlement. The Soviet Union's position on the issue had been reaffirmed in a letter addressed to the Secretary-General of the United Nations at the beginning of the present month, stating inter alia that the Soviet Union was prepared to work constructively with all who were sincerely interested in a just and lasting settlement and would do everything in its power to promote the convening of a conference on the Middle East as soon as possible.

The Soviet delegation shared the views of those who had voiced their concern about the conditions of the Arab population and condemned the policies of the occupying power in the Arab territories. It was grateful to the Director-General and the Special Committee for the documents presented, supported WHO's work in providing health and medical assistance to the population of the occupied Arab territories, including Palestine, and would vote in favour of the draft resolution, which fell fully within the scope of the Organization's competence.

Mr ZAHRNIA (Islamic Republic of Iran) refuted the claim that the draft resolution constituted an attempt to politicize the Health Assembly. Inquiry into the fundamental causes of what was a lamentable situation - epitomized by the comments on the mental health of the Palestinian people in section 3.2.5 of the report of the Special Committee - was not a political act. Though it might not be the Committee's business to solve the problem, it could not ignore the basic cause of the situation, which was an unprecedented denial of justice to a nation - an act for which the international community must bear some measure of responsibility. Innumerable resolutions on the issue existed already; although his delegation felt that resolutions alone were not enough, it would submit that the report and the draft resolution before the Committee made plain statements of fact and were fully in accordance with the basic principles and purposes of WHO. On the other hand, the arrogant claims by the Israeli delegation that health, employment and other conditions were actually better in the occupied Arab territories than elsewhere seemed to imply the view that occupation was itself a solution to the problem.

Mr NYAM-OSOR (Mongolia) said that it was inadmissible to juggle with extracts from the Constitution, taken out of context, to try to contravert the facts, as the delegate of Israel was doing. As far as the allegation of politicization was concerned, his delegation would submit that WHO had from the very outset been involved with political matters. Issues of public health necessarily involved issues of politics: health as a social phenomenon was always and everywhere bound up with politics, irrespective of the socio-political system of the country concerned. To talk about the apolitical nature of WHO and to deny that health had political aspects was an unworthy act, particularly where such events as the occupation of a country with all its consequences, including its effects on the health of a whole people, were concerned. His delegation welcomed the report of the Special Committee and fully shared the views of many of the preceding speakers. Mongolia wished to be included among the sponsors of the draft resolution before the Committee.
Mr BOYER (United States of America) drew attention to the progress the present Health Assembly had made in working out differences in the corridors, with a minimum of dispute on the floor of the committees or the plenary. Only the day before, some of the co-sponsors of the draft resolution currently under consideration had made important statements on the question of chemical warfare, many delegations expressing the view that it was inappropriate for discussion by the Health Assembly, especially in the light of all too pressing health problems. Over the past years, the Organization had earned a reputation for minimizing differences of opinion on potentially controversial issues. In 1983 a biennial programme and budget had been adopted and a Director-General elected without controversy. The present Health Assembly had dealt expeditiously with the issue of the Regional Office for the Eastern Mediterranean, with Cyprus, with Lebanon, with the health situation in Central America; there had been no resolution on disarmament; differences relating to the election of the Executive Board had been overcome; talks on the draft resolution on front-line States had been initiated; Committee A had discussed and reached a compromise on the subject of the new international order and was progressing with further discussion and compromise on the topics of infant feeding and essential drugs. In fact until the present item had been reached, the current Health Assembly had been one in which all delegations could have felt substantial pride.

He would not deny that some of the issues raised aroused strong emotional feelings and that serious differences of opinion existed; on most issues, however, delegations had been able to set aside those feelings in the interests of harmony and of keeping WHO focused on the technical health questions that were its key responsibility. The present issue appeared to be the only one where no effort at compromise had been made, despite the Director-General's advice at the beginning of the session that in discussion the waters should not be muddied with potentially controversial or confrontational debate on matters of little real relevance to the role of WHO. During the present discussion, one country's comprehensive plan for peace in the Middle East had once again been presented - as if the Health Assembly was in a position to act on that plan. The draft resolution before the Committee also largely addressed political concerns for which the Assembly had no responsibility, starting in operative paragraph 1 by endorsing the previous year's resolution (which he himself considered to be regrettable) on the same subject (a resolution that had been adopted even though only 40% of the Organization's membership had voted in favour of it in Committee B); going on to endorse all the - to his mind unfortunately-worded - resolutions on the same subject approved in past years; and finally, in operative paragraph 9, asking the Health Assembly to go through the entire exercise again in a year's time. Despite the advances made in other areas, the Health Assembly thus appeared to be making no progress in handling the present item. There must surely be a way to formulate a resolution which addressed legitimately the health conditions in the occupied territories, for example by noting the important work the Organization had accomplished in that field as reported by the Director-General, and urging continued action and improvement without indulging in extraneous political judgements.

He hoped that all those who thought that something better could indeed be done, and who shared his own belief in WHO as a noble and effective technical organization, strong enough and big enough to resist the temptation to debate issues outside its responsibility, would express those sentiments by joining his delegation in voting against the draft resolution.

Mr BRATKO (Czechoslovakia) said that there was not much to add to the report of the Special Committee of Experts and the further details provided by the representative of the Palestine Liberation Organization and other speakers concerning the health conditions of the Arab population of the occupied territories, including Palestine. His delegation wished merely to point out that as a matter of principle the promotion of health called for a dialogue between doctors and the community on the basis of mutual trust and social and economic stability. Accordingly, Czechoslovakia considered that the withdrawal of the Israeli army from the occupied territories and the exercise of all their national rights by the Arab population, including the right to self-determination, were basic prerequisites for the improvement of health conditions and for the realization of the Global Strategy for Health for All. It consequently supported the draft resolution.

The CHAIRMAN recalled that earlier in the meeting he had closed the list of speakers. The delegation of Israel had asked permission to exercise the right of reply before the vote on the draft resolution; under Rule 60 of the Rules of Procedure, he was empowered to accord that right to any member if in his opinion a speech delivered after the closure of the list made that desirable; in the case at issue, he did not consider it desirable to prolong the debate. On the other hand, he would give the floor to the Legal Counsel, who had been asked for an opinion by the delegation of Israel.
Mr VIGNES (Legal Counsel) said that, in attempting to reply to the question formally raised by the delegation of Israel concerning the constitutionality of the draft resolution submitted at the previous meeting, he wished to make three remarks, the first general, the second relating to the instance competent to settle problems of constitutionality, and the third procedural.

The general remark concerned Article 2(a) of the Constitution, which stated that WHO was "to act as the directing and coordinating authority on international health work". It followed that any activity was constitutional provided it was concerned with health at the international level, and as several delegations had pointed out, according to the WHO Constitution health was a global phenomenon of complete physical, mental and social well-being, not merely the absence of disease or infirmity. Yet it was not enough for an activity to be related to health or the global concept of health for it to be legitimately undertaken by WHO: it must also fall squarely within the field of health. That was a question which could only be determined by reference to principle. To illustrate that point, he referred to Article 2(n) of the Constitution, under which one of the Organization's specific functions was "to promote and conduct research in the field of health". Practice had shown that that function was to be carried out in an area that was not restricted to that of health in the narrow sense: the highest organ concerned with the subject, the global Advisory Committee on Medical Research, had defined research as multidisciplinary and involving various epidemiological methods and economic, behavioural, management and systems sciences. That definition clearly covered the economic and social as well as the physical aspects of research in the field of health as referred to in the Constitution. That global concept of health was given full application in all the reports of the Special Committee of Experts. Furthermore, since the establishment of the Special Committee in 1973, the World Health Assembly had successively adopted ten resolutions very similar in content to the draft resolution before the Committee without, as far as he remembered, any formal objection ever having been raised concerning their constitutionality. Certainly the Health Assembly had never been called upon to decide the question of its competence on the basis of Article 75 of the Constitution.

That led to his second remark: the organ competent to decide on the constitutionality of a proposal. Under Article 75 of the Constitution, it was for the Health Assembly to decide on its own competence and, hence, on the constitutionality of a text. Accordingly, if the Assembly had any doubts in that regard, it was not for the Legal Counsel but for the Assembly itself to take its sovereign decision on the matter. In order to facilitate that decision, he had provided the Assembly with the relevant background material at its disposal.

With regard to the procedural position (his third remark), if the Committee still had any doubts concerning its competence, and if a delegation formally so requested, those doubts could be dispelled by applying Rule 65 of the Rules of Procedure, according to which problems of competence had to be put to the vote before a vote was taken on the proposal in question.

Mr DOWEK (Israel) said that the Legal Counsel's explanation, interesting and detailed though it had been, did not cover the point he had raised. He had never challenged the authority or mandate of WHO in the field of health or its right to deal with the health problems of Palestinians in Judaea, Samaria and Gaza, for that was not only a right but a duty of the Organization. What he had questioned was the constitutionality of the draft resolution on political points which, with all due respect, he considered to lie outside the Health Assembly's competence. That was why he had sought the Legal Counsel's opinion as to whether certain political paragraphs of the draft, such as those stating that the Palestine Liberation Organization was the sole legitimate representative of the Palestinian people and calling for the immediate and unconditional withdrawal of Israel from the occupied territories, fell within the competence of the Health Assembly and its Committee B. It was true that the problem had not been raised from that point of view before, but it was not too late to remedy that omission.

He failed to see why Israel should be singled out as a scapegoat, especially when only the previous day the same Committee B had rejected a discussion on chemical warfare, even though poison gas had been used. If the Legal Counsel indeed believed that the Health Assembly was competent to deal with such issues, he would ask the Health Assembly itself to vote on the merits of the case; for his part, he persisted in the view that political problems, however interesting and important, had no place in the World Health Assembly, which had no right to pronounce on them.

The CHAIRMAN asked whether the delegate of Israel was invoking Rule 65 of the Rules of Procedure, which read as follows: "Subject to Rule 64, any motion calling for a decision on the competence of the Health Assembly to adopt a proposal submitted to it shall be put to the vote before a vote is taken on the proposal in question".
Mr DOWEK (Israel) said he wished to make it clear that he was at present merely asking for the Legal Counsel’s opinion on the question whether the draft resolution contained paragraphs of a political nature which were beyond the terms of reference of the Health Assembly and on which it was not competent to vote. For example, was the call on Israel to withdraw immediately from the occupied territories related to a health problem or to a political problem? The Legal Counsel could surely provide a clear answer to that question.

The DIRECTOR-GENERAL said that, with all due respect to the delegate of Israel, the Legal Counsel, who was under the authority of the Director-General, could not deal with that kind of question. He himself could not give a reply without pre-empting the sovereignty of the World Health Assembly. Perhaps the delegate of Israel would consider withdrawing his question.

The CHAIRMAN asked the delegate of Israel whether he maintained his question.

Mr DOWEK (Israel) said that he could not withdraw his question, since he considered it vital for WHO to determine whether it should deal with politics or health. Notwithstanding the Director-General’s explanation, he believed that the Legal Counsel was certainly in a position to answer the simple question he had been asked, and to do so before any vote were taken, or deemed necessary.

The CHAIRMAN said he understood the delegate of Israel to be calling for a decision on the competence of the Committee to deal with the draft resolution. As a matter of procedure, the Chairman could only comply with that request by putting the matter to the vote in accordance with the provisions of Rule 65 of the Rules of Procedure.

Mr DOWEK (Israel) said that if the Chairman so ruled, he could only comply with that ruling. He wished, however, to make it clear that he was asking whether the Committee was competent to deal with certain parts, not with the whole, of the draft resolution, and inviting it to consider the matter exactly as it had considered the draft resolution on the subject of chemical warfare.

The CHAIRMAN said that Rule 65 of the Rules of Procedure provided for a decision on an entire proposal, not on parts thereof. Did the delegate of Israel wish him to proceed accordingly?

Mr DOWEK (Israel) said that if such was the case, the vote must be taken on the proposal as a whole. He warned the members of the Committee of the dangerous precedent involved in deciding that the Committee was competent to deal with such a politically-oriented text.

The CHAIRMAN, in accordance with Rule 65 of the Rules of Procedure, put to the vote the motion for a decision on the competence of the Committee to deal with the draft resolution submitted to it.

By 63 votes to 8, with 28 abstentions, the Committee decided that it was competent to deal with the draft resolution.

The CHAIRMAN asked whether the Committee was now ready to vote on the draft resolution.

Mr DOWEK (Israel) said that it would be only just and fair if, after many years of approving political resolutions against Israel by a mere show of hands, the Committee were to decide on the draft resolution now before the Committee by secret ballot. He invited all delegations to join with him in so requesting, including those which had tried to convince him that there were no automatic majorities, and that an automatic majority was nothing but a majority voting against one’s country. The Israeli delegation contested that over-simplified theory, and sought fairness through a secret ballot.

Mr CHRISTENSEN (Secretary) read out Rule 78 of the Rules of Procedure relating to voting by secret ballot.

Mr AL-ARRAYED (Bahrain) opposed the request for a secret ballot.

The CHAIRMAN invited the Committee to vote on the request for a secret ballot.

The request was rejected by 56 votes to 23, with 19 abstentions.
Professor BENHASSINE (Algeria) requested a roll-call vote on the draft resolution.

Mr CHRISTENSEN (Secretary) read out Rule 74 of the Rules of Procedure relating to roll-call votes.

A vote was taken by roll-call, the names of the Member States being called in the French alphabetical order, starting with Zaire, the letter Z having been determined by lot.

The result of the vote was as follows:

**In favour:** Algeria, Angola, Austria, Bahrain, Bangladesh, Botswana, Brazil, Bulgaria, Cameroon, Cape Verde, China, Colombia, Cuba, Cyprus, Czechoslovakia, Democratic People's Republic of Korea, Democratic Yemen, Djibouti, Ecuador, Egypt, German Democratic Republic, Greece, Guinea, Guinea-Bissau, Hungary, India, Indonesia, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Madagascar, Malaysia, Maldives, Mali, Malta, Mauritania, Mexico, Mongolia, Morocco, Mozambique, Nicaragua, Oman, Pakistan, Poland, Qatar, Romania, Saudi Arabia, Senegal, Somalia, Spain, Sri Lanka, Sudan, Syrian Arab Republic, Thailand, Tunisia, Turkey, Union of Soviet Socialist Republics, United Arab Emirates, Upper Volta, Viet Nam, Yemen, Yugoslavia, Zimbabwe

**Against:** Australia, Belgium, Canada, Denmark, France, Federal Republic of Germany, Iceland, Ireland, Israel, Italy, Luxembourg, Monaco, Netherlands, New Zealand, Norway, Switzerland, United Kingdom of Great Britain and Northern Ireland, United States of America, Zaire

**Abstaining:** Argentina, Chile, Finland, Gabon, Ghana, Jamaica, Japan, Kenya, Lesotho, Liberia, Nepal, Nigeria, Papua New Guinea, Portugal, Seychelles, Sierra Leone, Singapore, Sweden, Togo, Uganda, Venezuela

**Absent:** Afghanistan, Albania, Antigua and Barbuda, Bahamas, Barbados, Benin, Bhutan, Bolivia, Burma, Burundi, Central African Republic, Chad, Comoros, Congo, Cook Islands, Costa Rica, Dominican Republic, El Salvador, Equatorial Guinea, Ethiopia, Fiji, Gambia, Guatemala, Guyana, Haiti, Honduras, Ivory Coast, Malawi, Mauritius, Niger, Panama, Paraguay, Peru, Philippines, Republic of Korea, Rwanda, Samoa, San Marino, Sao Tome and Principe, Solomon Islands, Suriname, Swaziland, Tonga, Trinidad and Tobago, United Republic of Tanzania, Uruguay, Zambia

The draft resolution was therefore approved by 67 votes to 19, with 21 abstentions.1

The CHAIRMAN asked that explanations of votes should be brief; in accordance with Rule 77 of the Rules of Procedure, no such explanations could be given by sponsors of the resolution.

Dr SUAREZ (Venezuela) said that his country noted with concern the plight of the Arab population of the occupied territories, including Palestine. In that connection his country had consistently, within the framework of WHO, supported all measures necessary to obtain the highest possible level of health for them, as understood in its physical, mental and social dimension. That objective was consistent with the aims of the Organization. The Venezuelan delegation appreciated the reports submitted to the Committee, and shared the concepts relating to purposes of medical and health assistance set out in the draft resolution. However, the latter contained political elements which were not part of the proper objectives of WHO, and which would be more appropriately debated in other bodies of the United Nations system. For those reasons and because the draft resolution had been voted on as a whole, the Venezuelan delegation had abstained.

Mrs NASCIMBENE DE DUMONT (Argentina) expressed support for all activities designed to improve or remedy the health situation of the people in the occupied Arab territories, including Palestine. Such activities were in harmony with the fundamental objective of the draft resolution just approved. However, the operative paragraphs of the resolution included expressions of political condemnation which were not relevant in resolutions of the specialized agencies, and particularly not in those of an essentially humanitarian organization such as WHO. For these reasons the Argentinian delegation had abstained.

---

1 Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA37.26.
Mr UTHEIM (Norway) said that his delegation had voted against the resolution. In the view of the Norwegian Government, the resolution contained elements of a political nature which did not fall within the competence of WHO and which should therefore be dealt with in appropriate forums of the United Nations. The Norwegian Government felt strongly that WHO as a specialized agency should avoid politicization, which could only interfere with its important activities in the field of health. Furthermore, his delegation failed to see how the report of the Special Committee of Experts justified the condemnatory language of the draft resolution. Norway's views concerning the territories occupied by Israel had been repeatedly stated both in the Security Council and in the General Assembly of the United Nations and were well known. They were based on the Fourth Geneva Convention of 12 August 1949 relating to the protection of civilians in time of war, which was applicable to all the territories occupied by Israel in 1967. Norway had repeatedly called on Israel to abide by its obligations under that convention.

Miss RIDDLE (New Zealand) said that her delegation had voted against the draft resolution for a number of reasons. Firstly, it was dismayed that political elements beyond the competence of the Committee had been allowed to intrude into a text which should deal only with health matters. In some respects also its wording was not consistent with generally approved language concerning certain of the issues raised. Secondly, after careful study of the report of the Special Committee of Experts, the delegation had concluded regretfully that the wording of the draft resolution was not entirely consistent with the findings of that body. Finally, the New Zealand delegation had noted that one health centre had already been designated on the West Bank, and that negotiations were under way concerning two others, developments which were to be welcomed as a move to implement the relevant provisions of resolution WHA36.27. The New Zealand delegation felt that the draft resolution had failed to take adequate account of those facts.

Mr PINTO DE LEMOS (Portugal) shared the concern expressed by other delegations over the health conditions prevailing in the occupied Arab territories, including Palestine, and supported all measures aimed at reinforcing WHO activities to improve the health of the inhabitants. Nevertheless, his delegation had abstained in the vote, since the draft resolution contained certain provisions which went beyond the activities of WHO. His country's views on the Middle East question were well known and had often been expressed in more appropriate forums of the United Nations.

Mr VERCNE SABOTA (Brazil) said that his delegation had voted in favour of the draft resolution, in accordance with his country's basic support for the right of the Palestinian people to self-determination, its condemnation of the continuing occupation of Arab territories and its concern for the health of the population in them. While supporting the general thrust of the draft resolution, his delegation would have preferred the redrafting of certain paragraphs, and the use of more moderate language, better suited to a technical organization such as WHO.

Mr IVRAKIS (Greece) said that his delegation had supported the draft resolution. But the Greek delegation could not give unqualified endorsement to sub-paragraph 2 of operative paragraph 8, which related to the programme of action adopted by the International Conference on the Question of Palestine of 29 August 1983, in which Greece had expressed several reservations.

Mr KUBESCH (Austria) said that while voting for the draft resolution, his delegation wished to recall its repeated condemnation of Israeli practices in the occupied territories. The vote was meant, furthermore, to express his country's concern, not only for the living conditions of the Palestinian population in those territories, but also for the health services available to them. He added that the Austrian delegation understood the expression "occupied territories, including Palestine" as equivalent in meaning to the expression, commonly used in the General Assembly of the United Nations, "Arab and Palestinian territories occupied since 1967".

Mr AREVALO YEPES (Colombia) said that his delegation had voted for the draft resolution, since some of its provisions were in harmony with the mission of WHO. Colombia supported all efforts to set up adequate institutions to provide medical and social services, and expressed its concern over the situation of the people of the occupied territories. He regretted, however, that the draft resolution included political elements which were at variance with the fundamentally humanitarian vocation of WHO.
Mrs LUOSTARINEN (Finland) said that her country's position on the Middle East question was well known. Security Council resolutions 242 and 338, and recognition of the right of the Palestinians to self-determination, were the elements of a comprehensive settlement. Finland's position on Israeli policies of settlement and on Israel's illegal activities on the Golan Heights and on the West Bank were equally well known. Those activities had continued to breed frustration and violence and had given rise to problems in many areas, including that of health. The Finnish delegation supported additional health and medical assistance through WHO and UNRWA, in order to improve living conditions in the occupied territories. However, the draft resolution contained elements and formulations which, in the view of the Finnish delegation, fell outside the competence of WHO and were too far-reaching. For this reason, the Finnish delegation had abstained.

Mr M'MBIJWE (Kenya) said that his delegation had abstained in the vote for two reasons. Certain political issues were inherent in the draft resolution that his delegation felt had no place in the present forum. Furthermore, the language used in certain paragraphs was not acceptable to his delegation.

Mr DOWEK (Israel) said that his delegation had voted against the draft resolution, deeming it to be unjust, unconstitutional and unacceptable. He reminded the delegates of Arab countries present of a text from the Holy Koran "God Almighty is with those who have patience". Israel was an ancient people, with a great deal of patience. Israel would indeed work for peace, believing that peace would come to the region, in spite of resolutions such as the present one, which were designed to block the way to peace.

Dr ÅSLUND (Sweden) said that his delegation recognized that Israeli occupation of Arab territories and Israeli settlement policy had created problems in many areas, including that of health. Sweden had repeatedly criticized Israeli policy in the occupied territories, and its views had been made clear many times in the General Assembly of the United Nations and elsewhere. WHO should do what it could in the health sector to improve the lot of the people in the occupied territories. Nevertheless, the Swedish delegation had abstained during the vote, since the draft resolution contained formulations which were too far-reaching and were outside the competence of the Organization.

The meeting rose at 17h25.
EIGHTH MEETING

Wednesday, 16 May 1984, at 9h00

Chairman: Dr N. ROSDAHL (Denmark)

1. INTERNATIONAL STANDARDS AND REFERENCE PREPARATIONS FOR BIOLOGICAL SUBSTANCES: Item 21 of the Agenda (Resolutions WHA26.32 and EB73.R4; Document A37/7)

The CHAIRMAN requested Professor Lafontaine, representative of the Executive Board, to introduce the item, which had been transferred to Committee B from Committee A.

Professor LAFONTAINE (representative of the Executive Board) said that two changes had been made in connection with the definition of international units since the Executive Board and the World Health Assembly had last addressed the problem.

Some international standards such as a few antibiotics were hygroscopic in character and many hormones were so potent that an ampoule might contain only a few picograms. The Expert Committee on Biological Standardization had therefore deemed it expedient in 1978 to define the international unit for particular materials in terms of the number of international units per ampoule rather than weight.

The second change stemmed from the fact that, in the past, there had been two designations for standards for biological substances, namely, international standards and international reference preparations. The question had arisen as to whether it was necessary to retain two designations as both standards and reference preparations serve the same basic purpose. The Expert Committee had addressed that issue in 1983. In that connection it had to be remembered that international standards defining units of biological activity had been established during the 1950s at a time of rapid technological progress in the field of antibiotics. As the process of designating an international standard was necessarily lengthy, it had been deemed advisable to establish as quickly as possible international reference preparations in order to avoid the confusion which would attend the uncontrolled proliferation of national standards. Such action responded to an immediate need, while the long-term need could be met by replacing international reference preparations with international standards. Subsequently, many other international reference preparations defining international units of activity had been established for other substances and had performed a useful role without, however, its being regarded as necessary to transfer them to the category of international standards.

The Expert Committee had recommended that only one category of standard preparations should be established for purposes of defining an international unit of activity, namely that of international standards. It might nevertheless continue to be necessary to regard certain substances as international reference preparations where no international units were involved. At an earlier stage only the international standards had been referred to the Executive Board and the World Health Assembly, but the Expert Committee proposed that all international standards and all international reference preparations, namely, preparations for which international units had been designated but which had not yet been adopted by the World Health Assembly, should be submitted to the World Health Assembly as quickly as possible for adoption. Such a procedure seemed essential in order to guarantee international acceptance of different international units of biological activity.

A list of international standards and international reference preparations had therefore been submitted to the World Health Assembly for recognition. Resolution WHA26.32 had authorized the Director-General to make additions to or replacements of those international biological preparations, under the advice of the members of the Expert Advisory Panel on Biological Standardization or other experts designated to deal with the standardization of particular biological substances. The terminology employed in the designation of standards did not conflict with the terminology of the International Organization for Standardization.

Against that background, the Executive Board had recommended in its resolution EB73.R4 a draft resolution for adoption by the World Health Assembly.

Dr MALONE (United States of America) said that his delegation supported the Director-General's report on international standards and units for biological substances, and
fully supported the adoption of the new lists of biological standards\(^1\) and their designation in international pharmacopoeias. The lists in fact brought conformity between designation and ongoing practice. He would anticipate that, when new designations were added to the list, the most current standards would be listed. He had noted for example that in List II, under Antigens, rabies vaccine was shown as having 10 international units per ampoule; in 1983 however the new standard adopted by Copenhagen provided for 7.8 international units per ampoule.

Dr BATCHVAROVA (Bulgaria) expressed high esteem for WHO activities in support of efforts to ensure proper control of biological substances, expressed appreciation for the valuable work accomplished by the Expert Committee, and fully endorsed the concepts embodied in the Director-General's report. The proposal to make a number of changes reflected problems which had arisen in the application of existing standards.

She suggested that the Expert Committee might consider including a list of enzymes now used for pharmaceutical control purposes.

She drew attention to certain inaccuracies in the Russian text of the lists of biological substances. Furthermore, the list contained no reference to BCG freeze-dried vaccines. The international reference preparation (Copenhagen, 1965) had still been in force in 1982; she asked what the situation was as some countries were still using that reference preparation.

Dr HARRIS (United Kingdom of Great Britain and Northern Ireland) said that his delegation supported the draft resolution recommended in resolution EB73.R4 on international standards and units for biological substances. The use of the proposed nomenclature would remove past confusion.

Dr AMER (Egypt) said that the Director-General's report was a very valuable document. It was not, however, sufficient to make standards available to Member States in a convenient form as a contribution towards the establishment of an acceptable level of quality for biological substances used in prophylactic and therapeutic medicine; there was also a need for cooperation with and between Member States in checking and controlling such substances, whether produced locally or imported. That could be achieved by making available to Member States the relevant technical know-how and equipment, either in existing control laboratories or through the services of the WHO collaborating centres. It was also essential that the labels on all containers for pharmaceuticals and biological substances should show clearly the amount of active ingredients and that such labels should not be easily removable.

Mr HAYASHI (Japan) said that his delegation supported the work of WHO on international standards and units for biological substances. He welcomed the international standards and international reference preparations and units for biological substances enumerated in the two lists annexed to the Executive Board's resolution EB73.R4 and supported the adoption of the recommended draft resolution.

Dr ELIAS (Hungary) said that his delegation greatly appreciated the Director-General's report. The establishment of international biological standards and reference preparations and their dissemination to the competent national regulatory agencies constituted major elements of drug quality assurance at national and international level. His country's national institutes participated regularly in the collaborative comparative studies which furnished the basis for international standards. That procedure was a precondition for the establishment of such standards.

If the recommendations of the Director-General were adopted, there would be no difference between international standards established through the established international procedure and international reference preparations selected without collaborative study. His delegation favoured the simplification of terminology but, in order to ensure that a difference was maintained between the two types of standards, his delegation would suggest that the term "provisional international standard" should be applied to existing and future international reference preparations.

His delegation agreed that in some cases, as with hygroscopic substances, it was preferable to assign international units on the basis of the content of ampoules instead of the weight of the material. In some cases, however, it would be better to define the unit in terms of both ampoule content and weight, as for example in the case of standards used in immunology.

His delegation supported the draft resolution recommended in resolution EB73.R4.

---

\(^1\) Document WHA37/1984/REC/1, Annex 4.
Dr PHILALITHIS (Greece) said that his delegation wished to congratulate the Director-General and all those who had collaborated in the excellent work reported in the Director-General’s report; it supported the proposals and the draft resolution recommended by the Executive Board, which Greece would take all necessary measures to implement.

Dr GECIĆ (Czechoslovakia) said that his delegation supported the report of the Director-General as well as the work on biological standardization reported in the Technical Report Series. It agreed with the Director-General’s recommendations and endorsed the lists of international standards and international reference preparations and units for biological substances annexed to resolution EB73.R4. The information was already being used in Czechoslovakia and had been incorporated into the fourth edition of the Czechoslovak Pharmacopoeia.

It was essential that Member States should maintain close contacts in order to facilitate the implementation and interpretation of the international standards.

Dr GALAHOV (Union of Soviet Socialist Republics) said that work on international standards and units for biological substances, together with other regulatory work in the field of standardization and classifications, represented a fundamental part of WHO’s tasks under Articles 21 and 22 of its Constitution. They would be a source of guidance to Member States. Countries must however retain the right to decide on the standards which would apply in cases where their own national health authorities were already applying higher standards than those proposed by WHO.

His delegation would vote in favour of the draft resolution recommended in resolution EB73.R4.

He asked whether the terms used by WHO were consistent with those of the International Organization for Standardization (ISO).

Professor LUNENFELD (Israel) thanked the Secretariat and the Expert Committee on Biological Standardization for their work. The delegation of Israel fully supported the two changes that had been made in the definition of international units and the designation of reference materials as international standards and international reference preparations.

He urged that international collaborative assays be completed in the shortest possible time to keep pace with rapid developments. This should in no way prejudice the quality of the assays. The standardization of biological substances used for treatment had been recognized, over 50 years ago, as the first and most important step in correct medication. It was of particular interest to have a full list of the standards and the activity, expressed in international units, for the products used in primary health care. As countries expanded their coverage of primary health care and included the use of such preparations as antibiotics, vaccines, hormones and blood products, standardization played an increasingly important part in the establishment of correct dosages. For countries dependent on importing antibiotics, vaccines, hormones and blood products, a first step in self-reliance was the use of national quality control laboratories; to have national reference materials based on international standards was of primary importance. When countries started to package, fill or even produce their own preparations, quality control became essential, and standardization based on international standards was a key element in this process.

Although the Biologicals programme had been established in the time of the League of Nations, it had kept abreast of modern developments. This was not only apparent in the formulation of requirements for the production and control of biological substances and, in particular, vaccines but also in discussions concerning the quality control of monoclonal antibodies and those biologicals produced by recombinant DNA technology. The quality control of blood collection and blood fractions was now dealt with under this programme, and realistic requirements had been established for the protection of the health of the donor as well as for the quality of the products offered to the recipient. To ensure good laboratory practice in its field, the WHO Special Programme of Research, Development and Research Training in Human Reproduction had distributed standards and matched reagents to collaborating centres and laboratories in many countries. That programme had had a significant impact on the quality of assays and was a good example of how other WHO divisions benefited from the work of the Biologicals programme.

Attention should be drawn to the hard work of the four international laboratories (situated in Amsterdam, London, Copenhagen and Weybridge) as custodians of the international standards. In spite of the heavy financial burden, they received only a small reimbursement from WHO. He suggested that the Committee should ask the Director-General to express the appreciation of the Health Assembly to the laboratories and their host countries for their important contribution.

There could only be one central organization for the establishment of international standards; more support should be given to the Biologicals programme to allow it to keep
abreast of the rapid developments that would take place in the near future. He said that the delegation of Israel fully supported the draft resolution recommended by the Executive Board in resolution EB73.R4.

The CHAIRMAN, having ascertained the approval of the Committee, asked the Director-General to convey the appreciation of the Health Assembly to the four international laboratories, as requested by the delegate of Israel.

Mrs RUMJANEK CHAVES (Brazil) said that the draft resolution recommended in Executive Board resolution EB73.R4 was in harmony with the steps being taken in Brazil to include international standards and units for biological substances in the next edition of the Brazilian Pharmacopoeia, in order to ensure an acceptable quality level for these substances, considering their relevance to public health. The Ministry of Health, in its National Institute for Quality Control, had already established a centre for standards of drugs and biological products along international lines.

Professor LAFONTAINE (representative of the Executive Board) said that he was gratified by the support shown by the Committee for the work of the WHO specialized services and the collaborating institutions. Replying to the delegate of the Soviet Union, he said that, although WHO and ISO terminology was not identical, it was compatible, and great care had been taken to choose terms that would not lead to misunderstanding or confusion. He noted the interest shown in new fields, such as enzymes, and the questions that would be raised in future by synthetic vaccines and monoclonal antigens.

Dr PERKINS (Biologicals), replying to the delegate of the United States of America on the need to keep the list up to date, explained that the list had been prepared for the Executive Board in order that it might consider recommending a resolution to the Health Assembly; the list had thus been drawn up from data published in Biological Substances. International Standards, Reference Preparations, and Reference Reagents, prior to the Expert Committee meeting held in 1983. Although WHO was aware of the first international standard for rabies vaccines with 7.8 international units, the only one available for quotation in drafting the list had been the third international reference preparation with 10 international units. He was, however, grateful to the delegate of the United States of America for pointing out that the list should always be kept up to date.

Referring to the point made by the delegate of Bulgaria regarding other substances that should appear in the list, he reminded the Committee that some enzymes were included, but in addition there was a list of international chemical reference substances at the back of the publication on biological substances. If a product could be defined by chemical or physical means, it was no longer a biological substance which, by definition, had to be assessed for its activity and potency by biological tests. For example, many penicillins had been transferred from the list of biological substances to that of chemical reference substances. As regards the BCG freeze-dried vaccine, he pointed out that, for many years, BCG had been the only bacterial vaccine containing living organisms. Its potency was assessed by the viable count; no international unitage was assigned to it and there was therefore no place for it in the list of biological standards or international reference preparations.

In reply to the request by the delegate of Egypt for more information on the international standards, he said that about 15,000 international standards had been distributed in 1982 and just over 11,000 in 1983. Each one had been accompanied by an individual leaflet giving instructions on how the standard should be used and incorporating all background data on the establishment of the standard and the international unitage assigned to that product.

A question had been raised about the need for continuing to declare the activity of the biological standard in weight. He drew the attention of the Committee to List I and List II included in the annex to document A37/7.1 The weight of the substance in each ampoule continued to be declared under the heading "Form in which available", but a further column, headed "IU per ampoule", had been added. An attempt had thus been made to facilitate the use of international standards but no important information had been left out. Countries could continue to use the old notation, if they so wished. The new notation had not changed the biological activity or unitage assigned to the preparations in the ampoules.

---

1 Document WHA37/1984/REC/1, Annex 4.
The CHAIRMAN invited the Committee to consider the draft resolution on international standards and units for biological substances recommended by the Executive Board in its resolution EB73.R4.

The draft resolution recommended by the Executive Board in resolution EB73.R4 was approved.1

2. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM: Item 33 of the Agenda (continued)

Assistance to the front-line States, to Namibia and national liberation movements in South Africa, and to refugees in Africa: Item 33.4 of the Agenda (continued from the fifth meeting)

Consideration of a draft resolution

The CHAIRMAN recalled that earlier discussion of the item had been halted to enable consultation to take place between the sponsors of the draft resolution and other delegations in accordance with a proposal by the delegate of the United States of America.

Dr MALONE (United States of America) said that he understood that the sponsors of the draft resolution had been unable to reach agreement regarding the proposals put forward by the United States of America. His delegation considered that the draft resolution contained unnecessary political rhetoric, employing stronger terms than had appeared in a similar resolution in the previous year. He therefore called for a vote. He stated that the United States would vote against the draft resolution. In view of the position of the United States in strongly supporting assistance to the front-line States, he regretted that it had proved impossible to obtain a consensus on the draft resolution.

Mr SIMANI (Observer for the Pan Africanist Congress of Azania) said that, despite the lack of facilities at its disposal, the Pan Africanist Congress of Azania (PAC) was paying considerable attention to health problems in South Africa, where millions of Africans were being deprived of their health rights under the present system of government. South Africa was among the richest countries in the world, but its people were among the most undernourished. There was a high incidence of alcoholism among the African population, with its attendant ills of mental confusion, liver failure, cardiomyopathy and other diseases. The incidence of occupational diseases, infant mortality, respiratory infections and criminal abortions was also high among the African population.

Many Azanians were living in refugee camps around the world, where health conditions were deteriorating. Bronchopneumonia, in particular, was killing many children, while ignorance, superstition and the lack of medical facilities and personnel were also playing their part. Mental disorders, peptic ulcers, malnutrition and malaria were common.

PAC was anxious to cooperate with all persons and institutions interested in giving practical effect to health for all by the year 2000. For example, it had embarked on a campaign to discourage smoking within its ranks and had managed to place all medical workers in positions of responsibility. It greatly appreciated the work done by WHO and the assistance which the front-line States were providing, despite their economic difficulties. The support received from working people, particularly in Asia and Eastern Europe, was also appreciated.

It seemed unlikely that the goal of health for all would be achieved by the year 2000 if Azanians were still economically exploited, politically suppressed, socially degraded and deprived of their freedom. Similar considerations applied to the Palestinian people. PAC therefore urged that more support should be given to national liberation movements in southern Africa and elsewhere in the form of medical training, drugs, instruments and health education. PAC was in favour of any draft resolution designed to further the progress of mankind in health matters.

Dr BATCHVAROVA (Bulgaria) said that her delegation supported the work done by WHO to assist the front-line States, Namibia and national liberation movements and refugees in Africa. Her Government was extremely grateful to the Director-General for the action which he had taken in respect of the innocent Bulgarian citizens unlawfully detained by UNITA. Thanks to WHO and to a number of other international organizations the Bulgarian citizens

1 Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA37.27.
concerned would soon be returning to their homeland. It was to be hoped that, as a result of the assistance rendered by progressive society, such incidents would decrease in number and that, if they did occur, WHO would play an active role in resolving them.

Dr OULD HACEN (Mauritania) said that the international community had a duty to condemn the practices of South Africa and to furnish active support to the front-line States and to peoples struggling for their liberation. His delegation therefore wished to be included in the list of sponsors of the draft resolution.

The CHAIRMAN called for a show of hands in a vote on the draft resolution (see page 194) as requested by the United States delegate.

The draft resolution was approved by 77 votes to one, with 10 abstentions.1

Mr IVRAKIS (Greece) said that his delegation had voted in favour of the draft resolution because it had consistently supported resolutions designed to provide assistance to the front-line States in southern Africa, which had to make sacrifices in order to develop their health infrastructures. Nevertheless, his delegation wished to dissociate itself from the language used in the first preambular paragraph, which incorrectly described the situation in that part of Africa.

Mr PINTO DE LEMOS (Portugal) said that his delegation had voted in favour of the draft resolution in order to demonstrate its support for action to strengthen medical cooperation with the front-line States, since the international community had an urgent political and moral duty to eradicate apartheid. However, his delegation would have preferred a different wording in certain provisions of the draft resolution. His country would always contribute towards the search for a peaceful solution of the problems afflicting southern Africa and welcomed the encouraging developments that had recently taken place.

Miss VAN DRUNEN LITTEL (Netherlands) said that her delegation's vote in favour of the draft resolution had once again shown her Government's support for help for the front-line States, which it was assisting in health matters. Her delegation was, nevertheless, opposed to the use of the political terminology contained in the draft resolution, since the World Health Assembly should be a technical, and not a political, forum.

Mrs FUNES-NOPPEN (Belgium) said that her delegation had most unfortunately been obliged to abstain in the vote, although it was in agreement with the spirit and purpose of the draft resolution and although it had voted in favour of a similar resolution in 1983. On the present occasion, however, the sponsors had introduced, in the first preambular paragraph, terms which seemed irrelevant and conceptually inconsistent with international law.

Professor GIANNICO (Italy) said that his delegation endorsed those sentiments.

Miss RIDDELL (New Zealand) said that her country recognized the genuine problems faced by the front-line States in the field of health. It had accordingly voted in favour of the draft resolution, which set out a number of steps designed to alleviate those difficulties. However, the text of the draft resolution was not enhanced by the intrusion of extraneous political elements or immoderate language.

Mr BLAUROCK (Federal Republic of Germany) said that his delegation fully supported the provision of assistance to the front-line States and greatly regretted that it had not been possible to delete the political language used in the first preambular paragraph of the draft resolution. It was to be hoped that at future Health Assemblies a consensus would be reached and that such political terminology would not be incorporated in similar resolutions.

Mr BROCHARD (France) said that at the previous Health Assembly his delegation had voted in favour of a similar resolution. In the present instance, however, it had abstained because of the language used in the preamble.

Mr CAMPBELL (Australia) said that his delegation had voted in favour of the draft resolution because it strongly supported the humanitarian objective of providing assistance to the front-line States, in keeping with his Government's support for the health objectives

---

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA37.28.
of similar resolutions adopted at previous Health Assemblies and with his country's well-known abhorrence of apartheid. Nevertheless, like many other delegations, his delegation felt obliged to express its regret concerning the intrusion of political issues into the work of the Health Assembly in the form of the extraneous terminology used in the first preambular paragraph of the draft resolution just approved.

Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa: Item 33.5 of the Agenda (Document A37/18) (continued from the fifth meeting)

The CHAIRMAN drew attention to the following draft resolution sponsored by the delegations of Mauritania and Mozambique:

The Thirty-seventh World Health Assembly,
Recalling resolution WHA36.29 concerning the drought and famine in Africa;
Recalling the relevant resolutions of the various summit meetings of the Organization of African Unity;
Recalling resolution AFR/RC33/R8 of the Regional Committee for Africa;
Considering the persistence of the drought and famine in many African countries;
Considering that the drought-stricken countries are unable to overcome the consequences in the short term and must at the same time take preventive measures in preparation for further periods of drought;
Aware that most of the drought-stricken countries in Africa are among the least developed countries;
Noting the continuing efforts by the governments concerned to cope with the drought and its consequences in their countries;
Noting with satisfaction the efforts made by the Secretary-General of the United Nations and the Director-General of WHO to mobilize resources rapidly on behalf of the countries concerned;

1. THANKS the Director-General for his initiatives aimed at providing appropriate support for the countries affected by drought, famine and other natural disasters in Africa;
2. CALLS UPON Member States to continue their support for the countries concerned;
3. REQUESTS the Director-General to:
   (1) take the appropriate steps to strengthen the present support mechanisms in collaboration with the relevant agencies of the United Nations system, donor countries, and governmental and nongovernmental organizations in order to improve the support of the international community for the countries affected by drought and famine in Africa, in accordance with resolution WHA36.29;
   (2) submit a progress report to the Thirty-eighth World Health Assembly on the application of the present resolution.

Dr OULD HACEN (Mauritania) explained that for purely technical reasons it had not been possible to include among the sponsors the names of other delegations that had assisted with the drafting.

The gravity of the situation obtaining in many African countries had been recognized by WHO in resolution WHA36.29 and by the United Nations system as a whole. He hoped that the draft resolution before the Committee would be approved and that support for the drought-stricken countries would be increased in 1984, since in many affected countries the rainfall in 1983 had been even less than in 1982.

Dr LISBOA RAMOS (Cape Verde) stressed the importance of the draft resolution and requested that his delegation be included in the list of sponsors.

Mrs LUETTGEN DE LECHUGA (Cuba) said that the situation in the drought-stricken countries of Africa, with its concomitant food and health problems, was one of the most dramatic catastrophes currently facing the world. Her delegation therefore wished to be added to the list of sponsors.

Dr OUEDRAOGO (Upper Volta) said that his country was one of those which had been severely stricken by drought since 1973. Especial thanks were therefore due to the Director-General and to the Regional Director for Africa for WHO's regular support.
Since the revolution of August 1983 efforts to counter the drought in Upper Volta had been intensified. A national solidarity fund had been established, and all civil servants and legal and physical persons were providing sums with which to purchase food for the most disadvantaged sectors of the population. In April 1984 a water retention project had been launched to make it possible for a vast agricultural area to be irrigated. In all those activities the National Council of the Revolution was endeavouring to ensure that international aid constituted an additional input rather than an indispensable factor. His delegation wished to be added to the list of sponsors of the draft resolution.

Dr DE Vinatea Collins (Peru) said that in his country, too, serious droughts and floods had been experienced and that arrangements had been made for all civil servants to contribute part of their salaries to a fund set up to alleviate the effects. With that in mind his delegation wished to be added to the list of sponsors of the draft resolution.

Mr Shenkoru (Ethiopia) expressed his delegation's gratitude to that of Mauritania which had presented the draft resolution and to others which had expressed support for it and proposed, in the interests of consistency with resolution WHA36.29, that the title of the draft resolution should include the words "and famine-affected", thus reading "Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa". The African Region comprised many of the least developed countries of the world, as economic indicators made clear, and the African countries were faced with very serious problems arising from drought and famine. As persistent drought had affected the region for more than ten years, special emergency action had been called for, involving the mobilizing of international financial and technical assistance to alleviate the situation. WHO itself had undertaken tremendous efforts to alleviate both drought and famine in Africa, and he hoped it would continue to do so and that there would be general support for the draft resolution, of which his delegation wished to be listed as a co-sponsor.

Dr Konare (Mali) said that for over ten years the countries of the Sahel, individually and jointly, had regularly alerted international opinion to the implacable drought affecting them and to the continuing advance of the desert southwards. United Nations bodies and friendly countries had replied favourably to appeals by providing medical and food aid. Despite hopes for improvement, evidence showed that the damage caused was becoming increasingly serious and permanent, as the United Nations Secretary-General himself had seen on the occasion of his visit to Mali and other drought-stricken countries of the region. His delegation wished to be listed as a co-sponsor of the draft resolution.

Mr Ismail (Sudan) expressed his gratitude to the delegation of Mauritania, which had presented the draft resolution, and to other delegations expressing support for it, as well as to the Director-General of the Organization for his efforts to support those African countries faced with the problems arising from drought.

Sudan was one of those African countries severely affected by natural disaster, particularly by desertification and drought, and whose development had been impeded as a result. Efforts had been made nationally to assist the affected eastern, northern and western provinces, with a large part of the nation's modest resources being allocated to assist the populations there; nonetheless the problems caused by drought remained unsolved. Recent legislation had made provision for the setting-up of a national fund to alleviate the problems of drought and desertification and ensure a supply of basic foodstuffs and other basic provisions in affected areas.

The appeal made by African countries in Khartoum in November 1983 had highlighted the fact that 30% of the world's arable land could be affected by desertification and that half of it was in Africa alone. An appeal had been made to the international community to help in intensive measures to combat desertification and its direct threat to man, flora and fauna. It was hoped that environmental measures would be implemented within the framework of the Organization of African Unity, in collaboration with aid organizations, and that a plan to halt desertification would be established, also in collaboration with countries and organizations providing assistance in the affected areas. His delegation wished to be listed as a co-sponsor of the draft resolution and hoped that it would be unanimously approved.

Mr LO (Senegal) supported the comments made by the delegate of Mauritania in his presentation of the draft resolution. Senegal, like most affected countries, had been trying to introduce specific national measures to find appropriate solutions to the problems and had organized a vast movement of solidarity within the country on behalf of the most affected areas. However, national action alone had remained insufficient, and particular thanks must
therefore be expressed to the international community for its efforts. The United Nations Secretary-General had had occasion personally to visit the affected areas and had manifested his solidarity in a number of specific measures. Equally, the Director-General of WHO had undertaken sustained efforts in that direction.

The delegation of Senegal wished to be listed as a co-sponsor of the draft resolution.

Dr BARRE MUSSE (Somalia) said that his country was among those affected by the drought and his delegation therefore wished to be listed as a co-sponsor of the draft resolution.

Mr AOUN-SEGHIR (Algeria) said that since the adoption in 1974 by the United Nations General Assembly of the programme of action on the establishment of a new international economic order, which included a special programme for the most affected developing countries, there had been little change. Over half the world's population had no organized form of health care, 90% of women gave birth without any form of medical care being available, 450 million people were suffering from hunger and 2000 million were without drinking-water.

In Africa, and particularly in the Sahel, there was evidence of progressive deterioration in the food situation. Drought and implacable desertification and the diseases and deficiencies resulting from the environment situation were leading to alarming infant mortality rates and reduced life expectancy. At the most recent meeting of UNICEF, held in Rome, it had been estimated that famine was threatening 170 million children out of the 200 million children under 15 years of age in the whole of Africa. Infant mortality in Africa was the highest in the world, and 70% of Africans lived beneath the "absolute poverty" threshold. Rainfall in the Sahel had been decreasing since 1968 and the River Niger and Lake Chad were almost dry. The great drought of 1973 had caused the death of 100 000 people and three-and-a-half million animals.

The international community must act resolutely and rapidly in the face of such disasters. Although most of the affected countries were making courageous efforts to combat disease and hunger, they could not achieve the objectives of health for all by the year 2000 without increased multisectoral aid. While it was important to provide medical aid, parallel efforts must be made to attack the socioeconomic root causes. WHO had an important role to play within the framework of collaboration with other organizations by showing that, in the field of health, international development was an indivisible whole. The health situation of the affected population, like that of the population of the Third World as a whole, was the consequence of plurisectoral development. It was therefore essential for WHO, together with other international organizations, to embark on a vast integrated programme to achieve simultaneous economic agricultural and social development.

His delegation wished to be listed as a co-sponsor of the draft resolution.

Mr NKOMBA (Malawi) said that his delegation wished to be included as a co-sponsor of the draft resolution as a demonstration of its solidarity with its immediate neighbours in southern Africa, which in recent years had suffered the ravages of devastating and unprecedented dry weather, and with States in the Sahel.

Mr TANOH (Ghana) expressed his delegation's thanks to WHO and other international organizations for their assistance in 1983, when particularly severe drought had affected his country. Ghana had been suffering the effects of food shortages resulting from poor harvests for some years, but the situation had reached alarming proportions in that year when the drought had affected areas which had previously had reasonable rainfalls. There had been many deaths, particularly among children and old people; streams and rivers had dried up and water supplies to urban areas had been severely curtailed with resulting health and sanitation problems, and the situation had been compounded by the eviction of over a million Ghanaians from a neighbouring State. There had also been an acute energy crisis resulting from the fall in dam-water levels. Matters were improving only marginally; the coastal savanna belt and many parts of northern Ghana still had very little rainfall, and the incidence of morbidity and mortality resulting from malnutrition remained very high. Food, medical and other resources were overstretched and inadequate and the assistance of WHO and other international organizations was required. Conditions were equally bad in many other African States, and for that reason his delegation fully supported the draft resolution and hoped that it would be adopted and implemented without reservation.

Dr SYLLA (Guinea) said that his delegation appreciated the quality of the progress report by the Director-General in document A37/18. The African Region, which included the least developed countries in the world, was faced with a number of serious socioeconomic and health problems. Drought and famine were affecting an increasing number of countries each
year; it was no longer only the countries of the Sahel which were feeling the effects of the drought but also countries such as his own. His Government had taken measures, including measures for reafforestation and against bush fires, to avoid a worsening of the situation and of effects on agriculture and health. An earthquake occurring without scientific warning in the north of the country had caused over 250 deaths, and thousands had been injured. In that connection he thanked United Nations bodies, governmental and nongovernmental organizations which had provided moral and material aid to the population in the disaster area. Nonetheless, despite such aid the alarming decrease in rainfall and the still distressing plight of the earthquake victims would require continued assistance from the international community.

His delegation unreservedly supported the draft resolution, which logically followed on resolution APR/RC33/R8 adopted in Brazzaville in September 1983 by the Regional Committee for Africa.

The meeting rose at 11h00.
NINTH MEETING

Wednesday, 16 May 1984, at 14h30

Chairman: Dr E. YACOUB (Bahrain)
later: Dr N. ROSDAHL (Denmark)

1. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM: Item 33 of the Agenda (continued)

Emergency health and medical assistance to drought-stricken and famine-affected countries in Africa: Item 33.5 of the Agenda (continued)

The CHAIRMAN invited the Committee to pursue its consideration of the draft resolution submitted at the previous meeting.

Mr NDOBE (Lesotho) fully supported the draft resolution and said that his country wished to become one of its co-sponsors.

Dr BATCHVAROVA (Bulgaria) commented favourably on the assistance WHO was providing to drought-affected countries in Africa; the Organization should continue its support to the countries concerned. Her delegation consequently supported the draft resolution and wished to join the list of its sponsors.

Dr SUAREZ (Venezuela) said the draft resolution was fully justified on the grounds of social justice, humanitarian sentiments and international cooperation and assistance. The Venezuelan delegation therefore gave it its full support and wished to become one of its co-sponsors.

Dr CHIDEDE (Zimbabwe) said that as the representative of one of the African countries affected by drought in Africa, his delegation wished to join the list of sponsors of the draft resolution.

Mr MOHAMMAD (Nigeria) said that his delegation fully supported the draft resolution and wished to become one of its co-sponsors. Many countries in the West African subregion had not yet fully recovered from the devastating effects of the drought experienced in the mid-1970s. Since then other countries in eastern and southern Africa had also been affected by the continuous failure of the rains. Many millions of people were threatened with famine, thousands had died and much livestock had been lost. In Nigeria, for example, the drought was directly affecting over 10 states and its indirect impact was being felt throughout virtually the entire country. The drought, a natural phenomenon that had brought untold misery to the peoples of Africa, called for concerted and vigorous action on the part of the international community as a whole. The Director-General had appealed for appropriate steps to strengthen the measures in which many countries and agencies were already participating; it was vital that those efforts should be coordinated so that the people of the affected areas received maximum benefit from them.

Professor EKRA (Ivory Coast) said the Director-General was to be commended on his efforts to find solutions to the problems posed by the drought in Africa, which was disrupting social and economic conditions in the countries affected. The Ivory Coast made common cause with all countries suffering from the spread of the disaster. His delegation fully supported the draft resolution and wished to become one of its co-sponsors.

Dr LOCO (Niger) said that his country too was affected by the drought. His delegation consequently supported the draft resolution. He hoped it would not remain a dead letter but would be promptly followed by practical action and concrete commitment to the affected countries, and in particular to those of the Sahel.
The CHAIRMAN recalled that the delegate of Ethiopia had, at the previous meeting, proposed an amendment designed to bring the title of the draft resolution into line with that of resolution WHA36.29. There had been no objection to that proposal.

The draft resolution, as amended, was approved.1

2. UNITED NATIONS JOINT STAFF PENSION FUND: Item 34 of the Agenda

Annual report of the United Nations Joint Staff Pension Board for 1982: Item 34.1 of the Agenda (Document A37/19)

Mr FURTH (Assistant Director-General), introducing the item, said that document A37/19, which was presented to the World Health Assembly in conformity with the regulations of the United Nations Joint Staff Pension Fund, briefly highlighted the financial situation of the Fund and summarized the action taken by the Pension Board at its sessions in 1982 and 1983. Full details could be found in United Nations General Assembly document supplement No. 9 (A/38/9), copies of which were available to delegates. The only action to be taken by the Health Assembly was to note the status of operation of the Joint Staff Pension Fund, as indicated by its annual report for the year 1982 and as reported by the Director-General in the document before the Committee.

Decision: The Committee decided to recommend to the Thirty-seventh World Health Assembly that it note the status of the operation of the Joint Staff Pension Fund, as indicated by the annual report of the United Nations Joint Staff Pension Board for the year 1982 and as reported by the Director-General.2

Appointment of representatives to the WHO Staff Pension Committee: Item 34.2 of the Agenda (Document A36/20)

The CHAIRMAN pointed out that the item covered the usual designation of a member and an alternate member of the WHO Staff Pension Committee for a three-year term of office 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.

Apart from the decisions taken in 1976, 1979 and 1982 by the Health Assembly to designate one Health 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 Health Assembly on the WHO Staff Pension Committee and the United Nations Joint Staff Pension Board, it had been the practice of the Health 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 Health Assembly was therefore now invited to appoint one member and one alternate member for a period of three years, and it was suggested that the usual practice be followed. If that was agreed, nominations were invited for the appointment of a member and an alternate member from the Member States recently elected to designate persons to serve on the Executive Board, to replace the member of the Executive Board designated by the Government of Japan and the member of the Executive Board designated by the Government of Seychelles.

He called for nominations of a Member State entitled to designate a person on the Executive Board whose designee would be appointed a member of the WHO Staff Pension Committee to replace the member of the Executive Board designated by the Government of Japan.

Mr HAYASHI (Japan) nominated the Republic of Korea.

The CHAIRMAN called for nominations of a Member State entitled to designate a person on the Executive Board whose designee would be appointed an alternate member of the WHO Staff Pension Committee to replace the member of the Executive Board designated by the Government of Seychelles.

1 Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA37.29.

2 Transmitted to the Health Assembly in the Committee's third report and adopted as decision WHA37(12).
Mrs REVERA (Seychelles) nominated the Ivory Coast.

Dr SEBINA (Botswana) seconded that nomination.

Decision: The Committee decided to recommend to the Thirty-seventh World Health Assembly that it appoint the member of the Executive Board designated by the Government of the Republic of Korea as member of the WHO Staff Pension Committee, and the member of the Board designated by the Government of the Ivory Coast as alternate member of the Committee, the appointments being for a period of three years.¹

3. SECOND REPORT OF COMMITTEE B (Document A37/36)

Dr DA COSTA (Indonesia), Rapporteur, introduced the draft second report of Committee B.

The report was adopted (see document WHA37/1984/REC/2).

The CHAIRMAN said that the meeting would be suspended to permit the preparation of the draft third report of Committee B, relating to the items just dealt with.

The meeting was suspended at 15h05 and resumed at 15h40.

Dr Rosdahl took the Chair.

4. THIRD REPORT OF COMMITTEE B (Document A37/37)

Dr DA COSTA (Indonesia), Rapporteur, read out the draft third report of Committee B.

Mrs ZHEN Yun (China) expressed her country's objection to the nomination of the Republic of Korea to designate a member of the WHO Staff Pension Committee.

The CHAIRMAN said that that objection would be noted in the summary record of the meeting.

The report was adopted (see document WHA37/1984/REC/2).

5. CLOSURE

The CHAIRMAN thanked all concerned for their assistance and cooperation and declared the work of the Committee completed.

The meeting rose at 15h50.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as decision WHA37(13).
INDEX OF NAMES

This index contains the names of speakers reported in the present volume. A full list of delegates and other participants attending the Thirty-seventh World Health Assembly appears in document WHA37/1984/REC/1, pages 137-176.

ABBAS, A. SHERIF (Somalia), 44, 94, 140
ABDULLA, M. H. (United Arab Emirates), 46
ACOSTA, A. N. (Philippines), 57
ABDOU, A. E. (Djibouti), 118, 141
AJLOUNI, L. AL- (Jordan), Chairman, Committee A, 5, 8, 10, 13, 20, 21
ALWASH, S. H. (Iraq), Vice-President of the Health Assembly, 14
AMER, N. (Egypt), 223
AOUN-SEGHIR, A. (Algeria), 230
APAKAN, E. (Turkey), 191
ARAPAT, F. (Palestine Liberation Organization), 208
ARÉVALO YEPEZ, C. (Colombia), 220
ARNOLD, R. (International Federation of Pharmaceutical Manufacturers Associations), 110
ARRAYED, J. S. AL- (Bahrain), 218
ÅSLUND, A. (Sweden), 221
ASVALL, J. E. (Director of Programme Management, Regional Office for Europe), 79
AHADI, A. R. AL- (Kuwait), 5, 12, 13, 14, 15, 77, 82, 83, 84

BANKOWSKI, Z. (Council for International Organizations of Medical Sciences), 39
BARKER, R. (New Zealand), 173
BARRE MUSSIE, H. (Somalia), 230
BARRIOS, A. M. (Nicaragua), 52
BASSIOUNI, I. (Egypt), 193
BATCHVAROVA, S. (Bulgaria), 42, 223, 226, 232
BEHAR, M. (Guatemala), 64
BELLO, F. E. (Venezuela), 47, 63, 115
BELMONT, R. (United States of America), 67, 81, 85
BENADOUDA, A. (Algeria), 29
BENVASSINE, M. M. (Algeria), 127, 219
BERMÚDIZ, H. EL (Egypt), 30, 81, 90
BERTAN, M. (Turkey), 63
BISHT, D. B. (India), 43, 83
BLAURKO, G. (Germany, Federal Republic of), 197, 227
BOBAREVIC, D. (Yugoslavia), 181
DONNER, R. (International Federation of Health Records Organizations), 53
BONOW, G. M. (Brazil), 23
BORGOMO, J. M. (Chile), 12, 13, 16, 18, 23, 28, 112, 118
BOROTHO, N. T. (Lesotho), 41, 137
BOUSSOUKOU-BOUMBA, P. D. (Congo), Vice-President of the Health Assembly, 17, 18, 19
BOYER, N. A. (United States of America), 5, 8, 9, 16, 17, 18, 136, 135, 164, 167, 170, 171, 172, 175, 186, 189, 193, 197, 216
BRAKER, H. (German Democratic Republic), 38, 62
BRATKO, J. (Czechoslovakia), 216
BROCHARD, H. (France), 157, 167, 207, 227
BURGER, R. DE (Canada), 182, 196

CABRAL, A. J. R. (Mozambique), 34, 71, 179, 182, 197, 198
CAMPBELL, N. (Australia), 19, 227
CARUANA, J. (Malta), 132
CASCIANO, E. A. (Brazil), 137
CASTELLÓN, P. (Nicaragua), 168, 191, 196
CHAHAN, P. P. (India), 180, 207
CHETTY, K. S. (Seychelles), 175
CHIDEDE, O. S. (Zimbabwe), Chairman, Committee on Nominations, 232
CHIORI, C. T. O. (Nigeria), 38
CHOLLAT-TRAQUET, C. M. (Managerial Process for WHO Programme Development), 163, 165
CHRISTENSEN, I., Secretary, Committee B, 183, 218, 219
COHEN, J. (Advisor on Health Policy, Director-General’s Office), 142
CORNAY, I. (Switzerland), 101, 118, 137
COSTA, S. DA (Indonesia), Rapporteur, Committee B, 177, 234

DEPUTY DIRECTOR-GENERAL, 142
DIALLO, A. N. (Mali), 132
DIRECTOR-GENERAL, 7, 9, 10, 11, 17, 18, 19, 203, 218
DILAMINI, Z. M. (Swaziland), 172, 175
DOWSON, T. (representative of the External Auditor), 153, 164, 165
DOOL, L. J. VAN DEN (Netherlands), 59
DOWEK, E. (Israel), 204, 206, 217, 218, 221
DRUEN LITTEL, M. A. VAN (Netherlands), 227

EKRA, K. F. (Ivory Coast), 232
ÉLISÁ, L. (Hungary), 89, 223

FARAGUI, S. AL (Egypt), 212
FARRUGIA, E. C. (Malta), 191
FEKH, M. (Tunisia), 138
FERNANDEZ, M. (Sri Lanka), 50, 55, 101
FLOURY, B. (France), 148
FORCÁCS, I. (Hungary), 131
FORMICA, F. (Italy), 141
FUNES-NOPPEN, C. (Belgium), 227
FUNKE, W. W. (Assistant Director-General), 152, 158, 165, 166, 168, 169, 170, 171, 172, 173, 177, 178, 233

GALAHOW, E. V. (Union of Soviet Socialist Republics), 157, 164, 170, 179, 183, 224
GARCÍA GARCÍA, E. A. (Panama), 85
GARCÍA LORENZO, J. T. (Cuba), 178
GAUDICH, C. (Germany, Federal Republic of), 131
GECK, K. (Czechoslovakia), 224

- 235 -
<table>
<thead>
<tr>
<th>Name</th>
<th>Country/Region</th>
<th>Page(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUMJANEK CHAVES, V.</td>
<td>Brazil</td>
<td>196, 225</td>
</tr>
<tr>
<td>NWASINE, J.-B.</td>
<td>Rwanda</td>
<td>70</td>
</tr>
<tr>
<td>SADRIZADEH, B.</td>
<td>Iran, Islamic Republic of</td>
<td>26, 65</td>
</tr>
<tr>
<td>SAGHER, B. (Libyan Arab Jamahiriya)</td>
<td></td>
<td>57, 101</td>
</tr>
<tr>
<td>SAIF, A. AL-</td>
<td>Kuwait</td>
<td>10, 137</td>
</tr>
<tr>
<td>SAKKAF, K. AL-</td>
<td>Yemen</td>
<td>9, 12</td>
</tr>
<tr>
<td>SALLAMI, A. O. AL-</td>
<td>Democratic Yemen</td>
<td>115</td>
</tr>
<tr>
<td>SAMSON, R. J.</td>
<td>Netherlands</td>
<td>108, 147</td>
</tr>
<tr>
<td>SARRAG, M. S. AL</td>
<td>Sudan</td>
<td>31</td>
</tr>
<tr>
<td>SAVEL'EV, M. N.</td>
<td>Union of Soviet Socialist Republics</td>
<td></td>
</tr>
<tr>
<td>SAVINO, E.</td>
<td>Argentina</td>
<td>26, 66, 81, 83, 130</td>
</tr>
<tr>
<td>SARKINA, D. B.</td>
<td>Botswana</td>
<td>10, 17, 19, 168, 172, 175, 180, 183, 195, 197, 234</td>
</tr>
<tr>
<td>SEKERAMAYI, S. T.</td>
<td>Zimbabwe</td>
<td>5</td>
</tr>
<tr>
<td>SENAUDT, R.</td>
<td>France</td>
<td>67</td>
</tr>
<tr>
<td>SEPÚLVEDA, B.</td>
<td>Mexico</td>
<td>107</td>
</tr>
<tr>
<td>SHENKOHU, K.</td>
<td>Ethiopia</td>
<td>229</td>
</tr>
<tr>
<td>SIMANI, S.</td>
<td>Pan Africanist Congress of Azania</td>
<td>226</td>
</tr>
<tr>
<td>SOFO, I. (Niger)</td>
<td></td>
<td>73</td>
</tr>
<tr>
<td>SOKOLOV, D. A.</td>
<td>Union of Soviet Socialist Republics</td>
<td>194, 214</td>
</tr>
<tr>
<td>SONE, M. (Upper Volta)</td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>SONG Lienshong (China)</td>
<td>China</td>
<td>35, 59</td>
</tr>
<tr>
<td>SOTELO FIGUEIREDO, J. M.</td>
<td>Peru</td>
<td>50</td>
</tr>
<tr>
<td>SUAREZ, H. (Venezuela)</td>
<td></td>
<td>219, 232</td>
</tr>
<tr>
<td>SUFI, K. M.</td>
<td>Somalia</td>
<td>189</td>
</tr>
<tr>
<td>SYLLA, M. (Guinea)</td>
<td></td>
<td>52, 230</td>
</tr>
<tr>
<td>SYLLA, O. (Senegal)</td>
<td></td>
<td>49, 140</td>
</tr>
<tr>
<td>SZCZERBAŃ, J.</td>
<td>Poland</td>
<td>61, 84, 121</td>
</tr>
<tr>
<td>TAKAHASHI, S.</td>
<td>Japan</td>
<td>156</td>
</tr>
<tr>
<td>TANOH, E. C. (Ghana)</td>
<td>Ghana, Chairman, Committee on Credentials</td>
<td>230</td>
</tr>
<tr>
<td>TAPA, S. (Tonga)</td>
<td></td>
<td>177</td>
</tr>
<tr>
<td>TAPRI, M. (Kuwait)</td>
<td></td>
<td>193, 199, 213</td>
</tr>
<tr>
<td>TCHERKNAVORIAN-ASENBÄUER, A. (United Nations Industrial Development Organization)</td>
<td></td>
<td>111</td>
</tr>
<tr>
<td>THOMAS, G. (representative of the Executive Board)</td>
<td></td>
<td>154, 167, 170</td>
</tr>
<tr>
<td>TJOIN JAW CHONG</td>
<td>Suriname</td>
<td>85</td>
</tr>
<tr>
<td>TO VADEK, M. P.</td>
<td>Papua New Guinea, Vice-President of the Health Assembly</td>
<td>18</td>
</tr>
<tr>
<td>TOGBA, J. N. (Liberia)</td>
<td></td>
<td>33</td>
</tr>
<tr>
<td>Touati, H. (Algeria)</td>
<td></td>
<td>195, 209</td>
</tr>
<tr>
<td>Traoré, G. (Mali)</td>
<td></td>
<td>101</td>
</tr>
<tr>
<td>TSHABALALA, R. (Swaziland)</td>
<td></td>
<td>49, 61</td>
</tr>
<tr>
<td>UTHEIM, B. S. (Norway)</td>
<td></td>
<td>220</td>
</tr>
<tr>
<td>VAIDYANATHAN, C. R.</td>
<td>India</td>
<td>98, 118, 126</td>
</tr>
<tr>
<td>VERCNE SABOIA, G.</td>
<td>Brazil, Brazil</td>
<td>220</td>
</tr>
<tr>
<td>VIGNES, C.-H. (Legal Counsel)</td>
<td></td>
<td>6, 8, 9, 10, 12, 14, 17, 19, 174, 183, 190, 217</td>
</tr>
<tr>
<td>VINAYADE COLINS, J. DE</td>
<td>Peru</td>
<td>229</td>
</tr>
<tr>
<td>VIOLAKI-PARASKEVA, M.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VOORLÄNDER, H. (Germany, Federal Republic of)</td>
<td></td>
<td>180</td>
</tr>
<tr>
<td>WALSH, J. H. (Ireland)</td>
<td></td>
<td>63</td>
</tr>
<tr>
<td>WARD-BREW, K. (Ghana)</td>
<td></td>
<td>42, 65, 121</td>
</tr>
<tr>
<td>WARTENSLEBEN, A. VON (United Nations Conference on Trade and Development)</td>
<td></td>
<td>130</td>
</tr>
<tr>
<td>WESTERHOLM, B. (Sweden)</td>
<td></td>
<td>37, 64, 140, 146</td>
</tr>
<tr>
<td>WILLET, L. J. (Australia)</td>
<td></td>
<td>76</td>
</tr>
<tr>
<td>WILLIAMS, G. (Nigeria)</td>
<td></td>
<td>92, 110</td>
</tr>
<tr>
<td>WOLF, C. (German Democratic Republic)</td>
<td></td>
<td>182, 186, 196</td>
</tr>
<tr>
<td>XU Shouren (China)</td>
<td></td>
<td>196</td>
</tr>
<tr>
<td>ZAHIRNIA, J.</td>
<td>Iran, Islamic Republic of</td>
<td>14, 187, 189, 191, 215</td>
</tr>
<tr>
<td>ZHEN Yun (China)</td>
<td></td>
<td>17, 234</td>
</tr>
<tr>
<td>ZHI Junbo (China)</td>
<td></td>
<td>124</td>
</tr>
</tbody>
</table>

**INDEX OF NAMES**
INDEX OF COUNTRIES AND ORGANIZATIONS

This index lists the countries, organizations and bodies represented by the speakers whose names appear in the index on the preceding pages.

ALGERIA, 29, 60, 127, 195, 209, 219, 230
ARGENTINA, 45, 66, 219
AUSTRALIA, 19, 68, 76, 227
AUSTRIA, 68, 220

BAHRAIN, 52, 95, 218
BANGLADESH, 32, 59, 122
BELGIUM, 227
BOLIVIA, 188, 191
BOTSWANA, 10, 17, 19, 94, 117, 142, 149, 168, 172, 175, 180, 183, 193, 197, 234
BRAZIL, 23, 137, 196, 220, 225
BULGARIA, 62, 84, 96, 223, 226, 232
BURUNDI, 118, 141

CAMEROON, 6, 94, 166, 179
CANADA, 84, 85, 114, 182, 184, 196
CAPE VERDE, 199, 228
CHILE, 12, 13, 16, 18, 23, 28, 112, 118
CHINA, 17, 35, 59, 124, 196, 234
COLOMBIA, 188, 189, 220
CONGO, 17, 18, 19

COUNCIL OF INTERNATIONAL ORGANIZATIONS OF MEDICAL SCIENCES, 39
CYPRUS, 31, 98, 191
CZECHOSLOVAKIA, 53, 81, 84, 97, 106, 216, 224

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA, 30, 196, 210
DEMOCRATIC YEMEN, 115
DENMARK, 9, 11, 14, 15, 20, 21, 107
DJIBOUTI, 118, 141

EGYPT, 30, 81, 90, 193, 212, 223
EQUATORIAL GUINEA, 175
ETHIOPIA, 229

FINLAND, 221
FRANCE, 10, 67, 148, 157, 167, 207, 227

GHANA, 42, 65, 121, 230
GREECE, 220, 224, 227
GUATEMALA, 64
GUINEA, 52, 230
GUINEA-BISSAU, 75

HUNGARY, 89, 131, 223

INDIA, 43, 83, 98, 118, 126, 180, 207
INDONESIA, 46, 67, 177, 236
INTERNATIONAL FEDERATION OF HEALTH RECORDS ORGANIZATIONS, 53
INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS ASSOCIATIONS, 110
IRAN, ISLAMIC REPUBLIC OF, 14, 26, 65, 187, 189, 191, 215
IRAQ, 14, 51, 99, 180, 214
IRELAND, 63
ISRAEL, 35, 61, 204, 206, 217, 218, 221, 224
ITALY, 141, 198, 227
IVORY COAST, 232

JAPAN, 30, 62, 156, 223, 233
JORDAN, 5, 8, 10, 13, 20, 21

KENYA, 74, 94, 118, 131, 221
KUWAIT, 5, 10, 12, 13, 14, 15, 77, 82, 83, 84, 137, 195, 199, 213

LESOTHO, 41, 137, 232
LIBERIA, 33
LIBYAN ARAB JAMAHIRIYA, 57, 101

MALAWI, 230
MALAYSIA, 73, 132, 181
MALI, 101, 132, 229
MALTA, 17, 132, 191
MAURITANIA, 176, 186, 210, 227, 228
MEXICO, 51, 95, 107
MONGOLIA, 72, 215
MOZAMBIQUE, 34, 71, 179, 182, 197, 198

NEPAL, 45
NETHERLANDS, 59, 75, 108, 147, 227
NEW ZEALAND, 173, 220, 227
NICARAGUA, 52, 168, 191, 196
NIGER, 73, 232
NIGERIA, 13, 19, 38, 92, 110, 232
NORWAY, 114, 220

PAKISTAN, 209
PALESTINE LIBERATION ORGANIZATION, 208

PAKISTAN, 209
PALESTINE LIBERATION ORGANIZATION, 208
PAN AFRICANIST CONGRESS OF AZANIA, 226
PANAMA, 85
<table>
<thead>
<tr>
<th>Country</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua New Guinea</td>
<td>18</td>
</tr>
<tr>
<td>Peru</td>
<td>50, 229</td>
</tr>
<tr>
<td>Philippines</td>
<td>57</td>
</tr>
<tr>
<td>Poland</td>
<td>61, 84, 120</td>
</tr>
<tr>
<td>Portugal</td>
<td>220, 227</td>
</tr>
<tr>
<td>Qatar</td>
<td>70, 133</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>19, 48, 68</td>
</tr>
<tr>
<td>Rwanda</td>
<td>70</td>
</tr>
<tr>
<td>Senegal</td>
<td>49, 140, 172, 175, 176, 181, 199, 208, 229</td>
</tr>
<tr>
<td>Seychelles</td>
<td>175, 234</td>
</tr>
<tr>
<td>Somalia</td>
<td>44, 93, 140, 189, 230</td>
</tr>
<tr>
<td>Spain</td>
<td>41, 97, 116</td>
</tr>
<tr>
<td>Special Committee of Experts Appointed to Study the Health Conditions of the Inhabitants of the Occupied Territories in the Middle East</td>
<td>201</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>50, 55, 101, 106</td>
</tr>
<tr>
<td>Sudan</td>
<td>31, 229</td>
</tr>
<tr>
<td>Suriname</td>
<td>85</td>
</tr>
<tr>
<td>Swaziland</td>
<td>49, 61, 172, 175</td>
</tr>
<tr>
<td>Sweden</td>
<td>37, 64, 140, 146, 221</td>
</tr>
<tr>
<td>Switzerland</td>
<td>101, 118, 119, 137</td>
</tr>
<tr>
<td>Tonga</td>
<td>177</td>
</tr>
<tr>
<td>Trinidad and Tobago</td>
<td>56, 118, 179, 183, 186</td>
</tr>
<tr>
<td>Tunisia</td>
<td>56, 138</td>
</tr>
<tr>
<td>Turkey</td>
<td>43, 191</td>
</tr>
<tr>
<td>Uganda</td>
<td>92</td>
</tr>
<tr>
<td>Union of Soviet Socialist Republics</td>
<td>17, 26, 66, 81, 83, 130, 157, 164, 170, 179, 183, 194, 214, 224</td>
</tr>
<tr>
<td>United Arab Emirates</td>
<td>46</td>
</tr>
<tr>
<td>United Kingdom of Great Britain and Northern Ireland</td>
<td>7, 10, 14, 17, 25, 69, 87, 127, 137, 154, 165, 172, 174, 175, 178, 179, 182, 223</td>
</tr>
<tr>
<td>United Nations Conference on Trade and Development</td>
<td>130</td>
</tr>
<tr>
<td>United Nations Industrial Development Organization</td>
<td>111</td>
</tr>
<tr>
<td>United Nations Relief and Works Agency for Palestine Refugees in the Near East</td>
<td>202</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>29, 139</td>
</tr>
<tr>
<td>United States of America</td>
<td>5, 8, 9, 16, 17, 18, 36, 67, 81, 85, 128, 134, 148, 155, 164, 167, 168, 170, 171, 172, 175, 186, 189, 193, 197, 216, 222, 226</td>
</tr>
<tr>
<td>Upper Volta</td>
<td>48, 228</td>
</tr>
<tr>
<td>Uruguay</td>
<td>10, 11, 18</td>
</tr>
<tr>
<td>Venezuela</td>
<td>47, 63, 115, 219, 232</td>
</tr>
<tr>
<td>World Federation of United Nations Associations</td>
<td>56</td>
</tr>
<tr>
<td>Yemen</td>
<td>9, 12</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>47, 81, 86, 87, 96, 181</td>
</tr>
<tr>
<td>Zambia</td>
<td>138</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>5, 70, 125, 232</td>
</tr>
</tbody>
</table>